Abstract  This chapter provides a synthesis of the health care jurisprudence that has been laid down through litigations in various intersecting domains of health care in the post-independence period. The foundations of health care jurisprudence were first laid down through litigations related to environmental justice, workers’ rights, civil liberties, and tort jurisprudence in India. Applying these foundational principles, the health care jurisprudence further evolved through subsequent litigations in key health care domains—viz. emergency medical care; drugs and medicines; reproductive and maternal health care; health care of children; mental health care and rights of persons with psychosocial disabilities; rights of persons living with HIV/AIDS; health care entitlements and elite government employees; patient rights and medical profession (medical negligence); and, litigations on the issues of public health and health care health services. Both the foundational jurisprudential principles as well as the health care jurisprudence crystallised through ten subdomains of health care, unpack the gains and challenges such processes entailed over five decades in India.

Society is guilty if anyone suffers unjustly (V.R. Krishna Iyer, J.)

Judicialisation of health care or the phenomenon of citizens accessing courts for better health care services is noted as an increasing trend in many developing economies (Yamin and Gloppen 2011). In India, adjudication on matters concerning health and health care became possible through a two-fold reform process in courts, especially in the 1970s and in the subsequent decades. One, increased access to higher judiciary of SCI and HCs of India through a liberal interpretation of the Articles 32 and 226 of the Constitution of India for fundamental rights violations; two, the expanded interpretation of the right to life articulated in article 21 to include right to health and health care.

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1Interview to Disability News and Information Service at the occasion of the new year (2005).
3.1 Health Care System Insights Through Litigations

The jurisprudence summarised in this chapter is based on the analysis of 401 case-laws including ongoing litigations selected through keyword search in the legal portals, references through interviews and cross-referencing through literature and case-laws. Fifty-two percent (207) litigations were in the domain of SCI and 48 percent (194) were in HCs and other judicial domains such as Central Administrative Tribunals, Patent Controller’s Office, and Consumer Redressal Commissions (Fig. 3.1).

The HC+ category of cases include a major portion in 18 HCs (162), and 32 litigations from other judicial/quasi-judicial domains such as National Human Rights Commission (3), National Consumer Disputes Redressal Commission (22), Central Administrative Tribunal (3), Controller of Patents (2), and Lokayukta (2) (Vide. Fig. 3.2).

The 162 HC litigations are distributed across 18 HCs covering the jurisdiction of 22 states (Table 3.1).

It was found that 38 case-laws had more than one strong and overlapping theme (for example: civil liberties and emergency medical care, environmental cases and health, and the like) and they are considered for analysis in two thematic domains (for example: medico-legal cases and reproductive health). This makes a total of 439 cases considered for thematic analysis of various domains related to health care (Fig. 3.3).

Thematic Distribution and Analysis

Analysis followed a five-step process using the concept of ‘case congregation’ along with thematic and content analysis.

1. Categorisation of 439 litigations into 14 thematic domains (Fig. 3.3)

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2Supreme Court Legal Aid Committee v. State of Bihar (1991) 3 SCC 482.
3.1 Health Care System Insights Through Litigations

Fig. 3.2  Distribution of litigations by non-supreme court judicial domains ($n = 194$). Source Author

2. Subcategorisation into two overarching themes: viz. four constitutional rights constituencies (78) and ten health care system constituencies (361)

3. Clustering of the health care constituencies into four core-themes:

- Basic health care services (emergency health care and drugs and medicines)
- Vulnerable populations/groups\(^3\) and SRHC (people with psychosocial disabilities, reproductive and maternal health care, people living with HIV/AIDS, and children)
- Health care of social elites\(^4\) and patient rights (medical negligence related to health care in private health institutions negligence and medical care claims of government employees of higher ranks)
- Public health care system issues\(^5\) (public health care system and public health measures).

\(^3\)These four categories of populations are categorised as ‘vulnerable group’ on the commonality of two key elements that render them vulnerable—(1) they need health and related care as a basic necessity; and (2) they are absolutely dependent on the health care provided by the State, as most of these litigations refer to the socially disadvantaged groups.

\(^4\)The phrase ‘Social Elites’ is used to demarcate two categories of people vis-a-vis the poor and vulnerable who absolutely are dependent on public health care system, viz. (1) middle and upper middle classes who could choose private commercial health care on account of the capacity to pay and (2) Government servants/bureaucrats of higher ranks whose health care expenses are taken care of the Government of India.

\(^5\)Litigations around two themes, viz. (1) those concerning institutions, infrastructure and services (and not individuals) and, (2) issues such as helmets, tobacco, junk food etc. are clubbed into this cluster. Clustering them into one is done also is driven by the logic of convenience.
Table 3.1 Distribution of litigations by high court location

| State (location of the litigation) | High Court | No. of Litigations |
|-----------------------------------|------------|--------------------|
| Maharashtra                      | Bombay     | 33                 |
| Goa                              |            |                    |
| Rajasthan                        | Rajasthan  | 7                  |
| Madhya Pradesh                   | Jabalpur   | 6                  |
| Odisha                           | Odisha     | 3                  |
| Uttar Pradesh                    | Allahabad  | 11                 |
| Andhra Pradesh                   | Andhra Pradesh | 15           |
| Gujarat                          | Gujarat    | 2                  |
| Kerala                           | Kerala     | 6                  |
| Tamilnadu                        | Madras     | 12                 |
| Haryana                          | Punjab & Haryana | 8           |
| Punjab                           |            |                    |
| West Bengal                      | Kolkata    | 4                  |
| Tripura                          | Guwahati   | 4                  |
| Nagaland                         |            |                    |
| Assam                            |            |                    |
| Delhi                            | Delhi      | 30                 |
| Bihar                            | Patna      | 7                  |
| Karnataka                        | Karnataka  | 11                 |
| Chattisgarh                      | Chattisgarh | 1               |
| Sikkim                           | Sikkim     | 1                  |
| Uttaranchal                      | Utranchal  | 1                  |
| **Total:**                       | 22         | 18                 | 162

Source: Author

4. Categorising case-laws and petitions in a judicial hierarchical order (i.e. SCI, HC and other) within each theme, followed by organising all orders in each of these categories in a chronological sequence on the basis of the date of judgments.  

5. Thematic and content analysis of each thematic domain (organised and arranged in terms of hierarchy of legal institutions and chronological sequence), to sift out the jurisprudential principles emerging in each of these themes.

The section *Constitutional Rights* outlines the foundational principles or building blocks that form the base of health care jurisprudence. The section *Domains of Health Care Litigations* examines the application of the basic jurisprudence to various

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6The date of judgment does not necessarily correspond to the chronological sequence of the incident due to the nature of the courts in dealing with the issues, the time the petition has taken to reach its finality etc. However, there is no way to verify the date of incident in most of the cases, and the date of judgment provides a standard to follow.
3.1 Health Care System Insights Through Litigations

Fig. 3.3 Distribution of litigations by thematic domains \((n = 439)\). Source Author

health care domains, thus furthering and consolidating the health care jurisprudence simultaneously incorporating any new principles that might have evolved during such a process in the domains of HCs. A time period trend indicates most litigations being in the post-1990 era where radical economic reforms were undertaken in India including becoming signatory to the World Trade Organisation (WTO) led TRIPS agreement. (Fig. 3.4)

3.2 Constitutional Rights and the Foundations of Health Care Jurisprudence

Three of the four key themes under this section, viz. right to a healthy environment, workers’ right to health, civil liberties, and medico-legal issues of prisoners and arrestees, correspond directly to the respective spheres of social movements and civil society struggles in the 1970s and 1980s, viz. environmental movement, workers’ movements, and civil rights movement. The fourth theme, i.e. tort jurisprudence, a weakly evolved branch of law in India, synthesises the jurisprudence relating to damages and compensation imposed by the constitutional courts responding to these social movements. Such measures aim at fixing the accountability of the State and its instrumentalities to pressing issues affecting their right to life. Notably, social or mass movements were primarily a civil society response to immense human suffering that was caused in the society at large, its manifestation in specific sectors, and to the State Apathy that exacerbated it.

A closer reading of these litigations suggests that a major portion of PILs echo the suffering and human rights violations of the masses (among others, represented in this book by workers, women, children and prisoners), and were stimulated by the ethos of civil society or mass movements demanding State accountability. The litigations
Fig. 3.4 Distribution of health care litigations by time-periods ($n = 401$). Source: Author
3.2 Constitutional Rights and the Foundations of Health Care Jurisprudence

Fig. 3.5 Constitutional rights constituencies and distribution of litigations by judicial domains ($n = 78$). Source Author

by civil society organisations such as Consumer Education and Research Centre (CERC), Rural Litigation and Entitlement Kendra (Dehradun) and social movements such as Bandha Mukti Morcha that advocated for the liberation of workers and bonded labourers, reflect the civil society ethos of this era.

Of the 78 case-laws considered for this section, 67 percent (53) were adjudicated in the SCI and 33 percent (25), in HCs of 14 states. HCs played a paramount role in consolidating the health care jurisprudence while dealing with matters intersecting with health and medical care (Fig. 3.5).

3.2.1 Environmental Rights Litigations and Health Care Jurisprudence

Article 47 (Public health) as the Principle of Constitutional Governance

The first historical petition on environmental issues—Municipal Council, Ratlam v. Vardichandand others—(hereafter, Ratlam case)—was filed by a citizen in public interest as a quasi-criminal petition under section 133 of CrPC against a municipality (Box 3.1). It sharply focuses on public health issues sanitation. It also invoked

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7 Municipal Council Ratlam v. Vardichandand others, AIR 1980 Supreme Court 1622; 1980 CriLJ 1075.
An Overview of Health Care Jurisprudence in India

section 123 of the Municipality Act which imposes the duty on the statutory body to (1) (b) cleaning public streets to abate public nuisances and section 188 of Indian Penal Code (IPC) 188 that imposes penalty for disobeying directions. It reached the SCI as an appeal against the HC order, during the normal course of its adjudicatory procedure that had begun at the court of sessions. The SCI order, among other directives, declared ‘public health as the principle of governance’ and part of the constitutional duty binding the municipality.

**Box 3.1 Facts of Ratlam Case**

Pollutants from an alcohol factory were let out in the open drains and were overflowing, causing public nuisance. Across the open drains, the bridge had not been built by the municipality for long. A citizen challenged the Municipality for allowing the public nuisance to continue in the court of law using the Municipality Act in the district sessions court which favoured the complainant. As the Municipality of Ratlam appealed against each and every order of the court at every stage, first in the HC and then in the SCI, the relatively unknown petition landed in the constitutional court through the normal course of a criminal litigation.

This judgment historically marks the beginning of invoking law and legal provisions for issues of health and public health. The imprint of jurisprudential acumen of Justice Krishna Iyer along with Justice P. N. Bhagwati is visible in crafting the landmark judgment. Being one of the earliest litigations, it laid the foundation for subsequent environmental litigations and became the cornerstone of the environmental movement and public interest cause in India.

In this petition, public health was propounded as the main basis to highlight public nuisance of ‘pollution’ and the negligence of the municipality to take appropriate remedial action. The order makes an important link between the duties of the public bodies towards citizens as part of public law and the power of the court to enforce such actions for the good of the community while doing away with the procedural issues of the traditional legal process. Public Health is laid down as the paramount principle of constitutional governance. The jurisprudence laid down in this order emphasises that (1) Procedural justice, access to justice and duty of public bodies to uphold public health are a part of the social justice; and (2) Article 47 of the Indian Constitution is reinforced as paramount principle of governance for improvement of public health.
Several HCs of India followed the principle of the primacy of Article 47 as the principle of governance and applied it to order complete free medical care, rehabilitation and monetary compensation in the fluorosis issue. Relating to public health governance, SCI also laid down the doctrine of preserving public health as ‘the public duty of the public authorities’, which is categorically stated in Ratlam Case (Para 14) as follows:

[a] responsible municipal council constituted for the precise purpose of preserving public health and providing better finances cannot run away from its principal duty by pleading financial inability. Decency and dignity are non-negotiable facets of human rights and are a first charge on local self-governing bodies.

In a similar vein, the raison d’etre of public health and health care was strongly argued in the issue of banning mining in Aravalli hill range.

Right to ‘Healthy Environment’

The petition Rural Litigation Entitlement Kendra (RLEK) v. State of Uttar Pradesh is considered as the one that pioneered environmental PILs in the country. In this petition, limestone quarry mining was alleged as the cause of bonded labour practised in quarries, in addition to the ecological degradation affecting crops and quality of air. The SCI reiterated that ‘right to live in a healthy environment’ as an integral part of right to life. In subsequent petitions, based on this jurisprudential principle, right to health was pronounced to include freedom from noise pollution and environmental damage and controlling pollution was stated as the State obligation. The international principles of sustainable development enunciated in the Stockholm Declaration and the principle of right to a healthy environment are applied in enunciating this jurisprudence. An evolved and mature jurisprudence was laid down in Virender Gaur v. State of Haryana in the mid-1990s. It states:

Article 21 protects the right to life as a fundamental right…Therefore, a hygienic environment is an integral facet of right to healthy life and it would be impossible to live with human dignity without a humane and healthy environment.

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8Citizens Action Committee, Nagpur v. Civil Surgeon, Mayo (General) Hospital, Nagpur and Ors AIR 1986 Bom 136; Siromani Mithasala v. President, Brindavanam Colony 2002 (1) ALD 136; 2002 (2) ALT 356; L. K. Koolwal v. State of Rajasthan and Ors. AIR 1988 Raj 2; 1987 (1) WLN 134; Prasanta Kumar Rout, Orissa Law Reviews v. Government of Orissa, Represented by Secretary, Urban Development Department and Others 1994 II OLR 444; Suo-moto v. State of Rajasthan AIR 2005 Raj 82; RLW 2005 (2) Raj 1437.

9Hamid vs. State of M.P AIR 1997 MP 191.

10M. C. Mehta v. Union of India (2009)6 SCC 142.

11Rural Litigation Entitlement Kendra (RLEK) Dehradun and Others v. State of Uttar Pradesh and Others (1985) 2 SCC 431, para 179–180.

12Farhad K. Wadia v. Union of India (2009) 2 SCC 442.

13A. P. Pollution Control Board II v. Prof. M. V. Nayudu (2001) 2 SCC 62.

14Virender Gaur v. State of Haryana, (1995) 2 SCC 377, Paragraph 25.
In an unusual case, which was later set aside for not being in public interest, the SCI further qualified the right to live in a healthy environment as essential for the ‘quality of life’. However such a reasoning provided additional wherewithal that was required to investigate similar issues. Under the environmental jurisprudence, allotment of public lands to private bodies such as medical trust for constructing hospital and a Dharmshala were ruled as violating the enhancement of the quality of life.

**Principle of ‘Absolute Liability’**

Subsequent to the Bhopal gas tragedy, in a similar incident of oleum gas leak, the issue of the private corporations’ liability for the health of the public was sharply raised in the SCI. The principle of ‘absolute liability’ that the SCI developed, declared that even the private corporations were liable to pay compensation. This was reinforced over and above an already existing principle of ‘strict liability’ applied to the ‘State and instrumentality of the State’. The principle of absolute liability implying that the corporation ‘owes an absolute and non-delegable duty to the community to ensure that no harm results to anyone on account of the hazardous or inherently dangerous nature of the activity which it has undertaken’ and ‘indemnifies all those who suffer on account of carrying on such hazardous or inherently dangerous activity regardless of whether it is carried on carefully or not’. Here, ‘reasonable care’ is not admitted as a defence. The principles of public duty and absolute liability, along with Article 47 as the principle of governance, formed a body of reciprocating jurisprudential principles, which subsequently were applied in several landmark environmental cases such as Ganga Water Pollution Case.

Employing the principle of ‘people’s right to live in healthy environment’, civil society actors continued to file several municipal law-based litigations in the HCs of several states. HCs in turn deepened the jurisprudence laid down by the SCI by unequivocally reinforcing the principle of public duty of safeguarding public health.

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15Subhash Kumar v. State of Bihar, AIR 1991 SC 420, 1991 SCR (1) 5, para 13.
16Bangalore Medical Trust v. B.S. Muddappa, [1991] 4 SCC 54.
17Virender Gaur v. State of Haryana.
18M.C. Mehta v. Union of India and Ors (Oleum Gas Case 3) 1987 SCC (1) 395.
19For the purposes of enforcing fundamental rights against them, as enunciated in the five criteria enunciated in R. D. Shetty v. Airport Authority of India (1979) 3 SCR 1014). That included (1) Financial assistance given by the State and magnitude of such assistance (2) any other form of assistance whether of the usual kind or extraordinary (3) control of management and policies of the corporation by the State-nature and extent of control (4) State conferred or State protected monopoly status and (5) functions carried out by the corporation, whether public functions closely related to government functions.
20Extending the principle of strict liability in Rylands v. Fletcher (L.R. 3 H.L.330), the Court, for the first time, enunciated the principle of absolute liability of corporations when they undertake hazardous and dangerous activity.
21M. C. Mehta v. Union of India and Ors (1987) 1 SCR 819, pg. 843.
22M. C. Mehta v. Union of India (Kanpur Tanneries) 1988 SCC (1) 471; also M. C. Mehta v. Union of India & ors., (1987) 4 S.C.C. 463.
as an absolute constitutional obligation of the State and public bodies. In *Gujarat Ambuja Cements Ltd. v. Chavi Raj Singh*, the appellant (cement factory) was asked to foot the medical bills of the villagers affected by tuberculosis (TB) and asthma in villages in and around the cement factory.

**Doctrine of ‘Minimum Condition of Public Health’**

In the case of the deaths of 12 children in 1991/92 due to cholera in the Pardi Mohalla of Gwalior city of Madhya Pradesh, a public spirited doctor’s litigation led to further consolidating the jurisprudence of public health governance. The court reiterated that the State is obligated to ‘provide at least the minimum conditions ensuring human dignity’ and the right to life with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition.

The environmental jurisprudence paved the way for establishing the fundamental health care jurisprudence laying down Article 47 as the principle of constitutional governance and ably integrating it with personhood jurisprudence enshrined in Article 21. In the same stroke, it established the ‘absolute duty’ of the public bodies to uphold and enforce Article 47. This is an important breakthrough in making health care justiciable. Legal experts have noted that the right to health as a fundamental right grew as an offshoot of environmental litigations initiated by environmental activists and that the judicial recognition of the right to ‘healthy environment’ in India preceded that of the right to health care (Desai and Chand 2007).

### 3.2.2 Workers’ Right to Health and Medical Care

Injuries, diseases, and mortality are closely associated with the occupational health issues of workers. The worker’s charter of rights includes social security, with health care being one of their key demands. The mandate for the social security of the workers in India is laid out in Articles 39 (e), 42 and 43 of the Constitution of India, with a prime focus on the promotion of the health of the workers (Government of

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23 Citizens Action Committee, Nagpur vs. Civil Surgeon, Mayo (General) Hospital, Nagpur and Ors AIR 1986 Bom 136; Corporation of the City of Nagpur v. Nagpur Electricity Light and Power Co AIR 1953 Bom 498; Dr. K. C. Malhotra v. State of MP and Others AIR 1994 MP 48; Citizens and Inhabitants of Ward No. 17, Municipal Corporation, Gwalior v. Municipal Corporation, Gwalior, 1992 (1) MPJR 93.

24 Gujarat Ambuja Cements Ltd. v. Chavi Raj Singh (2007) 15 SCC 632.

25 Dr. K. C. Malhotra v. State of MP and Others AIR 1994 MP 48.

26 Vikram Deo Singh Tomar v. State of Bihar, AIR 1988 SC 1782.

27 Francis Coralie Mullin v. Administrator, Union Territory of Delhi, AIR 1981 SC 746, (1981 Cri LJ 306 (Paragraph 7).

28 In this book, the concept of workers includes all citizens in the informal as well as formal sectors of economy. When not qualified as formal and organized sectors, it primarily means workers in the informal and unorganized sectors.
India and India.gov.in—National Portal of India n.d.). Though there is no substantially aggregated governmental data that is available on health conditions of workers, Leigh et al. (1999) estimate an annual incidence of occupational diseases that range between 924,700 and 1,902,300 in India, and about 121,000 annual deaths. Given the sheer volume of the unorganised and informal workforce, even such a calculation appears to be an underestimate. In 2007, the National Commission for Enterprises Among Unorganised Sector (NCEUS) categorised 77 percent of the population, constituting 92 percent of the workforce in the country, as informal and not having any social security (Government of India—NCEUS 2007).29 Notably, the PILs that were brought before the SCI reflected the pitiable plight of workers in the 1980s, 1990s and early years post-2000. They point to an irrefutable gaping hole that exists in providing them adequate health care as part of the much-needed social security. The issue of health care that is raised in these petitions, is a commentary on their working conditions and the lamentable status of their social security of workers especially in the informal and unorganised sectors even today. In contemporary times, the neglect of the wellbeing of informal sector workers became starkly visible in their plight during the COVID19 related lockdown in India that was imposed in view of the coronavirus.30 The jurisprudence laid down on the issue of health and medical care has the potential to strengthen the social security of workers.

Right to Medical Care as a Fundamental Right

The prime contributors to this jurisprudence are P. N. Bhagwati, V. R. Krishna Iyer and K. Ramaswamy, JJ. They infused social justice interpretation of the constitution in referring to litigations on workers’ rights that were primarily filed as PILs, raising the issues of constitutional rights of workers. Two petitions, i.e. Asiad Construction Workers Case (PUDR v. Union of India 1982) and the bonded labour case (Bandhua Mukti Morcha v. Union of India 1984) were admitted in the SCI in its ‘epistolary jurisdiction’, i.e. simple letters addressed to the court on conditions of workers that were admitted as PILs. Regional Director, E.S.I Corporation v. Francis De Costa and Another31 [henceforth, ESI corporation case] crisply summarises the essence of social rights jurisprudence stating that ‘Right to medical benefit is, thus, a fundamental right to the workman’.

Right to health to include medical care was pronounced as a fundamental right in this case by the division bench. Subsequently, a three-judge bench in Confederation of Ex-Servicemen Associations v. Union of India32 declared as a fundamental right, the right to health and medical aid to workers, both during as well as after the service.

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29This report by the National Commission for Enterprises Among Unorganised Sector 2007 has startling statistics on the unorganized sector, was not made public and was removed from the government website within a few days of its publication.

30The newspapers and online portals, starting from 23 March 2020, carried innumerable stories of over 150 million migrant workers, who were stranded in cities and highways, facing hunger and death, disease and denial of care, police brutality and inhuman living conditions.

31Regional Director, E.S.I Corporation v. Francis De Costa And Anr1992 SCR (3) 23; 1993 SCC Supl. (4) 100; JT 1992 (3) 332; 1992 SCALE (1)1083.

32Confederation of Ex-Servicemen Associations v. Union of India (2005) 13 SCC 265.
3.2 Constitutional Rights and the Foundations of Health Care Jurisprudence

In Pradip Chandra Parija v. Pramod Chandra Patnaik\(^{33}\) a five-judge bench, and later in Central Board of Dawoodi Bohra Community & Anr. v. State of Maharashtra\(^{34}\) [Dawoodi Bohra case], a seven-judge bench, affirmed and upheld the same.

Right to Health as Integral to the ‘Meaningful Right to Life’

The principle of ‘meaningful right to life’ further qualified and fortified the personhood jurisprudence in the judgment in Consumer Education & Research Centre v. Union of India (henceforth, CERC case, Box 3.2).\(^{35}\) This case unequivocally states:

> Therefore, we hold that right to health, medical aid to protect the health and vigour to a worker while in service or post retirement is a fundamental right under Article 21, read with Articles 39(e), 41, 43, 48A and all related Articles and fundamental human rights to make the life of the workman meaningful and purposeful with dignity of person (Paragraph 27).

Meanwhile, in another special leave appeal, in Kirloskar Brothers Ltd. V. Employees’ State Insurance Corporation\(^{36}\) [henceforth, Kirloskar Brothers case], jurisprudence reinforced that medical facilities and health insurance as fundamental rights of workers. Linking health and social justice, in L.I.C. of India and Another v. Consumer Education and Research Centre and Others,\(^{37}\) the court very strongly asserted that India was a welfare-state and every action of the State should be a step towards establishing socio-economic justice.\(^{38}\)

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Box 3.2 International Linkages of Occupational Health Jurisprudence in CERC case

CERC case is one of the first litigations which covered the health issues of workers in the asbestos industry, comprehensively. This case was seriously argued with the background of international conventions leading to a landmark jurisprudence in occupational health. Though in the previous petitions health was one of the grounds for granting relief and medical facilities, in the CERC case the health of the workers in asbestos industries suffering from and vulnerable to ‘asbestosis’ became the most important concern. SCI leaned heavily upon the ‘Asbestos Convention 1986’ which was adopted in the 162\(^{\text{nd}}\)

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\(^{33}\)Pradip Chandra Parija v. Pramod Chandra Patnaik (2002) 1 SCC 1.

\(^{34}\)Central Board of Dawoodi Bohra Community & Anr. v. State of Maharashtra & Anr, (2005) 2 SCC 673.

\(^{35}\)Consumer Education & Research Centre v. Union of India (1995) 3 SCC 42.

\(^{36}\)Kirloskar Brothers Ltd. V. Employees’ State Insurance Corporation, (1996) 2 SCC 682.

\(^{37}\)L.I.C. of India and Anr. v. Consumer Education and Research Centre and Ors. 1995 SCC (5) 482.

\(^{38}\)The Court invoked, amongst others, Articles 14 (right to equality), 21 (right to life), 38 (directive principle establishing the welfare nature of the state), 39 (right to livelihood and health of workers), 41 (right to social security) and 47 (duty of the state to improve standard of living and public health). India’s international obligations for socio-economic justice was specifically mentioned as owing obligations to Article 25 of the UDHR 1948 (right to a standard of living adequate for health and wellbeing of a person) and Article 7 of the ICESCR 1966 (right to enjoyment of just and favourable conditions of work).
International Labour Conference held in June 1986, to which India was a signatory. Subsequently, the Rules were framed by the International Labour Office, Geneva. It also drew on the social justice, equality, and directives for welfare of citizens and workers as prescribed in the constitution, and the Bill of Rights—UDHR, ICCPR, ICESCR (Para 22–23). In this historical case, SCI held that the right to health of a worker is an integral facet of a meaningful right to life. The court ordered maintenance of health records of workers, Membrane Filter Test to detect asbestos fibre, compulsory insurance health coverage to every worker, and compensation to all workers diagnosed with asbestosis.

_C.E.S.C. Ltd. v. Subhash Chandra Bose_ [henceforth, _CESC case_] further confirms the intersectionality between fundamental right to health care and social security of workers, on the grounds of the spirit of the preamble and Part IV of the Constitution of India being the incontrovertible bed-rock of an ‘egalitarian social order’.

Doctrine of Medical Aid and Hospitalisation as Part of ‘Right to Human Dignity’

In _Bandhua Mukti Morcha v. Union of India_, the three-judge bench (A. N. Sen, P. N. Bhagwati and R. S. Pathak) laid down key jurisprudential principles and articulated the firm link between right to life (Article 21) and workers’ right to dignity:

> right to live with human dignity enshrined in Art.21 derives its life breath from the Directive Principles of State Policy and Particularly clauses (e) and (f) of Articles 39, 41 and 42 and at the least, therefore, it must include protection of the health and strength of the workers, men and women, and of the tender age of children against abuse, opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity, educational facilities, just as humane conditions of work, and maternity relief. These are the minimum requirements which must exist in order to enable a person to live with human dignity (Paragraph 14). [emphasis added]

The Court was very emphatic when it affirmed that ‘no state neither the central Government has the right to take any action which will deprive a person of the enjoyment of these basic essentials’ and ‘it is the fundamental right of everyone in this country, assured under the interpretation given to Article 21 by this court in Francis Mullin’s case (1981) 1 SCC 608, to live with human dignity, free from exploitation’ (Ibid., Paragraph 14). In _ESI Corporation case_ the right to medical and disability benefits to a workman were declared as her/his fundamental right.

Private Law, Employment and Workers’ Rights

In India, the PILs focused on the accountability of the State and consequently, as related to the workers’ social security, the private employers escaped civil society’s
vigilance and as a practice they shrugged off their responsibility to the health and medical care of workers. Workers’ rights litigations, over a period, resulted in laying down a jurisprudence that related to the obligations of private employers and private entities to the health care and social security of workers. They are summarised here:

- **Private law and business principles are subservient to the constitutional ideals of social justice**: In *L.I.C. of India and Another v. Consumer Education and Research Centre and Others (LIC case)*, the court stated that actions of private companies had to be informed by concern for workers. It unequivocally held that the private and business entities had to comply with the constitutional ideals of socio-economic justice ensuring social security of workers. Further the jurisprudence notes that the Directive Principles of the Constitution laid a reasonable restriction on the freedom of trade and profession under Article 19 (1)(g).

- **Public Character of the Private Law**: Jurisprudence developed by Justice V. K. R. Iyer on public duty was reconfirmed in the *LIC case* laid down that laws and policies which ‘bear the imprint of the public character’ are to be subjected to the principle of public duty. Court declared that ‘when a policy bears the imprint of the public character, they are under constitutional obligations such as ‘the duty to act fairly is part of fair procedure envisaged under Articles 14 and 21’ (*LIC case*, Page 19). The court also noted that the plea of contractual obligations stands rejected when they are alleged to violate Article 14 of the Constitution.

- **Tortious and Vicarious Liability of the Employer for the Health of the Workers**: The tortious liability of the employer for the life and health care of workers was upheld and reinforced as part of ‘right to life’ in *CERC case*. In another case the tortious liability of the employer and the right to health of the workmen was upheld. The corresponding duty cast on the employers by the workers’ right to health was further defined by the Apex Court in *Kirloskar Brothers case*, in which it held that employers had a duty to ensure that their employees can lead a meaningful life. In the *CERC case* as employers even in private industries were obliged by the constitutional duty to provide health facilities to its employees. Gujarat HC laid down the principle that the employer is vicariously liable to pay damages in case of occupational diseases, herein this case asbestosis.

- **Enforcement of Fundamental Rights Against Private Entity/Individuals**: Bhagwati and Ramaswamy, JJ., both emphatically ruled on the enforceability of fundamental rights against private individuals in several judgments. In *People’s Union for Democratic Rights v. Union of India*, better known as the Asiad Workers case, it was emphatically stated:

> ‘[i]t is the constitutional obligation of the State to take necessary steps for the purpose of interdicting [such] violation and ensuring observance of the fundamental right by the

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42L.I.C. of India and Anr. v. Consumer Education and Research Centre and Ors. 1995 SCC (5) 482 (This was a civil appeal no.7711 OF 1994).
43Rajangam, Secretary, Dist. Beedi Workers Union v. State of Tamil Nadu AIR 1993 SC 401.
44Praveen Rashtrapal, I.R.S. v. Chief Officer, Kadi Municipality (2006) 3 GLR 1809.
45People’s Union for Democratic Rights v. union of India (1982) 2 SCC 235.
private individual who is transgressing the same’. (PUDR v. Union of India, Paragraph 493) [emphasis added].

- **Workers’ Good Health is Employer’s Obligation:** In *Mangesh Salodkar v. Monsanto Chemicals of India Ltd (Mangesh Salodkar case)*[^46] the court reiterated the inextricable link between the legislative intent of the welfare legislations and the duty of the State to protect and promote worker’s right to health. The order states:

  Support for the preservation and enjoyment of good health is hence an important obligation of the State and the employer. There can be no contracting out of such obligations. No fine print of exceptions can be countenanced. The mandate to support life is inalienable. (Paragraph 14)

- **Right to Medical Records:** In *Mangesh Salodkar case*, the HC directed that (i) the copies of medical records of workmen must be handed over to them as and when medical examinations are conducted; (ii) appropriate government to consider the issuance of suitable directions mandating the permanent preservation of medical records in the electronic form by factories engaged in hazardous processes.

- **Working Hours to be Rationalised, Made Just, Reasonable and Humane:** In *Seenath Beevi v. State of Kerala*,[^47] in the issue of the working hours of nurses, the HC of Kerala asserted the binding nature of respecting the worker’s rights on all. It states that ‘in the light of the Constitutional mandate under Article 21 no employer whether private, Government or quasi-Government has got the unfettered freedom to prescribe conditions of work and imposing duty hours exceeding certain limits.

  Some of the key principles that evolved as part of the jurisprudence on workers’ rights, discussed in this section, therefore include the obligations of State for the social security of workers as the principal employer, right to health and medical care as fundamental rights, tortious and vicarious liability of the employer, and the constitutional obligation that is caste on the private employers to the health care and social security of workers as part of the just and humane working conditions.

[^46]: Mangesh Salodkar v. Monsanto Chemicals of India Ltd. 2007 (2) BomCR 883 Bombay [Writ Petition No. 2820 of 2003]; cited exposure to pesticides was alleged as the reason for the brain haemorrhage suffered by one of the workers. Though the worker was hospitalized and the dispute between the worker and the employer was settled outside court for about 17.80 lakh rupees, the Bombay High Court took up the petitions on the larger issue of the right to workers’ health. The court appointed an amicus curiae and a commissioner to investigate into the issue. The commissioner filed an expert report by the Director of National Institute of Occupational Health (Indian Council of Medical Research) Ahmadabad.

[^47]: Seenath Beevi v. State of Kerala (2003) 3 KLT 788; This petition was filed by a head nurse who was working in the taluka headquarters at Thiroorangadi in the Health Services Department of the State of Kerala. In this petition she challenged 14 h of work for six consecutive days. The order stated that ‘compelling the petitioner to be on duty continuously for 14 h a day for 6 days consecutively in a week is illegal and unconstitutional’. (Ibid. Paragraph 24) Court ordered the state to stop the prolonged hours of work and to introduce three shifts for nurses on duty in all the government hospitals. The legal reasoning confirmed the jurisprudence of SCI. It rejected the argument of financial burden by the State.
3.2 Constitutional Rights and the Foundations of Health Care Jurisprudence

3.2.3 Civil Liberties, Prisoners’ Rights and Medical Care

Detention, imprisonment, house-arrests, torture, deprivation of civil liberties based on political opinion are often associated with the violations of rights to medical and health care. Chronic illness, including mental illness and access to health care are the constant issues that the inmates of prisons face due to the nature of incarceration, deprivation of liberty and imprisonment (Wilper et al. 2009; Watson 2012; Berkman 1995) In India, several eminent personalities, including jurists such as V. R. Krishna Iyer, had bemoaned the conditions of prisons and prisoners which directly reflected the status of deprivation of civil liberties due to the nature of their socio-economic status and lack of access to legal aid (Krishnaswamy 2015).

As in the cases of sexual violence such as rape, owing to the criminal nature of prosecution, health care jurisprudence conflicts with the forensic and criminal jurisprudence. In these instances, the overwhelming focus on the pursuit of evidence the survivors are deprived of timely access to emergency treatment and much-needed health care. In the mid-1970s and in the 1980s, responding to the civil society movements on civil liberties, the SCI emerged as the champion of prisoners’ rights with a focus on reforms in which legal aid and prison reforms were the key components.

The civil rights movement in India, through several litigations in the 1970s and 1980s, was successful in expanding the rights of prisoners and detainees. They directly addressed oppressive conditions of prisoners such as inhuman treatment, oppressive measures to curb political beliefs, torture and injury to prisoners, cases of mentally ill persons detained in prisons, restricted monthly visit by legal advisor or family members, and conditions of under-trials. The PIL movement then had opened doors of the SCI both to civil society leaders and the deprived with much receptivity to their pleas. PIL itself had its origins in a letter addressed to the courts by prisoners who were ill-treated and tortured, having no access to legal counsel. Most of them were under-trials and from poor families who did not have the capacity to engage a lawyer to represent them.

Issues of right to health care closely intersect with civil and political rights as exemplified in the issue of criminalisation of homosexuality and the right to health

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48 Intervention petition by CEHAT, a civil society organisation, on sexual violence. Original petition was by Ranjana Pardhi and others in the Nagpur bench of the HC of Bombay.
49 Bhuvan Mohan Pattnaik v. State of Andhra Pradesh AIR 1974 SC 2092.
50 Charles Shobraj v. The Superintendent, Central Jail, Tihar 1979 SCR (1) 512.
51 Veena Sethi v. State of Bihar AIR 1983 SC 339 (1982 (2) SCR 583); Sant Bir v. State of Bihar AIR 1982.
52 Francis Coralie v. Union Territory of Delhi 1981 (8) SCR 516.
53 Supreme Court Legal Aid Committee representing Under-trial Prisoners v. Union of India 1994 (6) SCC 731.
54 Sunil Batra AIR 1978 SC 1675.
55 Naz Foundation vs. Government of NCT of Delhi 2001 and 7455/2001 (2 July, 2009).
of transgenders. The case-laws considered here raise issues of medical care for the under-trials, right to medical care of persons in police custody and issues of negligence of medical care to persons in police or judicial custody.

Right to Life with Dignity

Vikram Deo Singh Tomar v. State of Bihar, one of the earliest writ petitions, was concerning the living conditions of female inmates in a ‘care home’ in Bihar. Through a letter, the inhuman conditions and ill treatment and lack of medical care were brought to the notice of SCI. The SCI applied the constitutional legal principles of right to life with dignity and ordered alternative accommodation, restoration of the existing home and the provision of sufficient amenities including furniture, cots, blankets, and clothing. The daily allowance was increased to Rs. 200/-.

Right to Medical Examination and Medical Care

D. K. Basu v. State of West Bengal marks a watershed concerning jurisprudence on the rights of prisoners against torture and ill treatment, and of the orders passed on the rights of arrestees, two of them pertained to health. The SCI defined the rights of the arrestees and convicts in this petition, in which right to medical examination and care becomes a constitutional right. The court too laid down procedures such as medical examination of arrestees and issuance of the ‘inspection memo’ and medical examination of the arrestee by a trained doctor every 48 hours during his/her detention in custody. This was reinforced in other subsequent petitions. In Poonam Sharma v. Union of India and others the court declared the right to emergency medical care as a fundamental right. The order in this petition clearly articulates that medical treatment of the arrestee/accused is a part of right to life, taking precedence over the criminal prosecution. That even the accused or a convict is entitled to the right to life is the core element that underlies health care jurisprudence that is laid down in this petition.

Doctrine of ‘Minimum Conditions of Human Dignity’ to Include Right to Medical Treatment/Facilities

The order in Marri Yadamma v. State of Andhra Pradesh (AP) further elucidated the minimum conditions that are to be ensured by the State as part of Article 21 of Constitution of India. Providing at least the minimum conditions of ensuring human dignity was prescribed by the courts as incumbent upon the State while assigning women and children to ‘Care Homes’. Furthering such principles, in Noorunissa

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56National Legal Services Authority v. Union of India & Ors. [(2014) 5 SCC 438] (NALSA case).
57Vikram Deo Singh Tomar Vs. State Of Bihar 1988 SCC Supl. 734
58Rama Moorthy v. State of Karnataka 1997 2 SCC 642.
59Poonam Sharma v. Union of India AIR 2003 Delhi 50.
60Marri Yadamma v. State of Andhra Pradesh AIR 2002 AP 164.
61Vikram Deo Singh Tomar Vs. State Of Bihar 1988 SCR Supl. (1) 755, page 3.
Begum v. District Collector, Khammam,\(^{62}\) [henceforth, Noorunissa Begum case] the court reiterated and summarised the jurisprudence as follows:

The fundamental rights of prisoners are conclusively established in various judgments. Health and medical care are part of the fundamental rights of prisoners based on various judgments. Emergency medical treatment to take precedence above criminal law (Paramanand Katara). (Paragraph 9)

Vicarious and Tortious Liability of the State for Negligence of Medical Care

The SCI in Chairman, Railway Board v. Chandrima Das\(^{63}\) [henceforth, Chandrima Das case] held that if the employees charged with the discharge of public duties commit an act of tort, their respective state governments will be held vicariously liable. A compensation of two lakh rupees was immediately ordered to be paid as compensation. Additionally, the order allowed petitioners to claim separate compensations for custodial deaths and for medical negligence. This case laid down the compensatory principles under the law of tort for the violation of fundamental rights. The petition was regarding a lady, national of Bangladesh, travelling in Indian Railways, who was accompanied to Yathri Nivas run by Railways. She was raped by an employee of the railways. The HC reasoned that rape was a private matter, that remedy was available only under private law, and that remedy under fundamental rights was not available to non-citizens. SCI reversed the HC order and overruled its reasoning. The principle of the instrumentality of the State was applied to the railways as the State enterprise under public law, holding it vicariously liable for the act. SCI ordered compensation in this case. The law of compensation under tort for the vicarious liability of the State and its instrumentalities, is firmly established through this judgment.

In another case,\(^{64}\) the wife of the deceased prisoner alleged that her husband died due to the denial of timely medical treatment by the jail authorities. The HC of AP upheld the allegation of negligence against the jail authorities and held the government vicariously liable, in the lines of Chandrima Das case.

Duty of the Doctors for Medical Care as ‘Absolute Duty’

In various litigations, courts evolved jurisprudence on the duty of the doctors to safeguard the rights of patients. In Paramanand Katara v. Union of India, [henceforth, Paramanand Katara case] the duty of doctors in the government hospitals to meet the State obligation of medical care to its citizens was declared as total, absolute and paramount. Emergency medical care is proposed as the basic rights of people in custody.\(^{65}\) Building on this, in the Noorunissa Begum case, the HC of AP, further elaborated the right to health and medical care jurisprudence. While decrying ‘death

\(^{62}\)Noorunissa Begum v. District Collector, Khammam And Ors. 2001 CriLJ 3857, paragraph 9.

\(^{63}\)Chairman, Railway Board v. Chandrima Das, 988 [Civil appeal no. 639 of 2000, (arising out of SLP © No.16439 of 1998) dt. 28 January 2000]; Judgment was delivered by R. P.Sethi and S. Saghir Ahmad, J. J., 28 January, 2000.

\(^{64}\)Marri Yadamma v. State of Andhra Pradesh AIR 2002 AP 164.

\(^{65}\)Pt. Paramanand Katara v. Union of India 1981 SCC (4) 286.
due to negligence’, HC in the same vein emphasised the ‘absolute duty of the doctors’ to save life. In addition to the compensation and disciplinary action against jail authorities, rule 10A to the prison rules was inserted to authorise police to take the prisoner to the hospital.

The sharp legal reasoning used by the bench in these case-laws, interlinks various aspects of the seminal case-laws developed in the 1990s with health care jurisprudence (Box 3.3). The key elements of such a harmonised fine-grain jurisprudence include several elements of criminal jurisprudence, public law, and constitutional governance. It interlinks, among others, the right to medical care under CrPC 53-54 (as part of the prisoners’ rights), jurisprudence on negligence (as breach of public duty), vicarious liability of the State, government’s duty as public duty, and right to life in the case of medico-legal cases

**Box 3.3 Negligence of Medical Care of Person in Custody**

Supreme Court Legal Aid Committee v. State of Bihar

This case is representative of the hundreds of cases in which the legal aid committee of the SCI took a keen interest in facilitating justice to the indigent during 1970s and 1980s. This case law is of particular significance to health care jurisprudence as the issues of medical and health care are construed as violations of the fundamental rights of persons in police custody. The SCI took a serious note of custodial deaths through this petition. The Supreme Court Legal Aid Committee filed this petition under Article 32 of the Constitution on the basis of a news item published in the *Illustrated Weekly of India* of July 1, 1989 that reported the inhumane behaviour meted out to a person in police custody resulting in death. In the instance of looting in a passenger train, the victim Mahesh Mahto was nabbed along with several other persons and was seriously injured by the police brutality. Mahesh had received serious injuries and had to be taken to the hospital for treatment. As no transport was available, a rickshaw was hired for the purpose of moving the injured to the hospital. By then the injured had become unconscious and the constable tied him with rope to the footboard of the rickshaw. As no timely medical treatment was provided to the injured, he succumbed to death.

This affidavit of the Deputy Superintendent filed along with the post-mortem certificate accepts that if appropriate and timely medical care had been provided, the life of the victim could have been saved. The court said that it is negligence of the police constable that has led to the death of the victim. The SCI, in its order, built up its legal reasoning stating that ‘it is the obligation of the police particularly after taking a person in custody to ensure appropriate protection of the person in custody including medical care if such person needs it’ (*Supreme Court Legal Aid Committee v. State of Bihar*, Paragraph 2). A sum of rupees twenty thousand was ordered as compensation to the heir of the deceased.
(as enunciated in *Paramanand Katara* case). The jurisprudence on the rights of persons in police or judicial custody has endorsed the right to medical care as integral to the right to life. In the subsequent decades, such jurisprudence further got refined around the issues of discrimination and de-criminalisation of same sex relationships, which raised considerable debate in the country in recent years.\(^{67}\) Access to health care constituted a strong ground to such a jurisprudence.

### 3.2.4 Tort Jurisprudence in Negligence of Medical Care

Law of tort is constructed on the legal maxim—*ubi jus, ibi remedium*, i.e. where there is a right, there is a remedy. This lays the foundation for compensation in matters of negligence. It primarily deals with breaches of duty, independent of contract giving rise to an action for unliquidated damages (Divan 2000). Legal scholarship has argued that the tort law in India is underdeveloped (Galanter 1986). Galanter, an eminent legal scholar, traces the roots to the colonial heritage in the weak civil remedy scenario in India. The British imposed *ad valorem* [literally meaning in proportion to the value] fees on the use of court and the principle of sovereign immunity of the Crown concerning the colonial government and officers. This was a legal hurdle for the development of tort jurisprudence in India.

In the post-independence period, the beginnings of the tort jurisprudence can be traced to the compelling socio-political circumstances of 1970s and 1980s. This was when the SCI exercised its jurisdiction under Article 32 of the Constitution of India read with Article 21 and fashioned the doctrine of awarding compensation for breach of fundamental rights. In the development of tort jurisprudence, Divan (2000) traces five key areas—i.e. defamation against government and public officials, the rule of absolute liability (as developed in *Shri Ram and Union Carbide gas leak* cases), the defence of sovereign immunity of the State, compensation/damages for breach of fundamental rights (tort, quasi-tort, or not a tort) and misfeasance in public office (arbitrary, oppressive, and unconstitutional actions by the State and its officials). The practice of tort jurisprudence began primarily for violation of the constitutional right of personal liberty where compensation was awarded. In several cases\(^{68}\) where the conduct of the public servants had been proved to be oppressive, arbitrary, capricious and unconstitutional, termed as a ‘misfeasance in public office’, the principles of awarding exemplary damages and compensation, were consistently followed (Divan 2000: 426).

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\(^{66}\)Supreme Court Legal Aid Committee Vs. State Of Bihar (1991) 3 SCC 482.

\(^{67}\)National Legal Services Authority v. Union of India & Ors. [(2014) 5 SCC 438] (NALSA case).

\(^{68}\)Rudal Shah v. State of Bihar (1983) 4 SCC 141; Nilabati Behera v. State of Orissa (1993) 2 SCC 746; D. K. Basu v. State of West Bengal (1997)15SCC 416; Lucknow Development Authority v. M. K. Gupta, Common Cause v. Union of India (1996) 6 SCC 530, (1996) 6 SCC 593; Shiv Sagar Tiwari v.Union of India (1996) 6 SCC 558, (1996) 6 SCC 599; Shiv Sagar Tiwari v.Union of India (1996) 6 SCC 558, (1996) 6 SCC 599; State of Andhra Pradesh v. Challa Ramkrishna Reddy [2000] INSC 264 (26 April 2000).
The key milestones in the tort jurisprudence included (1) upholding the rule of absolute liability in accordance with the principles evolved in *Rylands v. Fletcher*,69 (2) establishing the vicarious liability of the ‘sovereign’, applied here to the State, for the actions of its servants (removing the defence of a sovereign immunity in a tort action established on the dictum—the king can do no wrong;70 and, (3) ordering compensation/damages for the breach of fundamental rights.71 *Chandrima Das case* (discussed above) became a very significant landmark case in the application of the legal principle of compensation to the violations of fundamental right to life.

Negligence in Medical Care and Compensation Award

In many countries such as the USA, law of tort is the one which is used extensively in matters of negligence in health care when a patient suffers injury. Such a law which is not punitive but compensatory has not been adequately used in India in matters of health care. The Consumer Protection Act (CPA) 1986 purported to address this issue defining the health care issue in terms of deficiency of services wherein patients are construed as consumers. Such a move was fiercely contested and resisted by the medical associations. In the *Indian Medical Association v. V. P. Shanta*72 [henceforth, *IMA Case*], the SCI played a key role in bringing the private health care services under the ambit of CPA in 1995, almost a decade after its enactment, paving the path for the application of tort jurisprudence to medical and health care services.

Under the tort law, damages are awarded for the deficiency of services or negligence, considering it as a civil wrong. Damages are considered as compensation to victims and as deterrent for negligent behaviour of health care providers (Schwartz and Komesar 1978). In India, such matters of medical negligence find their space in public debates episodically, either when media highlights such issues taking place in private-corporate hospitals on issues catching its attention or when the SCI or National Consumer Disputes Redressal Commission (NCDRC) exceptionally awards a huge sum of compensation as in the case of Dr. Kunal Saha73 in 2014. In this case Supreme Court awarded Rs. 110 million (11 crore) to Dr. Kunal Saha in damages (inclusive of interest) against several doctors and a private hospital for the negligent death of the petitioner’s wife. Kunal Saha argues that in the event of failure of regulation by the Medical Council of India (MCI) ‘large pay-outs awarded by the courts of law may therefore be the only way to instil accountability for wayward doctors and to save lives’. For the legal right to compensation (tort liability) to be productive, it

69*Rylands v. Fletcher* (L.R. 3 H.L.330).
70*State of Rajasthan v. Vidhyavati* (1962) Supp 2 SCR 989; In the Constitution bench of five judges rejected the defence of sovereign immunity in a case when a man died under a jeep driven by the Collector’s driver. Both the defences, that the State was not liable under Article 300 of the Constitution and that jeep was being maintained ‘in exercise of sovereign functions’ were rejected; *Shyam Sunder v. State of Rajasthan* (1974) 1 SCC690; *Smt Basavva Patil v. State of Mysore* (1977) 4 SCC 358.
71Chairman, Railway Board v. Chandrima Das 2000 AIR 988 [Civil appeal no. 639 of 2000, (arising out of SLP © No.16439 of 1998) dt. 28 January 2000].
72*Indian Medical Association v. V. P. Shanta* (1995) 6 SCC 651.
73*Kunal Saha v. Sukumar Mukherjee* (2011) 13 SCC 98.
must, inter alia, ‘act as a deterrent against future negligent behaviour by other doctors and hospitals’ (Saha and Shetty 2014: n.d.).

Technically, the issue of negligence in health care includes the medical malpractice, deficiency of medical services and negligence in care (medical negligence) taking place both in the public as well as private-commercial health care sectors. However, the jurisprudence laid down in IMA case precludes the public health care services from the ambit of negligence on account of them being rendered free. It is only through the special leave petitions or writ petitions such issues of public health care hospitals are taken note by the higher judiciary. On the contrary, though the IMA case brought private health care services under the definition of consumer services, as public health experts point out, it is an onerous and uphill task for the aggrieved patient to prove medical negligence taking place in the private health care settings, due to the lack of appropriate legal or policy framework to regulate the commercial health care institutions (Jesani et al. 2004).

Two cases considered below illustrate the application of tort jurisprudence for negligence in medical care in health care institutions of the State. They were litigated in the first decade of this millennium and they provide jurisprudential insights of the creative mix of tort and fundamental rights (i.e. right to life) jurisprudence built on the principles of Constitutional duty (public duty) of the State and its instrumentalities in varied situations.

M. Vijaya v. Chairman and Managing Director, Singareni Collieries Co. Ltd. Hyderabad and Others

In this case, the principle of negligence as a violation of public duty imposed by public law, is applied. The HC awarded compensation in the case of an hospital affiliated to a government company that transfused blood infected with HIV. This case draws significance from the fact that a five-judge bench of HC of AP deliberated on a matter of health care and medical negligence. The Court ordered a sum of rupees one lakh as compensation. As part of the policy, the Court recommended the Government of AP to introduce legislation directed towards the prevention and treatment of HIV/AIDS in the state. It further issued exhaustive guidelines in this regard relating to the obligations of the state towards the prevention and treatment of HIV/AIDS in public and private hospitals. Among the number of directions issued, point no. 9 states that doctrine of constitutional tort should be recognised even for prevention and control of AIDS and State should be made liable for any negligence in health care services (Ibid. Paragraph 72).

Legal reasoning in this case is constructed on the personhood jurisprudence and the already established interrelationship with health care governance as enshrined in Articles 38, 39 and 47 of the Constitution of India. It asserted: ‘by reason of expansive interpretation of ‘life’ in Article 21 of the Constitution of India in various Supreme Court judgments, which is now the law of the land, right to life includes the right to all reasonable health facilities’ (Ibid. Paragraph 47).

74M. Vijaya v. Chairman and Managing Director, Singareni Collieries Co. Ltd. Hyderabad. And Ors AIR 2001 AP 502.
In addition, public law remedy is called upon as the constitutional ground for the tort (negligence) committed by the hospital. The Court held that the hospital was liable for negligence, for failing to conduct proper tests on the blood donated by the petitioner’s brother and for not detecting the presence of HIV therein.

State of Tripura v. Amrita Bala Sen and Others

Legal reasoning uses a different principle here as evidence, i.e. *res ipsa loquitur* is used to bolster the negligence in medical care. This petition was filed by two petitioners (Civil Rule No. 511 of 1996) alleging negligence by the health care providers and was considered by a single judge bench in the Gauhati HC. The petitioners were patients admitted in the B.R. Ambedkar Memorial Hospital at Hapania, West Tripura on 17 June 1996. After the eye operation, they developed infection and subsequently lost their eyesight. Writ petition prayed for a compensation of rupees two lakh, alleging negligence in health care. The single judge bench held that it was a case of negligence and ordered compensation of rupees 60,000/- to each of the petitioners. However, the state government appealed against the compensation, and the case was considered by a division bench consisting of Ranjan Gogoi, T V aiphei, JJ.

Along with the reasoning of negligence of public duty and the jurisprudence of tort, the division bench of the HC applied the principle of *res ipsa loquitur* for the consideration of medical care. *Res ipsa loquitur* is essentially a rule of evidence which literally means that ‘the thing speaks for itself’ and is applied to situations where negligence is apparent on face of the record. This principle of *res ipsa loquitur* has the effect of placing the burden of disproving negligence on the defendants. The division bench which heard the appeal, upheld both the negligence and the award of compensation. The court reasoned if tort is based on fact and if it is evident (*res ipsa loquitur*), compensation can be proceeded under Article 226 of the Constitution of India.

### 3.2.5 Brief Summary of the Health Care Doctrine Laid Down in Constitutional Rights Themes

The four constitutional rights themes discussed above, have laid down groundbreaking principles of jurisprudence that are applied in the issues of health care. They are briefly summarised.

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75State Of Tripura And Anr. vs Amrita Bala Sen And Ors. (2005) 1 GLR 7.
76This principle has received application to cases of medical negligence as is available in the judgment of the Apex Court in the case of State of Haryana and Ors. v. Smt. Santra (AIR 2000 SC 888). In this judgment, there is no explicit reference to the principle of *res ipsa loquitur*, but it is mentioned as 'negligence per se'. Besides applying this principle to cases of medical negligence, this has also been applied for determination of liability/culpability in a disciplinary proceeding against a Govt. servant [Karnataka State Road Transport Corporation v. B.S. Hullikatti, (2001) 2 SCC 574].
Environmental Jurisprudence

(1) Public duty of the public authorities under Article 47 of the Constitution of India is an absolute duty;
(2) Public health is an imperative of the statutory duty cast on the State (municipality). Article 47 is to be enforced relentlessly for public health governance and abating public nuisance;
(3) In a welfare-state, providing minimum conditions of public health is State’s constitutional obligation;
(4) Right to life under Article 21 of the Constitution of India includes the right to a healthy and decent environment;
(5) Preservation of ‘life and health of people’ is a Constitutional obligation. Obligation under Article 47 combined with right to life under Article 21, is a constitutional ground for the State’s obligation to improve health of the public;
(6) Consumers’ right to know (e.g. ingredients of food) is a basic right.

Workers’ Rights

(1) In the welfare-state, legislative intent is for an egalitarian social order and includes the intent to secure health of the workers;
(2) Welfare-state casts a constitutional obligation on the State for the social security and welfare of workers;
(3) Right to health and medical care is part of the socio-economic justice, constitutional goal of the welfare-state, integral part of the minimum conditions of right to human dignity and social security of workers, and is part of the meaningful right to life;
(4) Medical benefits and facilities and SRHC are the fundamental rights of workers;
(5) Any policy with an imprint of public character to be a public law imposing constitutional duty on the State and the parties;
(6) Private law and business are subservient to the Constitutional principles of socio-economic justice; the State is constitutionally obligated to enforce fundamental rights against private parties;
(7) Tortious liability binds the employer for the health of the workers; the private industries and employers are Constitutionally mandated by duty for the welfare of the workers.

Civil Liberties and the Right to Medical Care

(1) SRHC and the right to emergency medical care are part of right to life and are fundamental rights;
(2) Right to medical examination and medical care are the constitutional rights of the arrestees;
(3) Access to medical aid (among other rights), hygiene, nutritious food, conducive living conditions in prisons are part of SRHC;
(4) Constitutional obligation of the police towards person in custody includes ensuring appropriate medical care;
(5) Providing medical care [to persons in custody or jail] is an ‘absolute duty of the doctors’;
(6) Dereliction of public duty is negligence and gives rise to tortious liability;
(7) Deprivation of timely medical care is medical negligence;
(8) Government is vicariously liable for the wrong actions of its servants (doctors, police etc.). Compensation can be claimed for both the issues of custodial death and medical negligence.

Law of Tort

(1) If employees charged with public duties commit an act of tort, the state government is vicariously liable;
(2) On the grounds of vicarious liability, compensation is to be awarded under public law in the cases relating to custodial deaths and those relating to medical negligence;
(3) The State does not enjoy any immunity for the tortious act of its servants including jail authorities and medical doctors;
(4) Public law remedy is to be applied as a constitutional ground for the tort (negligence) committed by the hospital; compensation is to be paid for negligence if the act of the medical authorities is of the nature of negligence and in violation of a person’s fundamental rights to life and liberty under article 21 of the Constitution of India.

3.3 Domains of Health Care Services and Litigations

A total of 361 cases are considered here for analysing court interventions (and in a few cases other quasi-judicial institutions such as NHRC) that touch upon various aspects of health care of citizens. Using the methodology of ‘case congregation’ they were categorised into various thematic domains of health care and again subclassified into relevant subdomains. Table 3.2 presents the distribution of cases across various domains and subdomains of health care and indicates the location of judicial domains of these litigations.

- 18.6 percent (67) litigations relate to the basic or essential health care components viz. emergency care and access to medicines;
- 25.9 percent (93) litigations relate to health care issues of four groups viz., women (maternal and reproductive health care), children and adolescents, people with psychosocial disabilities and persons living with HIV/AIDS, which are considered together under the ‘vulnerable group’ category, on account of their extreme dependency on the public health care;
- 32.9 percent (119) refer to two privileged social groups considered here under the category of ‘social elites’ and consists of citizens belonging to the upper

77The higher echelons of the Government employees (Class I and II categories) accessed courts for enforcement of their entitlements. On the other hand, upper middle class patients accessing private
### Table 3.2 Distribution of litigations by thematic and judicial domains (n = 361)

| Theme                                      | Sub-domain                        | SC | HC | Others<sup>a</sup> | Total | Percentage | Cumulative % (No. of cases) |
|--------------------------------------------|-----------------------------------|----|----|--------------------|-------|------------|-----------------------------|
| Basic health care services                 | Emergency medical care            | 6  | 3  | 1                  | 10    | 2.8        | 18.6 (67)                   |
|                                            | Drugs and medicines               | 33 | 22 | 2                  | 57    | 15.8       |                             |
| Vulnerable citizen groups and access to    | Children and adolescents          | 5  | 1  | 6                  | 12    | 1.7        | 25.9 (93)                   |
| health care                                | Psychosocial disabilities         | 12 | 3  | 3                  | 18    | 5.0        |                             |
|                                            | People with HIV/AIDS              | 7  | 12 | -                  | 19    | 5.3        |                             |
|                                            | Repro—maternal health             | 24 | 25 | 1                  | 50    | 13.9       |                             |
| Health care of the social elites and       | Health care of Govt employees      | 6  | 15 | 2                  | 23    | 6.4        | 32.9 (119)                  |
| middle class                               | Medical negligence and patient     | 54 | 22 | 20                 | 96    | 26.5       |                             |
|                                            | measures                          | 16 | 25 | -                  | 41    | 11.3       | 22.6 (82)                   |
|                                            | Health care system                | 18 | 20 | 3                  | 41    | 11.3       |                             |
| Total                                      |                                   | 181 (50.1) | 148 (41) | 32 (8.9) | 361 | 100 | 100 |                             |

<sup>a</sup>Others NCDRC, CAT, NHRC, Controller of Patents, Lokayukta

Source Author

middle classes and those in higher ranks of government service. Both these, besides sharing somewhat a similar social ethos, their approach to health care and redressal had commonality as they sought health care in private-corporate health care institutions and approached courts for redressal of their grievances; and,

- 22.6 percent (82) refer to the category of systemic dimension of health care and determinants of health consists of two related themes—one directly concerned

health care filed litigations on varied issues such as medical negligence, professional misconduct and breach of professional ethics. The government employees of higher ranks are provided social security to health care and the middle/upper class citizens access private health care services primarily by choice. Both these social categories, having the financial capability, social capital and the other necessary wherewithal to access private health care and to access courts, together are termed as 'social elites' for this research in relation to their status in society and the privileges they have. Most of the litigations considered for analysis relate to doctors of allopathic medicine, and a few were concerning practitioners of non-allopathic medicine doing cross-practice.
with the health care system and the other issues related to public health such as smoking and pollution which are indirectly related to health care and institutional regulations.

50.1 percent cases (181) were litigated in the SCI, 41 percent (148) were in the HCs and 8.9 percent (32) were in other judicial/quasi-judicial domains. The other domains include National/State Human Rights Commissions (NHRC/SHRC), National Consumer Disputes Redressal Commission (NCDRC), Central Administrative Tribunals (CAT), Controller of Patents and Lokayukta Court.

The NCDRC considers complaints filed under CPA in its original or appellate jurisdiction and its orders concerning medical negligence are significant while considering the principles of jurisprudence in this domain. CAT adjudicates the disputes of government employees on various administrative matters including those concerning the provision of health care and medical reimbursements. Similarly NHRC adds a significant value to the litigations on health care or to the complaints brought before the commission. Though the rest of the legal fora are of limited significance for health care jurisprudence, they indicate both the diverse avenues employed seeking redressal as well as various legal spaces where the health care jurisprudence is applied. The analysis here has not included complaints filed in state medical councils and MCI, as systematic data on these complaints and redressals are not available in the public domain. Similarly, several cases tried at the district and sub-district level courts also include health care issues. They are not included in the analysis as such classified data on health care are not available in the public domain.\textsuperscript{78}

### 3.3.1 Thematic Cluster 1: Basic Health Care Services

Two health care domains which refer to essential or basic health care are discussed here, viz. emergency medical care and the domain of drugs and medicines.

#### 3.3.1.1 Emergency Medical Care

Of the 10 litigations analysed in this domain, eight refer to mishaps of various kinds (accidents, cardiac arrest, and custodial ill treatment), while two of them relate to generic policy issues (medical negligence and protection of bystanders). Of the former, three cases are concerning the accidents and delay in or denial of care in public health care institutions\textsuperscript{79}; one relates to the earliest litigation on record on medical

\textsuperscript{78} Under the court programme, presently the data on the number of cases litigated and pending is available for the district courts also. However the orders are not available and no disaggregated data on litigations concerning their themes is available.

\textsuperscript{79} Pt. Parmandand Katara v. Union of India and Ors. 1989 SCC (4) 286; Paschim Banga Khet Mazdoor Samiti vs State of West Bengal (1996) 4 SCC 37.
negligence in post-Independence India, viz. a litigation filed by a doctor against another doctor; one writ petition deals with the provision of emergency medical care in public enterprises in cases of accidents (railways, in this case); and, two are medico-legal and criminal cases dealing with the issue of duty of public authorities, custody and emergency medical care; and, one case is a landmark case regarding medical care and police. Collectively, the litigations point to the denial of care in public hospitals and to medical malpractices and ethical violations in private hospitals that include discontinuation of medical care for not depositing money instantly, negligence in medical care and charging exorbitant amounts for treatment. The complete failure to provide medical care for people in police custody is another aspect that is brought out by these cases.

Preservation of Life and Saving Life—Absolute Constitutional Obligation

The ethical dimensions of the jurisprudence in this area are founded on and are integral to the principle of the ‘right to life and dignity’, enshrined in Article 21 of the Constitution. Building on this principle, the SCI judgments have established that the ethical duty to ‘save or preserve life’ is the unequivocal jurisprudential principle. The courts declared that it is binding both on the State as well as the medical profession. In the Parmanand Katara judgment, access to emergency care was declared a fundamental right. In a litigation the Bombay HC applied the principle of ‘saving life’ to public services, specifically in the case of the railways, and issued directives for the establishment of an emergency response and care system. The scope of railway’s duty was fixed to save the lives of all accident victims within the railway premises (inclusive of those travelling without tickets).

Owing to the fear of harassment by police and courts, accidents, and unavailability of timely emergency care resulting in death is a major concern in medico-legal cases. In a PIL filed in 2012, by-stander protection in accident cases was prayed for. SCI took steps to usher in another law with respect to accidents and emergency care by asking the Central government to formulate guidelines for the protection of helping by-standers [Good Samaritans] from the police or other authorities in cases of emergencies and other medico-legal cases (Government of India2016). Earlier in Poonam Sharma v. Union of India, the Delhi HC had reinforced the constitutional obligation of policemen and doctors to treat the injured in medico-legal cases.

Duty of Care as the Foremost Obligation of the Medical Profession

The doctrine of ‘duty of care’ applicable to the medical profession and health care providers was declared as being ‘total, absolute and paramount’ as part of Article 21 of the Constitution and was read in conjunction with the duty of ‘saving life’. The ‘duty of care’ is declared to be unequivocally binding all medical professionals, both in public and private health care institutions.

Whether the patient be an innocent person or a criminal liable to punishment under the laws of the society, it is the obligation of those who are in charge of the health of the community

80Pt. Parmandand Katara vs. Union of India and Ors 1989 SCR (3) 997, p. 1005–7.
81Dr. Laxman Balkrishna Joshi vs Dr. Trimbak Bapu Godbole, AIR 1969 SC 128, pg. 16, 21 (filed in 1953, finally decided on May 2, 1968).
to preserve life … Every doctor, whether at a government hospital or otherwise, has the professional obligation to extend his services with due expertise for protecting life.82

Conversely, in the landmark *Pashchim Banga* case83 the jurisprudence clarified that the failure to provide medical treatment is a violation of right to life guaranteed under Article 21 (Paschim Banga, p. 5). The legal framework for the duty of care as a binding ethical and constitutional principle was provided by the SCI in a judgment which declared the Code of Medical Ethics84 as the prevailing law for the medical profession.85

Providing Adequate Medical Facilities as Constitutional Obligation

The jurisprudence reiterates the principles of welfare-state and emphasises the Constitutional obligation of the State in *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal* [henceforth, *Pashchim Banga case*], while it lays down such an obligation as an ‘absolute duty’. The SCI drew a parallel with the access to justice and legal aid as the constitutional duty:

> In the context of the constitutional obligation to provide free legal aid to a poor accused, this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints.86 The said observations would apply with equal, if not greater force in the matter of discharge of constitutional obligation of the State to provide medical aid to preserve human life.87

Through the jurisprudence of emergency medical care, the courts have emphasised the right to meaningful and dignified life in a welfare-state. In addition, constitutional obligation, and liability of the State as well as of health care providers and non-compliance with the constitutional obligations are declared to be part of Article 21 of the Constitution. Litigations in several other domains of health care evolved building on the fundamental jurisprudence that was laid down in emergency care litigations. The significance of emergency medical care jurisprudence is marked by the fact that the Law Commission took note of such a development and submitted the Law Commission Report 201 to the Ministry of Law recommending an enactment on emergency medical care in these lines (Law Commission of India 2006).

### 3.3.1.2 Drugs, Medicines and Medical Technology

Both the affordable drugs as well as availability of essential medicines are integral to the realisation of the right to health care. The litigations in this domain revolved

82Pt. Parmandand Katara vs. Union of India and Ors 1989 SCR (3) 997, pp. Pt. Parmandand Katara vs. Union of India and Ors 1989 SCR (3) 997, pp. 1005-7.
83Paschim Banga Khet Mazdoor Samiti vs State of West Bengal (1996) 4 SCC 37.
84Section 33 of the Indian Medical Council Act, 1956.
85Pt. Parmandand Katara vs. Union of India and Ors 1989 SCR (3) 997, pp. 1005–6.
86Khatri (II) v. State of Bihar, 1981 (1) SCC 627 at p. 631.
87Paschim Banga Khet Mazdoor Samiti vs. State of West Bengal (1996) 4 SCC 37, pp. 9–10.
around the legal framework developed around the time of independence that included two key legislations, viz. Drugs and Cosmetics Act 1940 (DCA) and Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954 (DMRA). While these focused on governance of manufacture and quality of drugs, legislations in 1970s and later—Indian Patents Act (IPA) 1970 and Drugs Price (Control) Order, (DPCO) 1978—relate to the public interest of availability and affordability of medicines.

Of the 57 litigations in the domain of drugs and medicines, 15 relate to technical issues such as definition of drugs, advertisement, storage and licensing; 30 litigations are concerned with range of issues of public interest, drug pricing and regulatory measures, constitutionality of the legal provisions, and drug pricing. Up to the mid-1970s, litigations were around the technical issues whereas, after the enactment of IPA 1970 and the promulgation of DPCO 1978, petitions have been filed on the issues of hazardous and spurious drugs, availability and affordability of medicines, and compliance with trade-laws.

Technical Issues on Legal Dimensions of Drug Legislations

The key issues that were raised through litigations related to the technical aspects of the definition of ‘drug’ under the DCA and DMRA, the propriety of advertisements on products and remedies and quality of drugs. The key litigators in this period were pharmaceutical companies who challenged the constitutionality of legislations and looked to wriggle out of the stringency of licensing, manufacturing, stocking and selling provisions of drugs by seeking exemptions of products from the definition

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88 The Drug Price Control Orders (DPCO) are issued by the Ministry of Chemicals and Fertilisers, which is the main nodal administrative ministry for pharmaceutical companies. They are issued under Section 3 of the ‘Essential Commodities Act 1955’. The aim of DPCO is to enable the Government to declare a ceiling price for essential and lifesaving medicines to ensure that these medicines—of late also referred to as formulations—are available at a reasonable price to the general public. The latest Drug Price Control Order (DPCO-2013) was issued on 15 May 2013. Since 2013, scheduled formulations consist of the essential medicines declared so by the Government through its National List of Essential Medicines (NLEM). National Pharmaceutical Pricing Policy (NPPP) is the policy governing price control and DPCO is the order by which price control is enforced. Drug prices are monitored and controlled by the National Pharmaceutical Pricing Authority (NPPA).

89 Section 3(b) of the Drugs and Cosmetics Act defines drugs as which includes:

(i) all medicines for internal or external use of human beings or animals and all substances intended to be used for or in the diagnosis, treatment, mitigation or prevention of any disease or disorder in human beings or animals, including preparations applied on human body for the purpose of repelling insects like mosquitoes;
(ii) such substances (other than food) intended to affect the structure or any function of the human body or intended to be used for the destruction of (vermin) or insects which cause disease in human beings or animals, as may be specified from time to time by the Central Government by notification in the Official Gazette;
(iii) all substances intended for use as components of a drug including empty gelatin capsules; and
(iv) such devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder in human beings or animals, as may be specified from time to time by the Central Government by notification in the Official Gazette, after consultation with the Board.
of drugs as defined in Section 3 of DCA 1940. Courts have given a liberal meaning to the term ‘drug’. Any article intended to influence the organic function of the human body was a declared ‘drug’. The jurisprudence was a strict construction and interpretation of the statute. It also laid down a twin test for classifying a substance as ‘drug’ or ‘medicament’. The twin elements of this test are (1) Common parlance test—if it is commonly accepted as ‘medicament’.\(^90\) (2) ‘not of common use’ test—if a substance is commonly understood as medicament it will not be an item of common use\(^91\) (Desai and Chand 2007).

Curtailing advertisement on drugs was challenged by industries as violating the freedom to speech and expression under Article 19(1) (a), in many instances. Most of such litigations dealt with Section 3\(^92\) of the Act concerning the advertisement. The jurisprudence laid down is not conclusive and ambivalent. In some cases SCI prohibited advertising as not violative of Article 19(1)(a).\(^93\) However, in some other cases such as items claimed to cure for tuberculosis and sexual rigour,\(^94\) bust developer articles,\(^95\) capsules for men to enhance vigour and vitality,\(^96\) and such other items challenged in courts as adversely impacting people, were ruled as ‘not drugs’ and thus precluding them from scope of the Act. Since the charges are of criminal nature, the criminal jurisprudence rather than public health, is taken as the ground by the Courts. In criminal jurisprudence, the onus of proving charges beyond reasonable doubt is on the prosecution.

The litigations considered under the subtheme of safeguarding quality—licensing, sale and stock of drugs dealt with storage of medicines and drugs covered by Schedule

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\(^90\)CCE V. Richardson Hindustan Ltd. 2004 9 SCC 136, Puma Ayurvedic Herbal (P) Ltd. v. CCE 2006 3 SCC 266.

\(^91\)Cadila Pharmaceuticals Ltd. V. State of Kerala AIR 2002 Kerala 357; Chimanlal v. State of Maharashtra AIR 1963 SC 665; Prabhudas Kalyanji Adhia v. State AIR 1970 BOM 134.

\(^92\)Section 3: Prohibition of advertisement of certain drugs for treatment of certain diseases and disorders. Subject to the provisions of this Act, no person shall take any part in the publication of any advertisement referring to any drug in terms which suggest or are calculated to lead to the use of that drug for—(a) the procurement of miscarriage in women or prevention of conception in women; or
(b) the maintenance or improvement of the capacity of human beings for sexual pleasure; or
(c) the correction of menstrual disorder in women; or
(d) the diagnosis, cure, mitigation, treatment or prevention of any disease, disorder or condition specified in the Schedule, or any other disease, disorder or condition (by whatsoever name called) which may be specified in the rules made under this Act.

\(^93\)Hamdard Dawakhana v. Union of India AIR 1960 SC 554; Sections 3(d) & 8 were also challenged for giving unhindered power to the executive under the Act, and both were held ultra vires. In 1963 Parliament rectified the flaws; Dr. Yash Pal Sahi v. Delhi Administration (1963) 5 SCR 582; K. S. Saini v. Union of India AIR 1967 P&H 322; Zaffar Mohammad v. State of West Bengal AIR 1976 SC 171.

\(^94\)State of Karnataka v. R.M.K. Sivasubramanya Om 1978 CRILLJ. 853 (Karnataka HC).

\(^95\)Kantirani Jaynarayan Mangal v. State of Maharashtra 1982 MLJ 822.

\(^96\)Anand Mohan Chapparwal v. State of Maharashtra 1996 CR LJ 596.
3.3 Domains of Health Care Services and Litigations

H. Transportation, storage of drugs in transit, licensing for such storage. These follow the criminal jurisprudence and are interpreted on a case-to-case basis. A key clarification evolved as an outcome of jurisprudence in this domain on exemption of storage of allopathic drugs was applied only to hospitals/dispensaries under the supervision of Government or local medical bodies, and not to private parties including charitable hospitals.

Public Interest of Health: Access to Affordable Medicines v. Right to Trade

In the post-emergency era, the routine litigations between the State authorities and drug companies continued. However, the character of the litigations changed in the 1970s and the issues of right to health care in public interest were raised. These litigations have a special significance, as not the availability of drugs in the market alone, but the appropriateness of the drugs that determines the right to health. SRHC is positively impacted by the availability and affordability of life-saving medicines. However, paradoxically, it is affected negatively by the inundation of markets with irrational and banned drugs which are either harmful or not justified on the grounds of therapeutic efficacy. What makes matters worse is the fact that such harmful drugs flood the market at the expense of the life-saving drugs. Not surprisingly, the issue of harmful and hazardous drugs has been at the centre of litigations on drugs and medicines in India.

Historically, three key petitions pioneered engaging courts in health care matters, viz. Stree Shakti Sanghatana and Saheli v. Union of India100 (Net-en trial case), All India Democratic Women’s Association v. Union of India101 (Quinacrine trial case) and Vincent Panikulangara v. Union of India102 (henceforth, hazardous drugs case).

Petitioner in the hazardous drugs case was from the Public Interest Law Service Society, Cochin (Kerala). This was the first petition filed in SCI for banning import, manufacture, sale and distribution of hazardous drugs, and such a ban was recommended by the Drugs Consultative Committee set up by the Government of India itself. The petition also prayed for the setting up of a high powered committee to identify the hazards suffered by people due to these drugs and for awarding compensation to such persons. SCI ordered the government to hold public hearings on this issue so that affected people can come and present themselves. Subsequently however, the SCI which had taken such a keen interest in the case, opined that Courts were not the appropriate forums to decide about such issues and left it to the government to act. Though the writ petition itself did not end up with any substantial jurisprudence, for

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97 Under the DCA and DCA Rules 1945, Schedule H lists a class of prescription drugs in India which are drugs that cannot be purchased over the counter without the prescription of a qualified doctor.
98 Kasim Bhai v. State of UP AIR 1956 Allahabad 703; Swarantraj v. State of Maharashtra (1975) 3 SCC322; Sagar Medical Hall v. State of Bihar (CWJC) Patna HC DT. 7/12/01.
99 Bharat Prasad Gupta v. State of West Bengal 1995 SUPP 3 SCC 640; Holy Cross Hospital v. State of Kerala, Kerala HC decided on 25/2/2002.
100 Stree Shakti Sanghatana and Saheli v. Union of India WP © 680 of 1986.
101 Democratic Women Association v.Union of India, (1998)5 SCC 214.
102 Vincent Panikurlangara v. Union of India (1987) 2 SCC 165.
civil society it was one of the first experiences of navigating through courts on matters related to health care. In health care jurisprudence, it stands out as one of the first PILs that paved the path for other litigations to follow. The critical issue of banned and bannable drugs was discussed in the highest judicial forum of the country with civil society and the State on either side. In this and some other litigations that followed, a few hazardous drugs got banned. For example, manufacture, sale, and distribution of fixed combinations of analgen and antispasmodics were banned as per the recommendations of the court appointed committee.\textsuperscript{103} Also, ayurvedic drugs with tobacco containing carcinogenic elements were banned in toothpastes.\textsuperscript{104} The practice of seeking expert opinions by courts on technical matters of health care, began with these petitions and continued through other drugs related petitions.

Another set of litigations include the issue of the government’s acts of surreptitiously introducing hazardous and anti-fertility drugs as contraceptives in public health programmes. These were challenged in the SCI by progressive women’s rights organisations and civil society alliances. These petitions consistently expose the discrimination of women that such services perpetuate and bring out vividly the vulnerabilities and violations that women’s bodies are subjected to (Sarojini and Murthy 2005). The petition in 1986 by Stree Shakti Sanghatana, Saheli and others challenged the introduction of Net-en (Norethisterone Enanthate), an injectable hormonal contraceptive, and prayed for an injunction on the same. This anti-fertility drug’s administration in public health services was undertaken by the Indian Council for Medical Research (ICMR) and was in the nature of a clinical trial. Subsequently, the introduction of Depo-Provera and quinacrine as contraceptives, also considered hazardous, was challenged in the SCI in separate litigations. Almost two decades later, a similar modus operandi of the government of India was seen in the HPV vaccine trial done on adivasi (tribal/indigenous) girls in the state of AP. It was undertaken in the guise of a research on prevention of cervical cancer, due to which deaths of several adivasi girls were reported. In 2011, SAMA, a women’s resource centre in Delhi, impleaded in the ongoing litigations on this issue in the SCI.

In all these, women’s groups, health groups and human rights groups collectively opposed the unethical move by the government of introducing anti-fertility hazardous technologies which besides being harmful to their health also compromised women’s autonomy. These litigations also ingrained within them the resistance to the authoritarian unilateral and top-down way such acts were done by the government, without involving civil society and providing adequate information on the drugs (Sama 2003). Although the litigations were inconclusive in providing a definitive jurisprudence, yet the court processes themselves served as a policy deterrent to their entry or continuation in public health services. In the case of quinacrine, during the inconclusive hearings, the government silently withdrew its plan to introduce them in public health services in India.

Another set of litigations pursued by the civil society organisations (CSOs) included the issue of regulating drug pricing towards making essential medicines

\textsuperscript{103} Drug Action Forum Karnataka (DAF-K) v. Union of India, WP (C) 698 of 1993.

\textsuperscript{104} Vincent Panikurlangara v. UoI; DAFK v. UoI; Laxmikant v. Union of India 1997) 4 SCC 739.
available and affordable to citizens. Civil society networks, All India Drug Action Network (AIDAN) being at the forefront, continued engaging constitutional courts on several issues related to drug pricing including price regulation. During the long-drawn litigation process, the Pharmaceutical Policy of 2002 which was perceived as overwhelmingly favouring the pharmaceutical industry for deregulation of prices was shelved by the Government of India and a National Pharmaceutical Pricing Policy 2012 was formulated. The petitioner in AIDAN v. Union of India, interviewed as part of this research on drug related litigations, described the new policy as ‘much better’ on matters of drug pricing, despite continuing to have its overarching problems. Quite notably, the issue of irrational drugs in the market, occupies a substantial amount of time in litigations as well as in the public discourse which civil society engages with. The regulatory machinery that is inadequately equipped with human and other resources by the government of India and on its own being resistant to exercising their authority under Section 26 of DCA, have been highlighted in these litigations. The sway of the drug manufacturers over the regulatory authorities and experts and this nexus resulting in inadequate enforcement of regulations was underscored in the 59th parliamentary standing committee report on the Central Drugs Standard Control Organisation (CDSCO). The report has indicted the collusion between industry, experts and doctors for the malfunctioning manifested in inundation of the market with irrational drugs adversely affecting access to medicines and public health (Parliament of India—Rajya Sabha 2012; Sandhya Srinivasan and Jesani 2012).

In March 2016, based on a government commissioned Kokate Committee recommendations, 344 Fixed Dose Combination drugs (FDCs) were banned on the grounds of safety, efficacy and therapeutic justification. This was hailed as a significant move by the government to protect public health (Srinivasan et al. 2016). However, slew of pharma companies filed 454 petitions in Delhi HC challenging this move. Delhi HC initially stayed and later quashed this notification dated 01 December 2016, on the ground of Drugs Technical Advisory Board (DTAB) not being consulted (Jain 2016: 4). A Special Leave Petition (SLP) was then filed in the SCI by Government of India and AIDAN challenging the Delhi HC order. The SCI while quashing the order of Delhi HC, [curiously], constituted another subcommittee to investigate

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105 Interview, P3 – Petitioner, dt. 30 May 2015, Baroda; Vide order of July 15, 2015 in AIDAN v. Union of India WP (C) 423/2003.

106 An FDC contains two or more active drug ingredients in a fixed ratio of doses. The Centre had banned 344 FDC drugs on 10 March 2016 citing health risks and lack of therapeutic justification. The ban covered brands of major pharma houses including Pfizer Ltd, Wockhardt Ltd, Alkem Laboratories Ltd, Cipla Ltd, Sanofi India Ltd, Sun Pharmaceutical Industries Ltd. The ban was imposed following a report by a six member committee headed by Chandrakant Kokate, vice chancellor of KLE University, Karnataka. The Kokate panel, which submitted its report on 20 January 2015, had termed 963 FDCs “irrational”, posing health threats. In December 2016 Delhi high court quashed the March 2016 notification, against which the Centre filed an appeal. On March 31, 2017, SCI stayed proceedings in all high courts against the ban on 344 fixed dose combination (FDC) drugs.

107 Pfizer Ltd. and ors v. Union of India, WP (c) 2212/2016, dt. 01 December, 2016, Delhi High Court.
the [very] scientific rationality underlying previous (Kokate) Committee’s recommen-
ded ban on FDCs itself. Based on the confirmation of the findings of the Kokate Committee
by the subcommittee, Govt. of India made a gazetted notification on ban of FDCs in August 2018. A slew of manufacturers of such FDCs then filed ‘vexat-
tious’ petitions in Delhi HC challenging the subcommittee report itself on flimsy
grounds such as clarity and communication in language in the report (Srinivasan 2018).

The contentious, inadvertent, and indiscr
te deployment of the power of judicial
review by the courts in matters such as these has surprised many civil society leaders. Even when the irrational combinations of drugs being harmful for public’s health has been established by two committees of scientists during the course of the litigations, courts allowed further ‘vexatious’ petitions of manufactures, not on content related grounds but based on language of the report (Ibid.). The contradictions of the court in its positions on the same matter also is a matter of grave concern for public health. In the hazardous drugs case, for example, the SCI opined that adjudication is beyond the scope of judicial review in policy matters. However, in the issue of FDCs it is seen that courts are wilfully interfering into the expert committees’ reports, even when not warranted. The pharma companies are heavily invested in engaging courts regularly to challenge moves intended for their regulation by regulatory agencies such as National Pharma Pricing Authority (NPPA) which draw its statutory power under Para 19 of the DPCO enacted under the Essential Commodities Act 1955 to regulate prices of essential medicines (Government of India 1955).

Civil society also confronted the government of India’s move to close the public sector vaccine production units in India in 2008. This move was perceived as part of the multiple ways of deregulating, outsourcing and privatising essential services—a process termed as privatisation -, viz. aimed at creating private markets for vaccines by abruptly shutting down public sector manufacturing, with serious consequences to drug prices and hence to people’s access to these drugs (Jan Swasthya Abhiyan 2014). The petition in the SCI challenged the closure of the vaccine manufacturing units and demanded their revival. When the petition was still pending, SCI abruptly closed the case without citing any order. Meanwhile, the civil society in India was able to build a strong public discourse on this issue through a concerted campaign demanding the revival of the units. The government of India, subsequently, restarted the vaccine production, a move that is ascribed, among others, to the pressure the civil society was able to exert including the usage of courts in addition to the campaign against such a move.

WTO Compliance, Trade and Affordability

Patents and trade agreements have constantly challenged the policy framework relating to drugs and medicines in India, affecting their availability and affordability to common people. Indian Patent Act 1970 protected the processes of manufacturing drugs and kept the prices under control. After becoming a signatory to trade related intellectual property rights (TRIPS) Agreement in 1995, which came into effect in India in 2005, new policy issues came before the judiciary. They included, among
3.3 Domains of Health Care Services and Litigations

others, patent issues, de-control of drug pricing, clinical trials, fixed dose combination drugs, and compulsory licensing. TRIPS related changes were effected in the domestic legal framework in India that included amendment to amend IPA 1970 to replace process patenting with product patenting. However, Section 3(d) of the IPA 1970 restricts granting patent for ‘incremental innovations’ in drugs devoid of any significant therapeutic advantages to existing molecules and also prohibits evergreening, thus is a deterrent for any monopoly in drug manufacturing. This section of IPA is at the centre of disputes in India around the Intellectual Property Rights (IPR) regime that have steered trade related relationships in the third millennium. Several corporate giants such as Novartis AG have challenged the constitutionality of this section and has inevitable links to the discourse on SRHC (Box 3.4).

Box 3.4 Case of Novartis’ Patent Claim on Gleevec (Imatinib)

In 1998, Novartis International AG, one of the largest pharmaceutical companies in the world, filed an application for the patent on ‘Gleevec’ (Imatinib), in the Indian Patent Office in Chennai. The drug is used to treat cancer, particularly Chronic Myeloid Leukaemia (CML). Novartis’ patent application was opposed by cancer patient’s society on the ground that the corporate giant was doing an ‘evergreening’. The application was rejected, after which the company appealed in the HC of Madras, where it lost the appeal. In both places it lost, based on Section 3(d) of the IPA 1970 which does not allow patenting to any drug if it is an incremental change over the molecules that already was discovered prior to 1995. Novartis filed a SLP in SCI, challenging the constitutionality of Section 3(d) of the IPA 1970. It became a test case in India between the public interest of the right to access to medicines and the right to trade and monopoly. The SLP was later dismissed in 2013.

Newer Medical Technologies and Clinical Trials

Post-2000, there was a surge in issues that closely related to employing newer technologies (including drugs) that infringed citizens’ rights. These include new drugs, clinical trials, testing of vaccines, life-saving devices such as stents and their pricing, newer reproductive technologies that were part of the global commercial ventures

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108 A process patent is a form of utility patent that covers methods of changing the functionality or characteristics of a material during a particular use. Whereas, a product patent regime bestows an exclusive right on the original inventor of a product, prohibiting anyone from producing the same product through the same or any other process. It implies that there will not be a competitor for the producer, hence increasing monopoly with exclusive right to dictate the price.

109 Evergreening implies that producers seek to extend the lifetime of their patents that are about to expire, in order to retain royalties from them, for longer periods of time than would normally be permissible under the law.

110 In the matter of an application for patent No. 1602/MAS/98 filed on July 17, 1998. Order of the Controller of Patents dated 25th January, 2006.
such as surrogacy and fertility clinics (Sama 2012). The varied types of violations of rights of people prominently including mortality and morbidity prompted CSOs to raise the rights and ethical issues linked to these ventures, some of them leading to litigations in the SCI. The core contentions included the lack or inadequacy of regulatory mechanisms, ethical violations, and absence of mechanisms to protect citizen’s rights. These wide range of issues are viewed and analysed together in this subsection. The litigations on clinical trials\(^{111}\) and administration of HPV vaccine to tribal girls in Andhra Pradesh\(^{112}\) illustrate the infringement citizens’ right to health care. Some of the outcomes in these litigations included suspension of all clinical trials during the pendency of the case, putting in place new stringent measures such as registration of the mandatory institutional ethics committees, video recording of the consent of participants in the clinical trials, and the like. The petitioners consider the discourse which emerged on regulatory gaps including weak monitoring mechanisms and complete absence of a legal framework to regulate contract research organisations (CROs), the parliamentary report which exposed the nexus of health authorities and pharma companies and some regulatory measures put in place to protect the rights of participants in clinical trials as some major gains this issue.\(^{113}\)

The new legislations such as Assisted Reproductive Technology (Regulation) Act, 2017 (passed in the parliament) and the Surrogacy (Regulation) Bill, 2019 (introduced in the parliament) are deemed to be measures to plug the regulatory gaps and an outcome of these discourses.

The practice of accessing courts on compelling life-saving issues by individuals from the society not linked to any CSOs have come to prominence in recent years (see Box 3.5). This research has not examined such cases exhaustively. However, it needs to be acknowledged that some of them, have significantly impacted some critical aspects of certain domains of health policy and programmes, as the issue of ‘stent-pricing’ illustrates. An advocate Birender Sangwan, moved by the plight of his friend’s family feeling the burden of stent prices, moved the Delhi HC in 2014 seeking price regulation of the life-saving device for which he received a favourable order to cap the prices on stents. When the government did not respond to Delhi HC order, it was followed by another contempt petition in 2016, praying that the coronary stents be brought under the National List of Essential Medicines (NLEM) to cap prices. The NPPA followed this up by declaring stent as a ‘drug’ and placing it in NLEM and capping its price to a maximum of Rs. 30,000/-. This policy move resulted in slashing the prices of stents by 85% (Kaul 2017).

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\(^{111}\)Swasthya Adhikar Manch v. Union of India WP (C) 33 of 2012 (along with AR 79 of 2012, KM 558 0f 2012).

\(^{112}\)Sama v. Union of India IA 921 of 2013.

\(^{113}\)Interview, P2 Petitioner, Delhi, dt. 03 July 2015.
Box 3.5 Access to Life-Saving Drugs and Treatment (Mohd Ahmed (Minor) v. Union of India & Ors. High Court of Delhi)
The petitioner, a young boy of seven years is a son of a rickshaw puller, aged about seven years was suffering from a rare genetic disease called Gaucher Disease which needed expensive treatment that was not available in the public health care system. The non-availability was contended as violative of Articles 14 and 21 of the Constitution. In this litigation, the Court upheld the non-negotiable and absolute nature of the obligations of the State under Article 21 to provide access to life-saving medicines at affordable prices. The Court directed the Government of NCT of Delhi, to discharge its constitutional obligation and provide the petitioner with enzyme replacement therapy at AIIMS free of charge as and when he requires it.

3.3.1.3 Brief Summary of the Application of the Health Care Jurisprudence in the Domain of Basic Health Care Services

Emergency Medical Care
(1) ‘Saving life’ or ‘preservation of human life’ is the constitutional obligation of a welfare-state, and providing adequate medical facilities part of this obligation;
(2) Preserving life is ‘paramount, absolute and non-negotiable’ duty of medical professionals under Article 21 of the Constitution of India, binding both government and private doctors;
(3) Duty of Care by doctors is a paramount obligation that flows from the Constitution; Emergency medical care is unequivocally declared as integral part of Right to Life (hence, a fundamental right);
(4) Negligence or failure to provide emergency and adequate medical treatment by public authorities (police and doctors included) is a violation of right to life;
(5) Code of Medical Ethics is the standing law for the medical profession;
(6) Right to seek parallel remedies in tort and private law are the rights of aggrieved citizens.

Drugs and Medicines
(1) Right to Health is a Fundamental Right;
(2) Availability of essential and life-saving medicines is integral to right to health and right to life;
(3) Reasonable restrictions on advertisement in public interest is not violative of Article 19(6) of the Constitution (to carry on trade or business);

114Mohd Ahmed (Minor) v. Union of India & Ors. W.P.(C) 7279/2013 (High court of Delhi).
115This is a Lysosomal Storage Disorder, wherein the body cannot process fat resulting in accumulation of fat around vital organs of the body. If this disease is left untreated, it can be fatal.
Adjudication, in policy decisions based on the consideration of people’s health and in matters when the Government acts on the advice of expert committee, is beyond the scope of judicial review;

Any article intended to influence the organic function of the human body is ‘drug’;

Twin test for classifying a substance as ‘drug’ or ‘medicament’ is laid down:
(1) ‘common parlance’ test
(2) ‘not of common use’ test

In this section of basic health care including emergency care and drugs and medicines, the application of jurisprudence developed on SRHC is varied and differential. While, in emergency health care, its application appears to be emphatic, in the domain of drugs and medicines, it appears to be differentiated and graded. In the policy measures concerning accessibility and affordability of medicines, courts have been cautious and slow in providing mandatory orders and enforcing them and have left it to the technical experts and the will of the executive.

3.3.2 Thematic Cluster 2: Health Care and Vulnerable Groups

3.3.2.1 Reproductive and Maternal Health Care

The violations of women’s reproductive and maternal health rights are located in India’s policy context that is marked by an overwhelming emphasis on population control (coercive sterilisations) and institutional deliveries even as the health services system continues to be neglected. India accounts for over 20 percent of global maternal deaths (Unicef India n.d.). Several intersecting policy issues have added complexity to the issue of maternal morbidity and deaths. They include the increased role of the unregulated private-commercial entities in health care provisioning, dis-incentivisation of home deliveries, de-legitimisation of traditional birth attendants, privileging institutional delivery over safe deliveries and the neglect of quality of care in reproductive and maternal health care.

Of the 76 litigations considered in this theme, 52 percent litigations ($n = 26$) are on reproductive health and 48 percent litigations ($n = 24$) are on maternal health care issues. The former indicates to three areas of systemic violations, viz. (1) policies and gender discrimination; (2) quality of reproductive health care services; and, (3) access to abortion services. The latter addresses issues of (1) access to maternal health care; (2) quality of care; and, (3) discrimination, negligence, and maternal deaths.

While 24 litigations filed in SCI were either appeals or PILs on policy matters, the 26 litigations in HCs specifically demanded better maternal health services in the context of specific violations. An overwhelming number of petitions (92 percent, $n = 46$) fall in the post-2000 era. They highlight systemic failures at the district level and below, along with the persistent gaps in primary health care services which are critical to
maternal health care. The petitions in HCs, generally served as questioning the lack of accountability of the governments rather than seeking for a new jurisprudence.

Reproductive Health Services

Some of the earliest litigations filed in SCI by women’s rights organisations in the 1970s and 1980s were concerning the policies and reproductive services that that were blotched with gender discrimination. The petitions questioning the commissioning of injectable contraceptives—Net-en, Quinacrine and Depo-Provera—brought forth the issue of adverse health impact these contraceptives had on women’s health. The petitions also highlighted the issue of commissioning them surreptitiously in public health programmes without adequate information and public debate and without framing any regulatory measures, all of which transgressed the provisions of Helsinki Declaration on Human Experiment (World Medical Association 1964). Though the prolonged court processes, did not result in any significant legal doctrine, Neten and Depo-Provera were successfully stopped from being introduced in the population control programme in India in the 1990s. The discourse on the role of ethics in public health programmes and the issue of women’s autonomy over their bodies got increased attention.

Another set of petitions that drew SCI’s attention were on the continued practice of sex-determination and sex-selective abortions despite the enactment of PNDT Act 1994, purported to curb the menace of sex-determination and the declining female child ratio. Alongside, the petitions related to the issue of population control engaged the civil society and courts on a considerable intensity as the civil society perceived them as infringing upon citizen rights. Over 100 petitions were filed against the two-child norm that was proposed as the eligibility criterion to contest Gram Panchayat elections in Haryana. SCI disregarded the argument of infringement of civil rights violations that this government order entailed and dismissed the petitions, which was a severe setback to civil society. Such a petition being dismissed in Apex Court meant that legal avenues were now shut for such petitions in the future. Given such a situation, many other states such as Maharashtra and Rajasthan subsequently made two-child norm as a precondition for jobs and for women to receive cash incentives such as Janani Suraksha Yojana (JSY). On another count, the right to

116 Stree Shakti Sanghathan and Others vs. Union of India WPC NO. 680 OF 1986.
117 [All India] Democratic Women’s Association and others v. Union of India.
118 The Declaration of Helsinki (DoH) is a set of ethical principles regarding human experimentation developed for the medical community by the World Medical Association (WMA). It is widely regarded as the cornerstone document on human research ethics. The Declaration is intended to be read as a whole along with other constituent paragraphs. The Declaration is addressed primarily to physicians, the WMA encourages other participants in medical research involving human subjects to adopt these principles. The original declaration is amended in the 8 subsequent General Assemblies of WMA and seeks to protect the rights of the human subjects. Cehat and Ors. v. Union of India AIR 2003 SC 3309.
119 Voluntary Health Association of Punjab (VHAP) v. Union of India WP (Civil) No. 349 of 2006.
120 Javed v. State of Haryana and ors AIR 2003 SC 3057.
contest election for any office was declared neither fundamental nor a common law right but as a conditional right.

The population control programme has continued to occupy a prime space in the national health programmes as central government’s flagship health programme. It was severely contested during the days of emergency for enforcing male sterilisation (vasectomy). However, in the subsequent decades, tubectomy was pursued as the key method of the population control programme and they were conducted in sterilisation camps where severe human rights violations were reported by civil society leaders and health rights activists.\(^{121}\) Since raising this issue on the grounds of population control was legally not possible after the setback received in *Javed v. State of Haryana*, a petition was filed in SCI on the grounds of ‘lack of quality of care’ in sterilisations.\(^{122}\) Though the SCI issued orders on maintaining quality standards in sterilisation camps, deaths and morbidity continue to be reported in the sterilisation camps (e.g. Bihar 2010; Chhattisgarh 2014). Civil society followed this up with a contempt petition in the SCI.\(^{123}\) This resulted in court orders to dismantle the camp as a method of population control and to provide them as routine services in health centres. However, given the proactiveness the SCI takes in its own judgements on social rights, there is scepticism if these orders will be implemented (Pinto 2016).

In petitions around sterilisation failures, the lower courts and some HCs invariably turned down the petitions, but on an appeal a few HCs awarded compensation.\(^{124}\) The courts reinforced that the State is vicariously liable for the negligence of its officers (in performing the sterilisation) and upheld that negligence is to be compensated in damages, while laying down the principle that claiming compensation in failed sterilisation comes only on account of negligence and not on account of child birth. Such reliefs, however, were not a standard remedy that HCs uniformly awarded. In *State of Punjab v. Shiv Ram and Others*,\(^{125}\) for example, the court exonerated the poor quality of services by doctors and de-linked medical negligence from sterilisation failure. Similarly, the judicial commission appointed to inquire into the matter of women’s deaths in Chhattisgarh (in 2014), exonerated the surgeon (Dr Gupta) and others on technical grounds after taking two and a half years for the investigation (Ghose 2017).

Another issue that has periodically occupied public discourse is the issue of access to abortion services and the manner with which courts have dealt with it. The Medical Termination of Pregnancy (MTP) Act 1978 stipulates 20 weeks of gestation as the permissible period for a legal abortion with the permission of the medical doctor. Two types of petitions have been dealt by courts in this matter. One, criminal petitions on causing miscarriage and death, and involves doctors as the accused/appellants

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\(^{121}\) Dr. Abhijit Das, *Interview*, Delhi, 13 June 2015.

\(^{122}\) Ramakant Rai and Health Watch UP & Bihar v. Union of India 1994.

\(^{123}\) Devika Biswas v. Union of India.

\(^{124}\) Ms. X v. Mr. Z and Anr 96 (2002) DLT 354, I (2002) DMC 448; State of Haryana v. Smt. Santara AIR (2000). SC 1888 [SLP]; State of M.P. v. Smt Sundari Bai AIR 2003 MP 284 [Appeal].

\(^{125}\) State of Punjab v. Shiv Ram and Ors AIR (2005) SC3280 [SLP].
in matters where they were not licensed to conduct abortions. The general pattern in these petitions was the conviction of the accused. The courts, however, did not express any opinion on the rights of the deceased woman or women’s right to abortion. Two petitions seeking termination of pregnancy beyond the stipulated 20-week time period, in peculiar and critical circumstances such as rape resulting in unwanted pregnancy especially in the case of minor girls (Press Trust of India 2015a, b, 2016). The analysis of these cases indicate that in such cases, the HCs have played safe and gone by the rule book without providing any quick relief to the survivor. However, on an appeal, the SCI in several cases has allowed the termination of pregnancy in such cases, invoking the legal reasoning of ‘in the best interest of woman’ (Desai and Chand 2007). The opinion built up in the media seem to be having considerable traction with the courts in minor girl rape survivors getting an urgent hearing and an immediate formation of medical board for an expert medical opinion and a subsequent relief.

However, filing a SLP in SCI in every case and getting an urgent hearing is not an option that is easily available for poor women, nor it can be seen as a substitute for the availability of abortion services is the public health care system. Taking a serious note of the non-availability of abortion services, National Alliance for Maternal Health and Human Rights (NAMHHR) filed a petition in the HC of Bilaspur, praying for making these services available. Most of the litigations in this domain are filed on a pragmatic basis and courts also have continued to treat this on a case-to-case basis. In general, the judiciary’s approach to these issues is very ad-hoc often marked by denial to terminate pregnancy (Deosthali and Rege 2019). A petition by a medical doctor sought to rectify the policy of limiting MTP to 20 weeks of gestation that was causing insurmountable burden on the hapless survivors of rape and other mishaps. Seeking an extension of the legally permissible period to 24 weeks and for systemic and policy mechanisms, he filed a SLP and is still pending in the SCI. In 2017, SCI, in an interim order, enhanced the duration to 24 weeks (Datar 2017).

Subsequently, in 2020, the cabinet approved this proposal and has tabled the bill in the parliament to enhance the period of gestation to 24 weeks. The Loksabha has passed the bill and is in the public domain for comments. Civil society organisations, led by women’s rights coalitions, have expressed certain persisting barriers in this MTP Amendment Bill 2020. Civil society strongly believes that laws that restrict access to abortion infringe on women’s privacy, dignity and decisional autonomy

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126 There are several media reports on these issues of rape victim abortions. for instance, refer: www.ndtv.com/topic/rape-victim-abortion.
127 Chandigarh Administration v. Nemo, High Court of Punjab & Haryana.
128 NAMHHR v. State of Chattisgarh WP 32 of 2014, a PIL was filed in Bilaspur High Court on June 30, 2014.
129 Special leave Petition, Dr. Nikhil D. Datar v. Union of India & Ors., S.L.P. (Civ.) No. XXXX of 2008 (Supreme Court of India).
130 Medical Termination of Pregnancy (Amendment) Bill, 2020 is proposed by the Government of India. Yet to be tabled in the parliament (10 February 2020).
131 Personal Correspondence, dt.13 June 2020—Subject: Civil Society Recommendations on making the Medical Termination of Pregnancy (Amendment) Bill 2020 a Rights Based Legislation.
with respect to their sexual and reproductive health. With this perspective, civil society coalitions, have highlighted some problematic issues in the draft bill such as, the amendment Bill has an overarching paternalistic doctor-centric framework of the MTP Act, where the decision to terminate vests with the doctor and not the pregnant person; the extension of the gestation limit from 20 to 24 weeks is made conditional to ‘certain category of women’ instead of making it universal to all women; the requirement of the medical board still continues which is a great barrier in seeking abortion; the Bill also allows a doctor to reveal details of the person whose pregnancy has been terminated to any person ‘authorised by law’ which is a violation of confidentiality and privacy; the Bill fails to incorporate the perspective of pregnant persons from marginalised groups, for whom systemic discrimination due to caste, class, religion and gender impacts livelihoods and access to quality health care service.

In general, dilemmas and confusions continue in the jurisprudence concerning abortions (Box 3.6). The discussion also highlights the derailment of rights when the laid down jurisprudence is proposed to find a legal framework. The overarching patriarchal and doctor-centric approach to health rights continues to be a severe stumbling block in legalising women’s reproductive rights.

**Box 3.6 Ambivalence in Abortion Case Adjudication**

In *Suchita Srivastava v. Chandigarh Administration* the issue of MTP reached the SCI in a case where a mentally ill woman was pregnant. The expert committee did not recommend MTP against which HC granted permission for the abortion. This was stayed and reversed by the SCI on a SLP that was filed. The pregnancy forces the survivors to break the silence on rape, however, by that time, the limitation of twenty weeks becomes a barrier. Many such cases are reported in the print media (Press Trust of India 2015b). Gujarat HC allowed termination of 22-week pregnancy, of a 14-year-old rape survivor, though she was very anaemic. A lower court had earlier rejected the petition. In a similar case earlier, Gujarat HC had declined termination of 24 week pregnancy of a 14-year-old girl raped by a doctor in PHC for which the court in Sabarkantha district and the HC both refused permission and the survivor had to get the nod from the SCI with an appeal (Press Trust of India 2015a). In a number of cases the Apex court has granted permission for the termination of pregnancy with the rationale of ‘best interest of the victim’ which has set the precedents for such cases. However, there is no consistent jurisprudence even in SCI as exemplified by several cases. In one case, a 10-year-old girl who was 30 weeks pregnant due to rape and was denied permission for abortion in August 2017 citing it was advanced pregnancy. On 29 July 2017, on the same day, SCI allowed MTP of a 21-year-old woman from Bombay who was 24 weeks pregnant and foetal abnormalities were found in the foetus (Datar 2017).
Maternal Health Services

It is estimated that about 45,000 women die in India annually, from complications related to pregnancy and childbirth. Most of these deaths are attributed to systemic deficiencies resulting in violations of women’s SRHC. Two civil society reports that have analysed the intersecting and compounding factors in maternal deaths in India allude to various structural factors and the unavailability of important life-saving health care services such as emergency obstetric care that could have saved life (Sri & Khanna 2014; National Alliance for Maternal Health and Human Rights 2016). Litigations in this subtheme are on three issues—(1) access to maternal health care services, (2) quality of care and, (3) maternal deaths.

Perusal of petitions from Madhya Pradesh,135 Bihar,136 Assam,137 and Sikkim138 point to two key aspects regarding the availability of and access to the services, viz. malfunctioning of PHCs (hence, inadequacy of ante-natal and postnatal services) and non-availability of allied preventive services such as nutrition. Maternal health and wellbeing are linked to various socio-structural factors, described as social determinants of health (CSDH-WHO 2008). The litigations highlighted the deficiency of nutrition services,139 lack of treatment for malaria,140 poorly maintained roads leading to delay in care,141 poorly functioning PHCs and the lack of general health care services.142 The key jurisprudence laid down declares maternal health as a fundamental right and obligates the State to comply with provisioning basic services. In Sandesh Bansal v. State of Madhya Pradesh,143 maternal death was declared a violation of fundamental right of the woman which would conversely mean maternal health is a fundamental right of the woman. The flip side of some of the promising declarations, however, is that they are devoid of any concrete directives to be complied with or time frame or accountability measures to be followed.

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132 Suchita Srivastava v. Chandigarh Administration (2009) 14 SCR 989.
133 This was the case of a pregnancy of a 16-year-old girl due to rape.
134 A girl of 14 years was raped by a doctor in a PHC in Sabarkantha district. The district court refused permission for the termination of pregnancy due to which they appealed to the high court. This case Chandrakant Janyantilal Suthan v. State of Gujrat was taken up in the SC and in a swift move the SC granted permission for MTP ‘in the best interest of the victim.
135 Sandesh Bansal v. Union of India, High Court of Madhya Pradesh at Indore W.P. 9061/2008.
136 Centre for Health and Resource Management (CHARM) v. State of Bihar & Ors., High Court of Patna W.P. (C) 7650/2011.
137 Promotion and Advancement of Justice, Harmony, and Rights of Adivasis (PAJHRA) v. State of Assam, Gauhati High Court W.P. 21/2012.
138 Shri Rinsing Chewing Kazi v. State of Sikkim & Ors., High Court of Sikkim PIL No. 39/2012.
139 People’s Union for Civil Liberties (PUCL) v. Union of India W.P. (C) 196/2001; Premlata w/o Ram Sagar & Ors. v. Government of NCT of Delhi, W.P. (C) 7687/2010.
140 Centre for Youth and Social Action (CYSA) v. Nagaland, Laxmi Singh w/o Manas Ranjan v. State of Odisha & Ors.
141 Shri Rinsing Chewang Kazi v. State of Sikkim & Ors., High Court of Sikkim PIL No. 39/2012.
142 Centre for Health and Resource Management (CHARM) v. State of Bihar & Ors., High Court of Patna W.P. (C) 7650/2011.
Lack of quality in maternal health services leading to morbidity was another issue that these litigations highlighted. Death of a woman due to the infection by left-over mop (towel) during sterilisation operation after delivery in Maharashtra, a death of another women in similar circumstances where a surgical equipment was left inside woman’s abdomen in Andhra Pradesh, instance of removal of uterus without consent while operating on ovarian cyst and abdomen pad left inside the stomach in Tamilnadu, a debilitating injury after child birth in a public hospital in Uttar Pradesh which developed into an obstetric fistula are some of the significant cases that HCs received. Several other petitions on issues of negligence, deficiency of services, discrimination, and irrational care such as unwarranted mass hysterectomies are still pending the SCI. These cases indicate multiple and multifarious negligence and interrelated issues surfacing in each of them. The response of HCs and the jurisprudence applied has been varied—in some, vicarious liability for the negligence of government servants is upheld resulting in compensation award. Relying on an earlier case the Court held that damages could be awarded for the violation of fundamental rights and directed the State to compensate the Petitioner. However, in several other cases such a reasoning is not followed and the ethics of informed consent, for example, is completely overlooked.

Several litigations dealt with the issue of systemic discrimination, violations of health care and maternal deaths. Maternal death incidents illustrate the multiple ways how the system fails women. For example, a contract labourer woman was denied permanent appointment as Junior Chemist on the ground of being pregnant for more than 4 months in a private company; maternity leave was not available for the non-regularised employees; medical reimbursement for the emergency lower segment caesarean section was refused. In these cases, the courts favoured the litigants. In the case of woman being denied employment in private company, the court directly incorporated the provisions of Article 11 of CEDAW, 1979 into the Indian Law and held that,

\[t\]he right to beget a child is undoubtedly a fundamental right and the state or an authority like the Respondent Corporation cannot, by enforcing a regulation, impose itself in this manner, curtailing the personal freedom of a woman who chooses to have a child. Depriving a woman of her right to earn a livelihood in spite of her selection, especially in times when

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143 Achutrao Haribhau Khodwa v. State of Maharashtra And Ors (2004) 3 CAL LT 609 (HC).
144 Mrs. Shantha v. State Of Andhra Pradesh and Ors AIR 1998 AP 51.
145 Arun Balakrishman Iyer and Anr Vs. Soni Hospital and Ors AIR 2003 Mad 389.
146 Snehalata “Salenta” Singh v. State of Uttar Pradesh PIL no. 14588/2009.
147 Narendra Gupta v. Union of India WP © 131 of 2013; Karnataka Janaaorgya Chaluvali vs. Union of India, IA along with Narendra Gupta v. Union of India petition (Interlocutory petition admitted in the SCI).
148 Nilabati Behra v. State of Orissa, (1993) 2 SCR 581.
149 S. Amudha v. Chairman, Neyveli Lignite Corporation (1991) IILLJ 234; WP was dismissed by a single judge bench, a review petition considered the petition favourably.
150 Municipal Corporation of Delhi v. Female Workers (Muster Roll) Special Leave Petition (civil) 12797 of 1998.
151 Veena Bhatia v. Department of Telecommunication and Others T.A. No.606/2009.
unemployment is widespread and acute cannot be appreciated. (S. Amudha v. Neyveli Lignite Corporation)

Considering the denial of maternity leave for non-regular employees, SCI held that not just regular women employees but even women who are engaged on a casual basis or on muster roll on a daily wage basis can avail of the benefits of the Maternity Benefit Act 1961. In the Laxmi Mandal Case, the HC of Delhi demonstrated its willingness to enforce these rights in the face of inaction and inertia by the government. [Vide. Box 3.7] The Court reiterated that it was unwilling to be a ‘silent spectator’ and ordered the state government to provide a review of state-funded shelters and reaffirmed its order to create at least two more shelter homes.

In the petition concerning a series of maternal deaths in MP, the Indore bench of the HC of MP issued interim orders for the state government to formulate an action plan to combat maternal deaths and provide appropriate health care services in the rural areas. This case is pending in the court for seven years. Similarly, a petition on the unhygienic conditions in Umaid Hospital in Rajasthan, HC in its interim orders asked Umaid hospital to file a report stating what support it got from district administration for maintaining cleanliness at hospital. Further, two litigations (viz. Laxmi Mandal and Sandesh Bansal) made some path-breaking jurisprudential declarations. The former declared that ‘to be protected from maternal mortality is a legally enforceable right’ while the latter declared that ‘access to maternal health services is a fundamental right’.

It can be noted that in HCs the application is not uniform and sometimes paradoxical. The HC of MP, for example, said that the doctor has to show only a reasonable standard of care, but cannot give a contractual warranty and cannot insure against all possible risks and cannot be held guilty for error of judgment. In another case, the HC stated that a child which was born due to the negligence and callous attitude of the surgeon (in a failed sterilisation operation), who is an officer of the State, it is the duty of the State to maintain the child. The compensation is awarded as part of Article 21 Right to life. Court also reasoned that in exceptional cases, court can exercise its powers under Article 226 of the Constitution of India and the court can grant relief by providing damages to an aggrieved person (Box 3.7).

**Box 3.7 Landmark Judgment by the Delhi High Court on Maternal Health**

The case of Laxmi Mandal, refers to two women and orders delivered on 4th June 2010 in the Delhi HC, has been cited as one of the very successful court interventions in streamlining maternal health services. (Centre for Reproductive Rights and Human Rights Law Network n.d.) The order also declared the right to maternity as a fundamental right which cannot be denied. There were two petitions clubbed together in this.

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152Shakuntala Sharma v. State of U.P 2001 ACJ 620, 2000 (2) AWC 1455, (2000) 2 UPLBEC 1804.
Shanti Devi case: In 2008, Shanti Devi, a poor woman belonging to Scheduled Caste, living in the slums of Delhi, was forced to carry a dead foetus in her womb for five days after being denied medical treatment at several hospitals because her husband was unable to show a valid ration card for medical services. On January 20, 2010, she died immediately after giving birth at home to a premature baby girl.

Jaitun case: Fatema, daughter of the Petitioner Jaitun, is a poor, uneducated, and homeless woman and suffers from epileptic fits. Her husband abandoned her after she became pregnant. She inquired at a Maternity Home run by the Municipal Corporation of Delhi (MCD), Jangpura for vaccination, and inquired about the cash benefits for which she received no response from authorities. On 29.5.2009 she delivered a girl child in full public view, under a tree. She made several visits thereafter to the Maternity Home but was refused payment. Writ petition was filed with the help of a human rights organisation in which Fatema’s mother prayed for compensation, proper implementation of schemes and providing mother and child with nutrition and health care.

Jurisprudence developed here, articulates that the right to be protected from maternal mortality as an unequivocal, legally enforceable right, and establishes that where women are deprived of this right, compensation must be provided. This is the first decision where the judiciary has used the reproductive rights framework into its decisions dealing with Article 21.

Although there are conflicting and paradoxical positions of the courts in these matters, it also mirrors the larger society’s viewpoint on these issues. It is important to note that the personhood of a woman either during pregnancy or motherhood is not treated with respect and dignity in India. The reproductive services available in the country subjects a woman’s body to the scalpel of the State machinery and the view taken by the courts is therefore seen to be instrumental most often lacking the lens of equity and justice.

3.3.2.2 Children’s Right to Healthy Development

India is home to the largest number of children in the world, of which 20 percent are in the age of 0–4 years, accounting for 20 percent of child-deaths in the world. Undernutrition and malnutrition have been identified as the most prominent reasons for children’s deaths worldwide, including India (United Nations Children’s Fund 2011). The litigations on children’s health, considered in this section, include issues of working children (child and bonded labour) and their nutrition, and cumulatively reflect the deep intersections of their life-conditions and wellbeing. PILs used United Nations Convention on the Rights of Children, Child Labour Regulation Act 1986,
and Juvenile Justice (Children in Conflict with Law and need of Care) Act 2000 to address the issues of children’s health and wellbeing. Right to health and a healthy environment formed the key grounds in these petitions. It is noted in these litigations that the issues of children reflected in these petitions are not systematic nor consistent. They have emerged in the context of issues identified by civil society actors, and hence appear to be anecdotal and not representative of all the issues faced by children. Hence, the orders and court directives too appear to be piecemeal.

In the Sivakasi and Kamraj district Child Labour Case\(^\text{154}\) the court prohibited direct employment of children in the manufacture of matches but allowed it in packaging. Constructing the jurisprudence on the principles of ‘sound physical growth’ and ‘adverse effect on health as a serious problem’, it directed to make available the dietary and medical facilities available to children in these workplaces. Court took a paternalistic view and sympathised with the issue, but did not take any position on enforcing prohibition on child labour. In the subsequent petitions on the same issue that were filed in the context of deaths of 39 children in a fire accident, seeking prohibition of child labour in the matchmaking factories of Sivakasi in Tamilnadu,\(^\text{155}\) the principles of ‘right to healthy development of the child’ and the arguments of public health are used. The jurisprudence in these litigations did not substantially alter court position on the total ban on child labour.

In petitions asking for banning child labour in carpet industry,\(^\text{156}\) SCI did not consider the prayer for a total ban on child labour but directed for a progressive elimination of employment of children. The legal reasoning was based on the International Covenant on the Rights of the Child and the Constitution of India Articles 21, 23 and 24. Addressing issues of child trafficking that is linked to the entertainment industry such as circus, in a petition *Bachpan Bachao Andolan v. Union of India and Others*,\(^\text{157}\) the petitioner brought to the notice of court the problems faced by children that included insufficient space, inadequate food, erratic sleep timings, poor sanitation and lack of health care in such a high risk entertainment industry. Lack of health care and medical personnel, among others, were presented as primary grounds for seeking relief to children. SCI directed the central government to issue notification to prohibit children below the age 18 in the circus, to protect their right to life and to rehabilitate them in Protection and Care Homes.

Several petitions raised the issue of children’s access to food for children in the wake of malnutrition and starvation deaths. In *PUCL v. Union of India and Others*,\(^\text{158}\) SCI issued orders to make food and nutrition available to children and the directives included operationalising universal midday meals, and the provision of supplementary nutrition for adolescent girls through Integrated Child Development Scheme (ICDS) and through Public Distribution System (PDS) (Right to Food

\(^{154}\)M.C. Mehta v. State of Tamil Nadu and Ors. AIR 1991 SC 417.

\(^{155}\)M.C. Mehta v. State of Tamil Nadu and Ors. AIR 1997 SC 699; (1996) 6 SCC 756.

\(^{156}\)Bandhu Mukti Morcha v. Union of India AIR (1997) 10 SC 2218.

\(^{157}\)Bachpan Bachao Andolan v. Union of India and Others, WP (Civil) 51 of 2006, Supreme Court of India.

\(^{158}\)PUCL v. Union of India and Others WP (C) 196 of 2001.
In a stark contrast to the issue of starvation, another petition prayed for restricting the availability of junk food in school campuses deemed to be adversely affecting children’s health. In *Uday Foundation and Others v. Union of India*, the petitioners drew on expert reports which link junk food as the cause for development disorder in children, and sought a ban on the junk food around schools. In this litigation filed in 2010, about 33 orders were passed and the final judgment was given on 25 February 2016 (*Uday Foundation, Delhi* n.d.). Food Safety and Standards Authority of India, the statutory body, was directed to form guidelines for the sale of quality and safe food in school campuses and within 500 yards of the schools. Compared to starvation and non-availability of food that reflects the reality of rural and hard to reach areas, the latter petition reflects an urban scenario and the problems generally faced by children coming from slightly privileged families.

As can be noted in the outcomes of these litigations, the courts applied the prevailing personhood jurisprudence along with the international human rights principles that include right to healthy development as the right of every child and emphasised the liability of the employer to the healthy development of the child. Right to health and health care is a firm but an indirect ground for the protection of right to life of adolescents and children in the petitions filed in the SCI. However, the jurisprudence lacked robustness to effect any substantial change in the lives of children on issues such as child and bonded labour.

### 3.3.2.3 Rights of Persons with Psychosocial Disabilities

The discrimination and violations of health care of persons with psychosocial disabilities in India are intrinsic to the construction of their ‘patienthood’ as having no legal rights and the simultaneous denial of ‘personhood’ to them. This is endorsed and upheld by a plethora of legislations (*The National Alliance on Access to Justice for People Living with a Mental Illness—NAAJMI 2011*; Davar 2015). Such a conception of ‘patienthood’ strips them of their citizenship itself as Davar (2015: 8) notes: ‘[t]he ‘mentally ill’,… the authorities first have to arrest them, strip them of all subjecthood and citizenship, and then bring them into an asylum/custodial treatment setting’.

The discussion on jurisprudence applied in this domain broadly comes from 18 litigations considered for the analysis. They are analysed under two categories—(a) under-trials, women and children in jails and mental illness (6 litigations) and,
(b) mental health institutions, and patient rights (12 litigations). In the 1990s, the NHRC played a pivotal role in the advancement of these litigations. The petitions on illegal detention of a mentally ill person for about 30 years, and 28 inmates in the Mental Asylum in Erwadi village in Ramanathapuram district (Tamilnadu) in 2001 164 symptomatically point to the severity of human rights violations both as individuals and as a community of persons with psychosocial disabilities.

Two Significant Cases Concerning Rights of Persons with Psychosocial Disabilities (PPSDs)

Ajoy Ghosh v. State of West Bengal

This is a story of one of the longest illegal detentions of a mentally ill person in the history of post-independent India. He was arrested in 1962 on charges of his brother’s murder. He was declared insane during his trial. His mother, the only relative, and all other witnesses died too during this trial. As an under-trial he could not be acquitted unless tried and could not be tried since he was of ‘unsound mind’. In 1989, a public spirited advocate Shri P. K. Sinha drew the attention of the HC of Kolkata to the plight of prison inmates, the case of Ajoy Ghosh surfaced and was taken up by the division bench of the HC in 1989. Subsequently, in 1999, this case was taken up by the SCI along with others, and was ordered to be released and put in the care of the Missionaries of Charity. The Court also ordered a two lakh rupees compensation to be paid to the Missionaries of Charity as donation. His release without a trial was realised after 37 years of his arrest. The magisterial report which was ordered by the SCI reveals that between the period 1964 and 1995 the Additional Chief Metropolitan Magistrate (ACCM) made no efforts to take any action in this case and no treatment was given. He was last produced in the court on 8 November 1962, and the next order was found to be dated 8 February 1964. There is absolutely no record of the trial whereabouts till 12 November 1983, on which the subsequent order is dated, confining him to judicial custody till he is ‘mentally fit’. The three member SCI bench headed by Justice Dr. A. S. Anand lamented the state of affairs: ‘This case presents a pathetic state of affairs and demonstrates the manner in which Ajoy Ghosh was treated. We are distressed. The blatant manner in which the fundamental human rights of Ajoy Ghosh, including the rights under Article 21 of the Constitution, have been violated, presents a depressing picture’ (Jai 2003).

Re. v. Union of India

This is the case of tragic deaths of 28 inmates in the faith based Moideen Badusha Mental Home in Erwadi village in Ramanathapuram district (Tamilnadu) in 2001, who were chained and tied to poles and beds. They were charred to death in the fire accident that occurred on the night of 6th August 2001. Based on the submission note of the Registrar (Judicial), the SCI took a suo motu action in taking up the case in public interest. A five-Judge Bench of the Supreme Court, comprising A. S. Anand

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163 Ajoy Ghosh v. State of West Bengal IA No. 4, WP © No.559 of 1994, decided on November 29, 2000 [IA in R. D. Updhyay v. State of Andhra Pradesh (2001) 1 SCC437].
164 Re. v. Union of India (2002) 3 SCC 31 [WP (C) 334 of 2001].
CJI, K. T. Thomas, R. C. Lahoti, N. Santosh Hegde and S. N. Variava, JJ., issued suo moto notice to the State and Central governments, on the basis of media reports on the Erwadi tragedy. Even after the enactment of the Mental Health Act (MHA) 1987, this incident showed the continued apathy and indifference shown by the State and private agencies towards the mental ill. However, what followed this incident is the closure of all privately run mental asylums and the State took all the inmates into its custody. Medical attention and monetary compensation were given by the government to the survivors (Krishnakumar 2001). In this case SCI issued orders for implementation of the MHA 1987 towards fixing accountability of the authorities. Notably, the MHA 1987 itself is fraught with serious problems as far as the rights of patients are concerned. There is insufficient research to suggest if any systemic level change happened due to this order in the way care and social support is offered to PPSDs.

Examination of litigations indicates that courts have used the jurisprudence of personhood (right to life), duty of the governments to safeguard human rights, and unconstitutionality of the incarceration of mentally ill. The Mental Healthcare Act 2017, which replaced the MHA 1987 has enacted certain provisions which incorporate this jurisprudence by acknowledging the legal personhood status of the PPSDs and among others, their legal capacity to consent in matters of their health care.

Duty of the State to Safeguard Right to Life and Access to Justice

Many petitions revealed how persons with mental illness were kept in indefinite judicial custody, unwillingness of the State authorities to order release of ‘insane acquittees’, abuse of human rights of women and children in State protective homes or jails, and conditions of convicts sentenced to death. Invoking the jurisprudence of the right to life of PPSDs, SCI reiterated their fundamental right to access justice, while laying down the imprisonment of non-criminal persons with mental illness as unconstitutional, and providing treatment and safeguarding human rights of the PPSDs as the duty of the State. Another set of persons whose right to life was negated were the convicts sentenced to death whose mercy petitions were rejected by the President of India and most of them were suffering from mental illness. Review petitions were submitted in the SCI to consider the grounds of delay, insanity, solitary confinement and procedural lapses as ‘supervening circumstances’

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165 Veena Sethi vs State of Bihar AIR1983 SC 339 [ W P ( Cri) No 73 Of 1982].
166 In criminal law, the provision of safe custody also extends to ‘insane acquittees’ (sic). When a court acquits a person on grounds of unsoundness of mind, acquittal does not mean discharge. The court can under Section 335 of the CrPC either release the ‘insane acquittee’ on security of a friend or relative or order the ‘insane acquittee’ to be kept in safe custody of jail or a mental hospital. Once again, release can be secured only if family support is available. The statute provides no guidelines on the periods for which ‘insane acquittees’ can be kept in place of safe custody.
167 Dr. Upendra Baxi v. State of Uttar Pradesh 1983 2 SCC 308; Sheela Barse v. Union of India 1986 3 SCC 632, Vide order dated 15.4.1986 (Children); Sheela Barse v. Union of India 1993 (4) SCC 204(Women and children).
168 Shatrughan Chahan and Anr vs. Union of India and Ors WP (Cri) 55 of 2013 (Supreme Court)
157 Ibid. para 24.
and to declare death sentences per incuriam. Consequently, the SCI commutated their death sentences to life sentences. 157

Constitutional Obligation of the State to Provide Medical Care

In Shukri v. State of Maharashtra 169 the negligence of medical care resulting in the death of the petitioner’s mother in the Central Institute of Mental Hygiene and Research, Yerwada, Pune was the issue. In Rakesh Chandra Nararyan v. State of Bihar, 170 letters on the conditions of Ranchi Mansik Arogyashala, a State run mental health care hospital near Ranchi were admitted as a PIL by SCI. SCI re-articulated the jurisprudential principles of welfare-state and duty of the State as applicable to these institutions:

In the welfare-state - and we take it that the State of Bihar considers itself to be one such - it is the obligation of the State to provide medical attention to every citizen. Running of the mental hospital, therefore, is in the discharge of the State’s obligation to the citizens … The State has to realise its obligation and the Government of the day has got to perform its duties by running the hospital in a perfect standard and serving the patients in an appropriate way.

Based on the orders in Rakesh Chandra Narayan on the Ranchi Manasik Arogyashala, the SCI legal aid committee took up the issues of deficiencies in Gwalior Manasik Arogyashala 171 and the Hospital for Mental Diseases located at Shahdara (Delhi Administration). 172 In these cases, it was ordered that an autonomous body to manage these institutions. In Chandan Kumar Banik v. State of West Bengal, SCI deplored the conditions of mental hospital at Mankundu of Hooghly District, 173 and ordered discontinuing the practice of tying up patients with iron chains followed by treatment. In other cases, courts regulated the prescription of indiscriminate electric shocks to mentally ill persons that were routinely done in several hospitals even without administering anaesthesia (CEHAT and ICHRL 2007). 174 In these PILs, the SCI orders included provisions to strengthen and refurbish the system of mental health care services. 175

Pursuant to ratifying the United Nations Conventions on Rights of Persons with Disabilities (CRPD) in 2007, the government of India enacted the Mental Health Care Act 2017. Incorporating some of the principles of jurisprudence laid down thus far, this legislation, among others, has de-criminalised suicide and has made provisions to accept the autonomy and personhood of the mental health patients (Government of India, Ministry of Law 2013). However, any measures towards strengthening mental health care institutions or commitments towards allocating required financial resources are not provided for in the said Act, including access to care and medicines.

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169 Shukri v. State of Maharashtra WP no. 7560 of 1988, Bombay High Court.
170 Rakesh Chandra Narayan v. State of Bihar 1989 SUPP 1 SCC 644.
171 Supreme Court Legal Aid Committee v. State of M.P. and Ors. 1994 Supp (3) SCC 489.
172 B. R. Kapoor v. Union of India, (1989) 3 SCC 387 [WP (Cri) No 1777-1778 of 1983].
173 Chandan Kumar Banik v. State of West Bengal 1995 Supp. 4 SCC 505.
174 S.P. Sathe v State of Maharashtra W P No 1537 of 1984, Bombay High Court.
175 Re. v Union of India (2002) 3 SCC 31; Saarthak Registered Society and another v. Union of India (2002) 3 SCC 31.
which are critical for the care of PPSDs. The transformability of the legislation into operational health system measures to realise the SRHC of PPSDs is not evident in this policy making process (Pinto 2017a).

3.3.2.4 Rights of People Living with HIV/AIDS

Human Immuno Virus (HIV) became the focus of public health policy and programmes in the mid-1990s. Litigations concerning People Living with HIV/AIDS (PLHAs) that came before the courts highlighted primarily the transgression of civil rights of infected persons and the issues of systemic gaps that manifested in making health care available to patients. The 19 litigations analysed here, 7 from SCI and 12 from HCs, bring out the palpable tension inherent in resolving conflicts of rights and striking a balance between protecting personal rights and addressing the concerns of the health of the public, as exemplified in the issue of right to privacy and confidentiality vis-à-vis the disclosure that is required to protect others. In the early years, a primitive jurisprudence emerged which made individual dignity, right to privacy and confidentiality subservient to public health. However, a more mature jurisprudence was eventually laid down within the framework of personhood jurisprudence. Quite importantly, this reflects the evolving understanding of the public health issues by the judiciary and its influence on the interpretation of the constitutional principles in their application to the specific issues in public health care.

Right to Dignity and Civil Rights

The persistent litigations concerning the issues of health care of the PLHAs over the years resulted in several court directed guidelines that upheld the jurisprudence of equality and right to life. They included, for example, anonymisation of names in court dossiers, and declaration of termination from employment owing to HIV status and mandatory testing without consent as discriminatory and as violative of Articles 14 and 21 of the Constitution. The stigma that is linked to the HIV status of a person and its intersectionality with civil and social rights came to the fore while challenging criminalisation of homosexuality embedded in IPC 377. This petition had its origins in the civil society coalition AIDS Bhedbhav Virodhi Andolan (ABVA) against the police harassment and policy barriers that restricted the provision of HIV preventive care and treatment to homosexuals as homosexuality was criminalised under IPC 377. The Delhi HC declared IPC 377 as unconstitutional on the grounds of violating several fundamental rights including equality (Article 14) and right to life (Article 21). This was, however, was reversed by SCI on an appeal by the state

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176 Mr. X v. Hospital Z AIR 2003 SC 664; Dr. Tokugha Yepthomi v. Apollo Hospital and Anr AIR 1999 SC 495.
177 Mr. X, Indian Inhabitant v. Chairman, State level Police Recruitment Board.
178 Naz Foundation v. Government of NCT of Delhi and Ors. (2009) DLT 27; Suresh Kumar Koushal and Anor. v. Naz Foundation Civil Appeal No. 10972 of 2013.
which also refused to admit any review petitions. Later, responding to the civil society and media outcry, through a curative petition, the SCI decriminalised IPC 377.

Right to Access Treatment with Dignity

There are few litigations that addressed the issues of systemic deficiencies in the provisioning of health care to PLHAs. In the order in a petition in Assam, the court presumed the constitutional public duty of the state of Assam through its public health department for the health of PLHAs. It issued various directions for proper implementation of guidelines, strategies and policies formulated by the National AIDS Control Organization (NACO).

Legal Doctrine

Two landmark legal principles were developed in *M. Vijaya v the Chairman and Managing Director, Singareni Collieries Company Ltd.* The Petitioner, wife of a Pump Operator working for the Respondent Public Sector Company, Singareni Collieries Co. Ltd. underwent a sterilisation operation. She got HIV infection through blood transfusion. The petitioner alleged that the Hospital did not test her brother’s blood for HIV at the time of donation. She filed a writ petition in the HC alleging negligence on the part of the Hospital. The judgment is firmly footed in the welfare state philosophy of the state and Articles 39 and 47 of the Constitution of India. The elaborate order takes into consideration all the fundamental rights judgments and HIV/AIDS related judgments delivered prior to 2002. The jurisprudence in this case attains significance on account of the five-judge constitution bench in the HC of AP that laid down the legal doctrine and that it took into consideration a whole gamut of preceding judgements.

1. Fundamental rights prevail over the doctrine of sovereign immunity and acts done in good faith (Ibid., Paragraph 68).
2. Doctrine of constitutional tort is applicable when right to life under Article 21 of the Constitution of India is violated (Ibid., Paragraph 69).

Call for civil society to enact legislation, finally was realised in the enactment of the *Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act 2017*. This Act has a predominant focus on addressing the issue discrimination which relates to the civil rights of citizens. It, however, does not address the issue of access to care of PLHAs which is a social right (Pinto 2017b).

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179Subodh Sarma and Anr. v. State of Assam and Ors. WP (Civ) No. 3984/96, decided on 26.9.2000 (Gauhati High Court).
180*M. Vijaya v. The Chairman and Managing Director, Singareni Collieries Company Ltd, 2002 ACJ 32 [WP No. 5104 of 2001, Andhra Pradesh HC].
3.3.2.5 Brief Summary of the Application of Health Care Jurisprudence for the Rights of Vulnerable Groups

Reproductive and Maternal Health

(1) The right to beget a child is a fundamental right and the State or an authority cannot curtail the personal freedom of a woman who chooses to have a child;
(2) Right to be protected from maternal mortality is an unequivocal, legally enforceable right, and where women are deprived of this right, compensation must be provided;
(3) The inability of a woman to survive pregnancy and childbirth violates her fundamental right to live guaranteed under Article 21 of the Constitution of India;
(4) State is under obligation to secure their [mother and child] life. It is the primary duty of the government to ensure that every woman survives pregnancy and childbirth;
(5) Right to life in Article 21 of the Constitution of India extends to receiving proper and complete medical attention from medical practitioners, whether working in a government or private hospitals;
(6) Claiming compensation in failed sterilisation comes only on account of negligence and not on account of childbirth;
(7) Doctrine of ‘best interest of the woman’ is to be followed in medical termination of pregnancy;
(8) Patient rights and ethical protocols are part of fundamental right to life with dignity;
(9) The State is vicariously liable for the negligence of its officers and liable for compensation.

Rights of People Living with HIV/AIDS

(1) Criminalisation of one’s personality based on sexuality is violative of Articles 14 and 21 of the Constitution of India;
(2) It is the constitutional public duty of the State to provide medical care;
(3) People living with HIV/AIDS have a right to access ‘treatment with dignity’ in State run hospitals;
(4) The doctrine of sovereign immunity is subservient to the fundamental rights; State is liable if it violates fundamental rights (applicable to HIV/AIDS cases);
(5) Doctrine of constitutional tort and remedy in public as well as private law for negligence is applicable [the violations of constitutional rights];
(6) Right to life includes the right to all reasonable health facilities;
(7) Any act of discrimination towards an employee based on their HIV-positive status is a violation of Fundamental Right;
(8) Justification on grounds of executive policy is not acceptable when the policy itself is discriminatory and arbitrary. Articles 14 and 16 of the Constitution of India is applicable to administrative actions. (e.g. Mandatory testing without
explicit consent of the patient, including for ‘pre- or in-service’ employment screening or insurance procedure is discriminatory).

**People with Psychosocial Disabilities**

1. Duty of the State and governments to provide medical care to all citizens;
2. Right to life and human rights [of the inmates] imply adequate medical care and treatment;
3. Imprisonment of the non-criminal mentally ill is unconstitutional;
4. Right to life under Article 21 and right to access justice under Article 32 of the Constitution are available even for convicts sentenced to death.

### 3.3.3 Thematic Cluster 3: Health Care of Social Elites and Patient Rights

In this section we consider the health care issues of the government employees of higher rank and citizens belonging to middle and upper classes. The former is covered by the Central Government Health Scheme (CGHS) and have filed several litigations on issues related to their health care. The latter, accessed health care in private institutions, and had the wherewithal to litigate against the medical negligence. Hence, we assume they belonged to a class which could afford both health care and access to justice in the matters of health care. Distinguishing those who solely are dependent on public health care system, referred to as ‘the marginalised’—the subject matter of most of the litigations considered in this book—, the protagonists of jurisprudence emerging from the select litigations in this section are considered under the nomenclature of ‘social elites’.

#### 3.3.3.1 Health Care Entitlements of Elite Government Employees

In India, the protocols for medical care of persons in permanent government employment and persons in armed forces are well developed. The policies and rules for medical attendance are developed and amended periodically by the respective Departments of Personnel either at the central or state government level for its employees under the Constitutional provision of ‘conditions of service’ articulated in article 309 of the Constitution of India. Central government employees are covered under the Central Government Health Scheme (CGHS), for whom medical care is provided through hospitalisation in public hospitals or through medical reimbursements.

The disputes concerning the reimbursement of expenditure by the CGHS is the key issue in the petitions analysed under this theme. Six petitions in the SCI, 14 in the HCs and three in CATs are taken into consideration for analysis in this section. In four of the six petitions, the aggrieved individuals had appealed against the order of the HC and the SCI heard the matter. Significantly, in two petitions, the state of Punjab is the appellant against the order of the HC—*State of Punjab and Others. v. Mohinder*
Singh Chawala\textsuperscript{181} (hereafter, Mohinder Singh Chawala) and State of Punjab v. Ram Lubhaya Bagga\textsuperscript{171} (hereafter, Ram Lubhaya Bagga). These two petitions consolidate the jurisprudence in adjudicating such matters in the HCs as landmark judgments. They also gain significance due to the strong character of the jurisprudence principles laid down marked by a conclusive and incontrovertible position of courts in these matters.

Jurisprudence

The courts primarily leaned on the earlier four landmark litigations to develop jurisprudence in this domain, viz. Right to life (CERC case), right to health of the workers (Kirloskar Brothers), right to health (Hazardous drugs case) and right to emergency medical care (Paschim Banga case). Mohinder Singh Chawala and Ram Lubhaya Bagga are the key petitions where the preceding cumulative jurisprudence was applied in matters of health care.

Right to Health is Integral to the Right to Life with Dignity

In Mohinder Singh Chawla, the SCI ruled that room rent was an integral part of the expenses for treatment and should therefore be reimbursed. This claim was refuted in the appeal in the SCI, on the ground that rent at the cost of AIIMS was not part of the policy of the government. SCI upheld the decision of the HC stating that the government had a constitutional obligation to pay for medical bills incurred by its current and retired employees and as per the policy formulated by the state government. The jurisprudence laid down by the bench, K. Ramaswamy, J. as the author, is based on the socialistic interpretation of the Constitution and highlights the principle of the constitutional obligation of the State ‘to bear the expenses of the government servant while in service or after retirement from service’ and the duty of the government ‘to fulfil the constitutional obligation’. In several other petitions, courts reinforced the right to medical reimbursements as part of right to life, reasoning that the right to health is an integral part of right to life and reiterated the constitutional obligation of the State to reimburse the entire amount incurred as expenditure.\textsuperscript{182}

This jurisprudence was further reinforced in Ram Lubhaya Bagga, in which a policy that was amended to reimburse lower costs was challenged. The health care jurisprudence in this important case further emphasises the concept of welfare-state and the obligation of the State to ensure conditions congenial to good health,\textsuperscript{183} and the right to life of citizens. It also emphasises the corresponding duty of the State

\textsuperscript{181}State of Punjab and Ors. v Mohinder Singh Chawala AIR (1997) 2 SCC 83 [CIVIL APPEAL NOS.16980-81 OF 1996 @SLP (C) Nos.12945 and 18828 of 1996 & CA No.16979/96 @ SLP (C) No.12472/96] \textsuperscript{171}State of Punjab v Ram Lubhaya Bagga (1998) 4 SCC 117.

\textsuperscript{182}Daljit Singh v. State of Punjab and Ors. 1997 (116) PunLR 600 (Para 7); Milap Singh v. Union of India 113 (2004) DLT 91; 2004 (76) DRJ 126; Prithvi Nath Chopra v. Union of India 2004 (74) DRJ 175; Kartar Singh Virk v. State of Punjab and Ors. (1997) 116 PLR 573.

\textsuperscript{183}‘In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health….. In a series of pronouncements during the recent years, this court has culled out from the provisions of Part- IV of the Constitution, the several obligations of the State and called upon it to effectuate them in order that the resultant picture by the
explained in Article 47 of the Constitution of India, terming it as the ‘one of the most sacrosanct and a valuable right of a citizen and equally sacrosanct sacred obligation of the State’.

Self-preservation of One’s Life as Part of Right to Life

In Sadhu R. Pall v State of Punjab, and Surjeet Singh v State of Punjab, the court incorporated the principles of self-preservation to declare the right to health and medical care as part of right to life. It stated that ‘self-preservation of one’s life is the necessary concomitant of the right to life enshrined in Article 21 of the constitution of India, fundamental in nature, sacred, precious and inviolable’.

Special Considerations to Social Elites

The special consideration bestowed on the social elites by the courts, primarily the government employees of higher ranks, is tangible in the judgements of the courts. It manifests in two-fold ways, viz. striking down some policies of reimbursement on the grounds of discrimination and being generous in providing reimbursements classifying some of them as emergency cases.

In several cases courts struck down policies which denied full reimbursement or medical facilities to the current or retired employees, and in some cases even to their spouses, on the grounds of discrimination. In two cases, courts struck down policies that excluded reimbursement and medical facilities to pensioners, as violative of articles 14 and 21, and hence unconstitutional. The legal reasoning was that the subordinate legislation is a policy and must be consistent with the Constitution. In Veena Sharma v. State Bank of India and Ors, the court ordered the respondent to reformulate the Rules keeping in mind the constitutional mandate. In some cases, the HC of Delhi overruled the office memorandum containing the revised rates which was more than two years old, based on which a full reimbursement was not given.

In another instance, CAT applied the jurisprudence of State obligation to provide health care respecting the principle of equality, and expanded the scope of medical reimbursements to cover even the pensioners.

In some instances, Courts were lavish in offering special consideration of emergency situations and were very generous in granting concessions to Government servants. For example, reimbursement beyond the permitted levels was allowed citing
emergency in the case of kidney operation; \(^{190}\) apex court in one case \(^{191}\) and HC in another case \(^{192}\) ordered full reimbursement even if disease was not a recognised one in the policy; where a govt hospital was not available, the rates of the private hospital were directed to be reimbursed. \(^{193}\)

The imprint of K. Ramaswamy J. is visible in two of the widely acclaimed cases discussed above. Most of these cases were in the mid-1990s. K. Ramaswamy’s socialist interpretation of the Constitution forms a common thread between the jurisprudence of right to health of the workers and right to health/medical care in the case of government employees, workers of a dissimilar character and status. The articulation of social justice, welfare-state philosophy and consequent state responsibility for citizen’s health and medical care is found in these principles of justice in health care. The petitions perused unequivocally apply the health care jurisprudence in reimbursements and even striking down the executive policy making which is discriminatory.

In addition to the already existing practice of reimbursements of medical expenditure by the State, in 2013, the Department of Personnel and Training (DOPT) offered to reimburse to the rank of IAS and IPS officers, the entire medical expenditure incurred abroad. When the health sector is continuously being under-resourced, academicians and policy analysts have criticised the move for the misplaced priorities and for the nexus and collusion that this move would promote as part of reciprocation between politicians and civil servants. It is a move that will impair health care in India besides sending ‘wrong signals for the public health care policy in India’ (Baru 2013).

3.3.3.2 Patient Rights and Medical Negligence

The path to attain patient rights in India through litigations has been indirect and tortuous. Most of the litigations that we analyse in this chapter do not refer to any particular patient right, but the violation of right to health care in general. The litigations concerning medical negligence, among all the domains considered in this chapter, draw the closest links with the rights of individual patients or patients’ rights. Such 47 litigations considered here—SCI (5), HCs (21) and Consumer Redressal Commissions (21) -, include issues that directly refer to patient rights such as duties and conduct of medical professionals, doctor—patient relationships, medical negligence and medical malpractice. The analysis of jurisprudence is summarised here under three themes, viz. (1) principles of medical negligence (2) remedies for medical negligence, and (3) medical practice. In the end, the discussion on jurisprudence in this domain is synthesised in the context of patient rights.

\(^{190}\)Devindar Singh Shergil v State of Punjab (1998) 8 SCC 552.

\(^{191}\)Suman Rakheja v State of Haryana and another, (2004) 2 SCC 563.

\(^{192}\)Mani v. Secretary of Government 2007 (3) MLJ 34 [W.P. No.3947 of 2006].

\(^{193}\)K.P. Singh v Union of India (2001) 10 SCC 167.
Jurisprudence on Principles of Medical Negligence

The international medical jurisprudence has laid down the test of medical negligence on the doctrine that consisted of three principles, viz. duty of care, doctrine of ‘res ipsa loquitur’, and discovery rule. Indian jurisprudence primarily has applied and confirmed these as tests of medical negligence. These principles are elaborated below.

Doctrine of the Duty of Care

Bolam test lays down the scope of negligence as applicable to the medical profession. In *Bolam v Friern Hospital Management Committee*194 duty of care was laid down as determining the scope of negligence for the medical profession.195 Building on international jurisprudence, SCI in *Jacob Mathew v State of Punjab*196 confirmed the essential ingredient to test medical negligence as duty of care and defined as ‘an ordinary competent person exercising ordinary skill in that profession’. However, such an explanation was muddled with a lot of confusion and ambivalence when the same judgement excluded ‘a simple lack of care, an error of judgment or an accident’ as proof of negligence on the part of a medical professional’ and added that additional considerations will apply without specifying them. Jurisprudence laid down in several judgments, however, continuously reiterated the standard applied to determine negligence as that of an ordinary person exercising skill in that profession while clarifying that the highest and specialised skills were not expected to be employed.197

Doctrine of ‘Res Ipsi Loquitur’

The doctrine of *res ipso loquitur* was applied in M/s Spring Meadows Hospital Case.198 *Res Ipsi Loquitur* literally means that the thing speaks for itself. When the plaintiff/complainant does not have the knowledge of the true cause of mishap but knows only the medical doctor as closely related to it and is in a position to prove the accident, then the principle of *res ipso loquitur* is invoked. The accident is shown to be under the management of the defendant or his subordinates, and the accident as such does not happen in the ordinary course of things if the professional were to use proper care. In *Shyam Sunder v State of Rajasthan*,199 this was discussed in the context of a medical mishap and the plaintiff’s inability to prove negligence.

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194 *Bolam v Friern Hospital Management Committee* 1957 2 ALL ER 118.
195 Basic ingredients of Bolam test include: (1) Existence of a duty to take care, which is owed by the doctor to the complainant; (2) Failure to attain that standard of care, prescribed by the law, thereby committing breach of such duty; and, (3) Damage which is both casually connected with such breach and recognised by the law, has been occasioned to the complainant.
196 *Jacob Mathew v State of Punjab* (2005) 6 SCC 1.
197 Postgraduate Institute of Medical Education and Research (PGIMER) v Jaspal Singh (2009) 7 SCC 330; (2009) 3 SCC (Cri) 399.
198 M/s. Spring Meadows Hospital & Anr. v Harjol Ahluwalia (1998) 4 SCC 39 (in Civil Appeal No. 7858 of 1997).
199 *Shyam Sunder v State of Rajasthan* AIR 74 SC 876.
The court illustrated the instances of employing this doctrine by stating that ‘gross medical mistake will always result in a finding of negligence’.

Discovery Rule

Discovery of the injury or negligence and its relation to the cause of injury holds prime key in adjudicating on medical negligence. Several instances of medical negligence come to light after a considerable amount of time has lapsed and are impeded by limitation of time for admission in the court of law. In V. N. Shrikhande (Dr) v Anita Sena Fernandes,200 after nine years of her surgery, the respondent nurse discovered the cause of her abdominal pain as the gauze pieces left behind by the doctor who operated on her. The SCI held that where the effect of negligence is manifest, the cause of action arises on the date on which negligence was committed. But when the effect is latent, cause of action arises when harm or injury is discovered or could have been discovered by exercising reasonable diligence. In this case, it was held that the respondent was barred by limitation (of time) and the discovery rule was not applicable to her.

Select Prominent Cases in Medical Negligence Jurisprudence

- **Malay Kumar Ganguly v Dr. Sukumar Mukherjee**201
  In this case, the patient’s death was attributed to the combined effect of giving treatment contrary to established medical treatment protocols and the negligence of the hospital. Patient suffering from Toxic Epidermal Necrolysis (TEN) was not diagnosed initially by a doctor (who was not a dermatologist) prescribed a high dose of long-acting steroid, depomedrol. A second doctor prescribed a quick-acting steroid, prednisolone, without considering the harmful effect of the already accumulated steroid in the patient’s body. A third doctor, when the patient was diagnosed with TEN, failed to provide supportive therapy. Patient died eventually. In this case, the doctors individually and the hospital were held negligent on the grounds of the lack of due care.

- **Jacob Mathew v State of Punjab**
  In this significant and landmark judgment, SCI stipulated guidelines to be followed in the prosecution of doctor for criminal negligence. On February 15, 1995, a patient was admitted in the private ward of a hospital. On February 22, 1995 at about 11 p.m., when the patient experienced difficulty in breathing, the complainant’s elder brother, who was present in the room, contacted the duty nurse, who in turn called a doctor to attend to the patient. The doctor came to the room only after about 25 min and connected the oxygen cylinder to the mouth of the patient, however, the breathing problem increased further. The oxygen cylinder was found to be empty, and as there was no other gas cylinder available in the room, the patient’s son brought a gas cylinder from the adjoining room. However, there was no arrangement to make the gas cylinder functional and meanwhile, a precious time of 5–7 min had lapsed. Another doctor who meanwhile reached the room

200V. N. Shrikhande (Dr) v Anita Sena Fernandes (2011) 1 SCC 53; AIR 2011 SC 212.
201Malay Kumar Ganguly v Dr. Sukumar Mukherjee (2009) 9 SCC 221; (2010) 2 SCC (Cri) 299.
examined and declared the patient dead. A criminal complaint was filed, and a case was registered under Sections 304-A and 34 of the Indian Penal Code. The appellant, a medical doctor, filed a plea for quashing the criminal complaint. The single judge who heard the petition formed an opinion that the plea raised by the appellant for quashing the charge was not made out. Feeling aggrieved, the appellant filed a special leave petition before SCI. In the judgment, the SCI laid down guidelines towards the prosecution of medical professionals (Subrahmanyam 2013). [Vide. Section criminal jurisprudence in medical negligence, below]

- **Samira Kohli v Dr. Prabha Manchanda**

  The appellant, an unmarried woman of 44 years, approached the respondent for treatment for excessive menstrual bleeding. After the ultrasound test, she was advised laparoscopic procedures for a surgery. However, only when the patient was under general anaesthesia, the doctor took oral consent from the mother and conducted hysterectomy (removal of uterus) and bilateral salpingo-oophorectomy (the surgery to remove the ovaries and fallopian tubes) on the patient. Subsequently, when the patient contested this and refused to pay the doctor, the respondent doctor lodged a complaint with the police for non-payment of bills, in addition to sending her a legal notice. The appellant in turn, filed a complaint with the NCDRC for compensation, which was dismissed on the grounds that ‘the informed choice has to be left to the operating surgeon depending on his/her discretion’, which prompted the appellant to approach the SCI. The jurisprudence considered the issue of ‘consent’ at length, contextualising the case law in the inadvertent practices of profit-making in private-commercial health care institutions, thus making this a landmark reference case in the issue of patient’s right to ‘consent’. The judgement, inter alia, finds the position of the NCDRC on the issue of consent untenable, and adds the element of valid/real consent after discussing at length the issues of ‘express’ and ‘informed’ consent (Box 3.8). In this case, the SCI concluded that there was no real consent for the surgery and set aside the order of NCDRC, while ordering a compensation of Rs.25,000/- to the appellant to be paid by the doctor. The prevailing medical jurisprudence referred to ‘informed’ or ‘express’ consent which relies on the principle of ‘reasonably prudent patient test’. However, the court emphasised the need to go beyond this to real or valid consent in India:

  We have however, consciously preferred the ‘real consent’ concept evolved in Bolam and Sidaway in preference to the ‘reasonably prudent patient test’ in Canterbury, having regard to the ground realities in medical and healthcare in India. But if medical practitioners and private hospitals become more and more commercialized, and if there is a corresponding increase in the awareness of patient’s rights among the public, inevitably, a day may come when we may have to move towards Canterbury. But not for the present. (Ibid., Paragraph 33)

- **Martin F. D’Souza v. Mohd. Ishfaq**

  __202__Samira Kohli v. Dr. Prabha Manchanda (2008) 2 SCC 1 [WP Civil 1949 of 2004].

  __203__Martin F. D’Souza v. Mohd. Ishfaq (2009) 3 SCC 1 [CIVIL APPEAL NO. 3541 OF 2002].
The respondent already suffering from chronic renal failure was brought to Nana- 
vati Hospital, Mumbai, for an acute urinary problem which needed immediate 
medical attention. He was administered an antibiotic amikacin. Later, he under-
went a kidney transplantation in a different hospital and subsequently lost his 
hearing. He filed a complaint against the appellant for damages in the NCDRC (Commission), holding him responsible for the loss of hearing on account of 
administering the antibiotic amikacin. The commission appointed an expert from 
AIIMS to examine the complaint who submitted his report which said that the 
antibiotic amikacin which was administered was a life-saving drug. However, 
the commission held the act of the appellant as medical negligence and ordered 
compensation. The Commission on 9 April 2002, awarded Rs. 4 lakh with interest 
@ 12% from 1.8.1992 as well as Rs.3 lakh as compensation in addition to Rs. 
5000/- as costs. The appellant filed an appeal in the SCI under Section 23 of the 
CPA, 1986. The SCI considered the issue of medical negligence at length, set aside 
the medical negligence order of the Commission, and upheld the jurisprudence 
laid down in Jacob Mathew case. It laid down as follows:

[Before issuing notice to the doctor or hospital against whom the complaint was made 
the Consumer Forum or Criminal Court should first refer the matter to a competent doctor 
or committee of doctors, specialised in the field relating to which the medical negligence 
is attributed, and only after that doctor or committee reports that there is a prima facie 
case of medical negligence should notice be then issued to the concerned doctor/hospital. 
This is necessary to avoid harassment to doctors who may not be ultimately found to 
be negligent. We further warn the police officials not to arrest or harass doctors unless 
the facts clearly come within the parameters laid down in Jacob Mathew’s case … the 
policemen will themselves have to face legal action (Dr. Martin F. D’Souza v. Mohd. 
Ishfaq, Paragraph 117).

Box 3.8 Defining ‘real’ or ‘valid’ consent (Samira Kohli v Dr. Prabha 
Manchanda)

1. A doctor has to secure the consent of the patient before commencing a ‘treat-
ment’ (the term ‘treatment’ includes surgery also). The consent so obtained 
should be real and valid, viz. the patient should have the capacity and compe-
tence to consent, consent should be voluntary, it should be on the basis of 
‘adequate information’ concerning the nature of the treatment procedure;

2. The ‘adequate information’ to be furnished by the doctor who treats the 
patient, should enable the patient to make a balanced judgment as to whether 
he should submit oneself to the treatment or not. This means that the Doctor 
should disclose (a) nature and procedure of the treatment and its purpose, 
benefits, and effect; (b) alternatives if any available;

3. Consent given only for a diagnostic procedure, cannot be considered 
as consent for therapeutic treatment. Consent given for a specific treatment 
procedure will not be valid for conducting some other treatment procedure. 
The fact that the unauthorised additional surgery is beneficial to the patient,
or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery;

4. There can be a common consent for diagnostic and operative procedures where they are contemplated;

5. The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree [mentioned in Canterbury], but should be of the extent which is accepted as normal and proper by a body of medical persons skilled and experienced in the particular field.

Jurisprudence Regarding Remedies for Medical Negligence

There are three remedies available for patients alleging medical negligence primarily in the private-commercial health care facilities. The course of litigations has further refined the nuances of these existing pathways, thus in several ways redefining the potency of these pathways for securing justice for citizens. [Vide. Chap. 4, for a detailed discussion]

- **Civil Remedy** This consists of a civil suit for damages or for compensation for the injuries suffered, followed under the law of tort. The CPA 1985 aimed at simplifying procedures and provides redressal outside the formal court through the consumer redressal forum.

- **Criminal Prosecution** In the case of deaths or gross negligence, IPC Section 304B (culpable homicide not amounting to murder), Section 336 (causing danger to human life or personal safety through a rash or negligent act), Section 337 and 338 (causing simple or grievous hurt) are invoked. The punishment entails imprisonment and cash compensation.

- **Complaint in Medical Councils Against Professional Misconduct** The Medical Councils are regulatory bodies for the medical profession and function as quasi-judicial bodies. In addition to civil and criminal remedies, complaints against a doctor can be filed before the state medical councils for professional misconduct asking for suspension of license of medical practice with a possibility of appeal in the medical council of India (MCI).

Civil Negligence and Deficiency of Service

Doctor-patient relationship is considered as a private contractual relationship under law for which civil law is deemed to be the appropriate legal framework offering private remedy. The burden of proof in such a private law remedy rests on the plaintiff. In India, however, the doctor-patient relationship itself—which is closely related to defining medical service—was not legally defined for long, constituting a critical barrier to access justice in matters of health care. When the CPA 1986 was enacted, resistance of medical professional associations to consider medical care as ‘service’ delayed the application of CPA to issues of medical negligence for over a decade. Only
in 1996 in the Indian Medical Association v V. P. Shantha (henceforth IMA case), jurisprudence decisively brought the medical profession and medical services within the scope of ‘service’, thus subjecting it to the jurisdiction of CPA (Box 3.9).

**Box 3.9 Definition of ‘Service’ and ‘Consumer’ (IMA v. V. P. Shantha)**

1. Services rendered to patient by medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medical and surgical, would fall within the ambit of services as defined in Section 2(1)(o) of the Act.
2. The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and/or State medical Councils would not exclude the services rendered by them from the ambit of the Act.
3. Services rendered at private or Government hospital, nursing home, health centres and dispensaries for a fee for all, are ‘services’ under the Act.
4. Services rendered free of charge for all, are exempted from the definition of service. Payment of a token amount for purposes of registration will not alter the nature of services provided for free.
5. Services rendered at a Government or a private hospital, nursing home, health centres and dispensaries where bulk of services are rendered on payment of fees to those who can afford, and free of charge to those who cannot, is also ‘service’ under Section 2(1)(o) of the Act. Hence in such cases the persons who are rendered free services are ‘beneficiaries’ under Section 2(1) (d) thereby ‘consumer’ under the Act.
6. Services rendered free of charge by a medical practitioner attached to a hospital/nursing home or where he is employed in a hospital/nursing home that provides free medical facilities, is not ‘services’ under the Act.
7. Where an insurance company pays, under the insurance policy, for consultation, diagnosis and medical treatment of the insurer then such insurer is a consumer under Section 291)(d) and services rendered either by the hospital or the medical practitioner is ‘service’ under Section 2(1)(o). Similarly, where an employer bears the expenses of medical treatment of its employee, the employee is consumer under the Act.

The nature of the doctor-patient relationship was clarified as ‘contract for service’ and not a ‘contract of service’. The latter ‘implies a relationship of master and servant and involves an obligation to obey order in the work to be performed and as to its mode and manner of performance’:

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204 Indian Medical Association v V.P. Shantha (1995) 6 SCC 651.
205 Kishore Lal v ESI Corporation (2007) 4 SCC 579.
The relationship between a medical practitioner and a patient carries within a certain degree of mutual confidence and trust and, therefore, service rendered by the medical practitioners can be regarded as a service of a personal nature, but since there is no relationship of master and servant between the doctor and the patient the contract between the medical practitioner and his patient cannot be treated as a contract of personal service and it is a contract for service… (Kishore Lal v ESI Corporation, Paragraph 8)

**Factors Constituting Negligence or Deficiency of Service**

The nuances of what constitutes ‘deficiency of service’ continue to be refined through the ongoing litigations. The following illustrate some of those defined as such as deficient services:

- Failure of the hospital to maintain nurses’ register in a private hospital—(*Malay Kumar Ganguly v. Dr. Sukumar Mukherjee*);
- Nurses not keeping a watch over a patient or not administering medicine in the pretext of preventing infection to themselves—(Ibid.);
- Doctors treating without having requisite expertise—(Ibid.);
- Doctors not following medical treatment protocols laid down by experts—(Ibid.);
- Duty to act with reasonable care and skill not exercised in a failed sterilisation operation—(*State of Haryana v Santra*);
- Persons lacking requisite skill which one professed to possess and failure to exercise with reasonable competence the skill possessed by a professional—(*PGIMER v Jaspal Singh*);
- Failure to prevent nosocomial infections (‘health care associated infections’ that appear in a patient which was absent at the time of admission). It is the duty of the hospitals to prevent infections when a patient has high risk of infections—(*Malay Kumar Ganguly v. Dr. Sukumar Mukherjee*);
- Failure to provide basic amenities by hospitals—(Ibid.);
- Informed consent of the patient or his relative/attendant is not taken—(Ibid.);
- Omission to carry out requisite preparation tests due to which the operation culminated in acute paraplegia and lack of complete investigation prior to actual operation—(*Nizam’s Institute of Medical Sciences v Prasanth S. Dhananka*);
- An error which a hospital/doctor exercising ordinary care would not make is not an error of professional judgment but a case of medical negligence—(*PGIMER v Jaspal Singh*).

Notably, such articulations as mentioned above, are not conclusive. Intermittently, anomalies and ambiguities crop up indicating the inchoate character of jurisprudence in this domain. For example, the SCI concluded that the proof of medical negligence

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206 State of Haryana v Santra (2000) 5 SCC 182; AIR 2000 SC 1888.
207 Post Graduate Institute of Medical Education & Research (PGIMER), Chandigarh v Jaspal Singh & Ors CIVIL APPEAL NO. 7950 OF 2002, order of SCI dt. 29 May, 2009.
208 Nizam’s Institute of Medical Sciences v Prasanth S. Dhananka and Others, CIVIL APPEAL NO.4119 OF 1999, SCI order dt.14 May 2009.
is intrinsically linked to the liability of doctors, while reiterating that unless negligence of the doctor is established, primary liability cannot be fastened on them (Ins. Malhotra v Dr. A. Kriplani).\footnote{Ins. Malhotra (Ms.) v. Dr. A. Kriplani Civil Appeal No. 1386 OF 2001, decided on 24 March 2009.}

Criminal Jurisprudence in Medical Negligence

Both the criminal complaints against doctors as well as medico-legal cases come under the purview of criminal jurisprudence, where the State assumes the role of the prosecutor. The HCs and SCI have progressively ruled in favour of doctors and courts have applied cautious and guarded approaches in fixing criminal liability of medical professionals.\footnote{Dr. Anand R. Nerkar v. Smt Rahimbi Shaikh Madar 1991(1) Bom. C. R. p. 629; C. P. Sreekumar (Dr) v S. Ramanujam (2009) 7 SCC 130; Kusum Sharma v. Batra Hospital (2010) 3 SCC 480; (2010) 2 SCC (Cri) 1127.} In Malay Kumar Ganguly v Dr. Sukumar Mukherjee, the court distinguished between the negligence considered under civil as distinguished from criminal law:

Jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of \textit{mens rea} must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be of much higher degree. A negligence which is not of such a high degree may provide a ground for action in civil law but cannot form the basis for prosecution (Paragraph 180) [emphasis added].

Distinction between civil and criminal negligence was sorted out in Kusum Sharma v. Batra Hospital case. The jurisprudence laid down that ‘simple lack of care’ attracts civil liability whereas ‘very high degree of negligence’ is a requirement for it to be considered as criminal negligence. The following broad principles have been evolved in the consideration of criminal negligence in jurisprudence.

\textit{Criminal Prosecution in ‘Gross Negligence Only’}

The SCI has laid down that simple lack of care or an error of judgment is insufficient to constitute medical negligence, while emphasising that such negligence ‘must be of a gross or a very high degree’.\footnote{Dr. Suresh Gupta v. Govt. of Delhi (2004) 6 SCC 422.} The following guidelines have been laid down in the criminal prosecution of doctors: (1) A credible opinion given by another competent doctor to support the charge of rashness or negligence; (2) The investigating officer, before proceeding against a doctor, should obtain an independent medical opinion preferably from a doctor in government service qualified in that branch of medical practice; (3) The accused doctor should not be arrested in a routine manner unless his arrest is necessary for furthering investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor will abscond. Hence, the degree of negligence manifested as ‘recklessness and indifference to the consequences and the knowledge of imminent injury’ as an essential component of criminal negligence (Kusum Sharma v Batra Hospital, Malay Kumar Ganguly, Sreekumarn (Dr.) v. S. Ramanujam).
3.3 Domains of Health Care Services and Litigations

Cautious Application of ‘Res Ipsa Loquitur’

Against the incontrovertible proof of medical negligence of *res ipsa loquitur*, i.e. the thing speaks for itself, the courts have opined that *res ipsa loquitur* is not of universal application. In significant judgments, courts have cautioned that this principle must be applied with extreme care in the case of professional cases such as doctors.\(^{212}\)

Test of Criminal Negligence

In *Jacob Mathew*, the Bolam test is applied to determine criminal jurisprudence in addition to other factors. The following doctrine is laid down as a test of criminal negligence:

To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent (*Jacob Mathew*, Paragraph 48/7).

In matters of deaths in hospital, which forms a considerable ground for pursuing criminal prosecution, the court laid down a precondition to invoke Section 304-A IPC. It states:

>[i]t is necessary that the death should have been the direct result of a rash and negligent act of the accused, and that act must be the proximate and efficient cause without the intervention of another’s negligence. It must be the causa causans; it is not enough that it may have been the causa sine qua non’ (*Ibid.*, Paras 48(6) and 38).

Expert Opinion and Evidence

The requirement of an opinion of the medical experts (a medical practitioner or a medical board) has been set as the precondition for the criminal prosecution of medical professionals. While this protects the medical professionals to a large extent, such a requirement presents insurmountable legal challenges for the complainant to pursue the matter. The unwillingness of doctors to testify against other doctors\(^{213}\) and even when patients (complainants) do manage to get a medical opinion, conflicting medical opinions offered by the accused party supporting their action are some of the key hurdles that patients/complainants face. In *Senthil Scan Centre v Shanthi Sridharan*,\(^{214}\) NCDRC awarded compensation to the plaintiff for failing to detect deformity in the foetus. The SCI, holding that there was no expert evidence to counter the claims of the appellant centre and in addition, accepting that the doctor was qualified and ultrasound was done with due care and diligence, reversed the award of NCDRC. The issue of expert medical opinion is fraught with severe confusion at the level of processing complaints. Later, a case *V. Kishan Rao v Nikhil Super Speciality Hospital*\(^{215}\) which traversed from the district consumer forum to state and national

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\(^{212}\)Jacob Mathew v. State of Punjab 2005 6 SCC 1; 2005 SCC (Cri) 1369.

\(^{213}\)Ins. Malhotra v. Dr. A. Kriplani (2009) 4 SCC 705; (2009) 2 SCC (cri) 561.

\(^{214}\)Senthil Scan Centre vs. Shanthi Sridharan (2010) 15 SCC 193; (2011) 3 CPJ 54 (SC).

\(^{215}\)Also refer to Marghesh K. Parikh v Dr. Mayur H. Mehta (2011) 1 SCC 31 (page 38).
commissions, and then while landing in the SCI, the court provided a clarification that expert opinion is required only when a case is complicated enough warranting expert opinion (Paragraph 106).

Summary of the Prominent Jurisprudence on Medical Negligence (Jacob Mathew Case)

Jurisprudence in Jacob Mathew v State of Punjab, represents the current benchmark in the consideration of medical negligence in India. It attained a landmark status by its reinforcement and consolidation in other litigations such as Martin F. D’Souza v. Mohd. Ishfaq, C. P. Sreekumar (DR) v. S. Ramanujam and V. Kishan Rao v. Nikhil Super Speciality Hospital. Key components of this jurisprudence are summarised here below.

- **Bolam Test:** In a claim of medical negligence, it suffices for the defendant to demonstrate that the standard of care applied was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill (Bolam Test).
- **Standard of Care and State of knowledge:** Standard of care when assessing the practice adopted in a case, is judged in the light of knowledge available at the time of the incident and not at the date of trial. [Paragraphs 48(2), 48(4), 19 and 24]
- **Standard of care in case of failure of equipment:** If the equipment was not generally available at the time of incident, the charge of negligence is not applicable. [Paragraphs 48(2), 48(4), 19 and 24]
- **Failure to take precaution:** It is to be seen whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be standard for judging the alleged negligence. [Paragraphs 48(2), 48(4), 19 and 24]
- **Mere accident is is not negligence:** Mere accident during medical or surgical treatment and error of judgment is not negligence per se and depends on the circumstances. If it is made by a reasonably competent professional who held himself out to be possessing that skill, then it is negligence. If it is done by acting with ordinary care, it is not negligence. [Paragraphs 25, 33 and 45]
- **Deviation from normal practice is not a sufficient ground for negligence:** If it can be found that the procedure which was in fact adopted was one which was acceptable to medical science at the time of alleged incident, the medical practitioner cannot be held negligent merely because s/he chose to follow one procedure and not another and the result was a failure. Liability arises if (1) there is a usual and normal practice; (2) that the defendant (medical professional) has not adopted it; and (3) that the course adopted is one that no professional man of ordinary skill would have taken had he been acting with ordinary care. [Paragraphs 21, 23 and 25]
Jurisprudence Relating to Medical Profession and Patient Rights

Litigations and ensuing jurisprudence in this domain relate to two broad themes, viz. medical practice, and the duties of doctors (towards profession and patients).

Medical Profession and Practice of Medicine

The principle briefly summarised as ‘the statutory duty to practice what one is licensed to’ represents the key doctrine regarding the medical practice in relation to medical negligence. Practice by those not qualified amounting to negligence has been the reasoning that has prevailed in several judgments in this theme. In *M. Jeeva v. R. Lalitha*, the NCDRC awarded compensation of Rs. 2 lakhs in the case of a qualified nurse and midwife not qualified to practice medicine running a gynaecology hospital for 40 years. In *Poonam Verma v Ashwin Patel*, the SCI ruled that a homeopath undertaking allopathic practice amounted to an actionable negligence. In *Mukhtiar Chand (Dr.) v State of Punjab*, it was held that the right to prescribe drugs and issue certificates is concomitant to the right to practice medicine. The right to prescribe allopathic medicines was held to be restricted only to those registered for the practice of that branch of medicine.

The constitutional validity of imposing reasonable restrictions on medical practitioners to limit their practice to any designated branch of medicine of their qualification was upheld by SCI in the interest of Public Health, under Articles 19(1)(g) and (6) of the Constitution of India. In *Ayurvedic Enlisted Doctors’ Association v State of Maharashtra*, it was stipulated that one could not practice unless the practitioner’s name was included in the Central Register maintained under the Indian Medicine Central Council Act, 1970. Following the same reasoning, in *Akhtar Hussain Delvi (Dr.) v State of Karnataka*, a registered allopathic medical practitioner who sought the right to prescribe ayurvedic medicines was disallowed.

Duties of Doctors (in Relation to Patients’ Rights)

Patients rights have neither been codified nor have been notified in India. The pathway of identifying and recognising some of them have been been through litigations on medical negligence and hence, they find a mention as the corresponding duties of medical professionals towards their practice of medicine. Through several litigations, they evolved as guidelines, precautions, reminders or as reprimands of the medical profession for their failure in safeguarding lives of patients.

1. Duty of self-regulation and accountability to the public: In *State of Punjab v. Shiv Ram*, the SCI reminded the doctors and medical establishments of their

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216 *M. Jeeva v. R. Lalitha* 1994 2 CPJ 73.
217 *Poonam Verma v. Ashwin Patel* (1996)4 SCC 332.
218 *Mukhtiar Chand (Dr.) v. State of Punjab* (1998)7 SCC 579.
219 *Ayurvedic Enlisted Doctors’ Association v State of Maharashtra* (2009) 16 SCC 170; *Udai Singh Dagar v. Union of India*, (2007) 10 SCC 306; *Rajasthan Pradesh Vaidya Samiti v. Union of India* (2010) 12 SC 609 at pp.625, 627.
220 *Akhtar Hussain Delvi (Dr.) v. State of Karnataka* AIR 2003 Karnataka 388.
221 *State of Punjab v. Shiv Ram* (2005) 7 SCC 1.
ethical duty to the society and ‘self-regulation as the heart of their profession’ (Paragraph 34).

2. Duty to take express consent from patients: In an elaborate jurisprudence laid down in *Samira Kohli v Dr. Prabha Manchanda* the issue of informed consent was elaborately discussed as the duty of a doctor and a corresponding right of the patient, while explicating the nuances of valid and real consent. It was laid down that consent must be an express consent, known in American jurisprudence as ‘informed consent’ and in the UK as ‘real consent’. *NIMS v Prasanth S. Dhananka* further held that the implied consent (consent given for one, by inference, taken as implied consent for another) was no consent.

3. Duty to disclose and inform the patient: In *Malay Kumar Ganguly v Dr. Sukumar Mukherjee*, duty of disclosure implying a reasonable guarantee of a patient’s right self-determination was established.

4. Duty of the doctor not to use privileged medical information in criminal investigation without consent: In *Selvi v State of Karnataka,*222 upholding the medical ethics, it was held that testimonial acts such as results of psychiatric examination cannot be used in evidence without the subject’s informed consent.

5. Duty of the Doctors to act in emergency: Duty of the doctors to treat patients in emergency was reinforced in *State of Kerala v Raneef*223 and in *Martin F. D’Souza v. Mohd. Ishfaq* the mandate to commence treatment without waiting for the police formalities was reiterated. Such prescriptions followed from *Parmanand Katara v. Union of India* which held that immediate medical aid to injured persons with an obligation to preserve life was a professional obligation of all doctors in emergency situations.

6. Duty to protect a patient’s privacy and to maintain confidentiality: Right to confidentiality and privacy is a well-established right of a citizen. This was applied to the corresponding duty of the doctors in HIV related cases, where the issue of privacy was closely associated with the stigma patients faced. This was vitiating in ‘X’ v *Hospital ‘Z’*224 where the court held such a duty as not binding on doctors in the case of HIV patients. However, later in ‘X’ v *Hospital ‘Z’*,225 the three-judge bench reversed the opinion. Such an impediment was partially overcome with the clarity that was provided in *Selvi v State of Karnataka* upholding patient’s right to privacy.

7. Duty of Care and liability for medical negligence: In *Laxman Balkrishna Joshi v Trimbak Bapu Godbole*—one of the earliest and long-drawn court battle in post-independent India that involved two medical doctors as the litigants-, the issue of doctor’s ‘duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment’ was firmly articulated. The order stated that a breach of any of those duties gives a right of action for negligence to the patient. This was explained as

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222Selvi v. State of Karnataka (2010) 7 SCC 263.
223State of Kerala v. Raneef (2011) 1 SCC 784.
224‘X’ v. Hospital ‘Z’ (1998) 8 SCC 296.
225‘X’ v. Hospital ‘Z’ (2003) 1 SCC 500.
a duty to act with reasonable care and skill, the failure of which makes the doctor liable for negligence.\textsuperscript{226} This duty of care was buttressed with the doctrine of legitimate expectation, casting an obligation on a medical profession that entitles a patient to a legitimate expectation of a standard of care and treatment. The doctrine of legitimate expectation which was evolved in administrative law was extended to medical treatment as part of duty of care (Malay Kumar Ganguly v. Dr. Sukumar Mukherjee). The jurisprudence on duty of care was decisively clinched in the Jacob Mathew case.

Patient Rights and Challenges

Notably, there have been very few litigations on the rights of patients in India. Although a jurisprudence on health care has been articulated as seen in this chapter, distinct rights of patients have not been laid down as part of these litigations. Hence a clear articulation on patients’ rights has been missing in the health care jurisprudence in India. In a few other cases, rights of patients were articulated during litigations. The application of such entitlements, however, at best, has been limited to the particular case in hand. The universalisation of such entitlements as rights of patients has suffered due to the lack of a cohesive legal framework to embed them.

Analysis of litigations on quality of care, medical negligence and professional misconduct provide a very patchy picture of jurisprudence on the medical profession and and indicate to the piecemeal gains accrued on the citizens as patient rights. Right to medical records (Raghunath Raheja, Mumbai),\textsuperscript{227} admitting medical opinion as evidence through video conferencing—in this case expert medical opinion of a doctor based in the USA, admitted for the first time in India by the Bombay HC (P. C. Singhi v. Dr. P. D. Desai)\textsuperscript{228}—illustrate such piecemeal gains. Most of the litigations in this domain predominantly represent issues as individual grievances as they are litigated on a case-to-case basis, thus overwhelmingly obscuring the systemic malaise of unaccountability and non-regulation that triggers violations of patients’ rights. Consequently, the outcomes of litigations too have been confined to individual cases without making a dent in rectifying the systemic mishaps that sporadically manifest as violations of patients’ rights at scale.

Meanwhile, in the realm of medical negligence, a transition in the scale of violations of patient rights in the private-commercial health care institutions, has gained

\textsuperscript{226}This judgment was based on the jurisprudence developed in a number of other judgments on medical negligence and was based on a two-judge bench. However, it is deemed to have been overruled by the State of Punjab v. Raj Rani which was delivered by the division bench (2 judges) along with the jurisprudence developed in State of Punjab v. Shiv Ram (3 judge bench).

\textsuperscript{227}Raghunath Raheja v. Maharashtra Medical Council, Writ Petition No. 3720 of 1991, decided on 11th January 1996.

\textsuperscript{228}The State of Maharashtra v Dr Praful B. Desai. April 1, 2003. Cri. L.J. 2033; Dr PB Desai v State of Maharashtra, Criminal Revision Application No. 166 of 2012, High Court of Bombay, order dated October 15, 2012; Dr PB Desai v State of Maharashtra, Criminal Appeal No. 1432 of 2013 (arising out of SLP (Cri.) No. 9568 of 2012, Supreme Court of India, order dated September 13, 2013.
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centre stage in public discourses (Gadre and Shukla 2016). The unregulated commercial sector in health care driven by an unbridled profiteering motive and a lack of regulatory framework fixing its accountability, is seen to be the immediate context of such grave medical malpractices prominently marked by irrational medical practice and ethical aberrations. The unwarranted hysterectomies conducted on 471 tribal women in 37 private hospitals in a small district of Kalburgi in Karnataka (2011–2015), or clinical trials related deaths of over 1800 persons in several states, among others, anecdotally point to both the scale and intensity of such violations.

Charter of Patient Rights

In a recent move, NHRC has compiled some of the accrued rights of patients into a charter of patient rights in 2019 and has recommended the same to the MoHFW. The Charter enumerates 17 rights of patients that emanate from the international human rights commitments, the right to life enshrined in Article 21 of the Constitution of India and deems it to be a guidance document for the central and state governments to take adequate measures for the protection of patients’ rights and make them operational and enforceable by law (Box 3.10). Notably, the imperative for such a charter is acknowledged as the regulatory gap that exists in India for mediating patients’ rights. It states that ‘India does not have a dedicated regulator like other countries and the existing regulations in the interest of patients, governing the healthcare delivery system is on the anvil…’ (NHRC 2018:2). Codification of these rights is a significant step in their recognition. Though most of them evolved through litigations in SCI or HCs as a body of rights, however, as a charter they merely serve as an advisory to the central government, and would need a statutory recognition to acquire the force of an enforceable right. The Charter of Patient Rights compiled by NHRC is a guidance document and is recommendatory in its nature, leaving much to the political will of the State to take it into consideration.

| Box 3.10 Patient Rights as per the Charter |
|------------------------------------------|
| 1. Right to Information                   |
| 2. Right to records and reports          |
| 3. Right to emergency medical care        |
| 4. Right to Informed consent              |
| 5. Right to confidentiality, human dignity, and privacy |
| 6. Right to the second opinion            |
| 7. Right to transparency in rates and care as per prescribed rates |
| 8. Right to non-discrimination            |
| 9. Right to safety and quality care according to the standards |
| 10. Right to choose alternative treatment options if available |
| 11. Right to choose the source for obtaining medicines or tests |
| 12. Right to proper referral and transfer, which is free from perverse commercial influences |
| 13. Right to protection for patients involved in clinical trials |
14. Right to protection of participants involved in biomedical and health research
15. Right to take discharge of the patient, or receive the body of deceased from the hospital
16. Right to patient education
17. Right to be heard and seek redressal

Challenges in Safeguarding Patient Rights

Media is galore with stories of individuals from diverse parts of the country facing similar issues of negligence in medical care, exorbitant costs of care, subsequent deaths and challenges to prove medical negligence explained as ‘rocky road to justice’ marked by delay, harassment and uncertainty. In a contemporary case that occurred in Lucknow (Uttar Pradesh) where a patient died in a private hospital in 2014 and only in 2020, after an arduous struggle over six years, the NCDRC awarded compensation holding the doctors guilty of medical negligence (Pattanaik 2020). During the COVID19 pandemic times, there have been several instances where patients needing critical care have been turned away in the pretext of attending only to COVID19, the corona virus infected patients have been charged exorbitantly in the private-commercial hospitals, and such infected persons from the marginalised communities have not been given timely treatment resulting in deaths. Such accounts illustrate the gaping hole in safeguarding patient rights and in providing redressal as part of health justice. They are also indicative of the unsurmountable challenges faced by citizens in pursuing justice in health and of the health justice governance related confounding factors in such a pursuit.

One, the moral, ethical and governance decline and practically a collapse of MCI in the last twenty-five years (1995–2020) has added to the existing woes of medical regulation in India. MCI, which was suspended intermittently on account of malgovernance and corruption is finally repealed by a parliamentary Act, viz. National Medical Commission Act 2019. Even while being suspended and placed under the oversight body appointed by the SCI earlier, MCI did not show any signs of reform. The MCI as an institution symbolises the rot of malgovernance, corruption and unaccountability that runs deep into its institutional structures of medical professional governance stretching upto the state and district levels. The disbanding of the MCI appears to be only a symbolic act that needs a comprehensive reform for patients to repose their trust in the medical profession. The National Medical Commission Act 2019 promises, inter alia, to reform medical education and the governance of medical profession.

Two, while the collapse of medical professional governance under the MCI had serious repercussions for the protection of patient rights, it is only exacerbated by the collusion of the public authorities and medical professionals with private-commercial

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229Word used in place of bad governance or misgovernance to mean not only bad or poor governance but bad governance with a moral connotation such as corruption entangled governance.
health care establishments that include the pharmaceutical and diagnostic industry. In an abysmally regulated policy and regulatory ecosystem in India, the private-commercial health care institutions enjoy an absolute immunity from being transparent and accountable, that provide a conducive atmosphere for the violations of patient rights. Medical profession, through its unquestioning acceptance of and collusion with the profiteering commercial health care establishments and putting up organised resistance to any reform of regulation in health care has exacerbated the vulnerability of patients, and in turn, the cycle of violations of patient rights.

Three, adding further uncertainty to establishing patient rights, in the Consumer Protection Amendment Act of 2019, the hard-fought legal doctrine of ‘health as service’ has been dropped. This marks an uncertain future for the very possibility of litigations on medical negligence in India.

Four, the legal framework in India and the jurisprudence on medical negligence, has added additional burdens on patients that impede the pathways for justice. An overtly doctor-sympathetic judiciary (and the legal profession) and a non-relenting medical profession do appear as the major barriers in the health care jurisprudence being successful in effecting systemic changes towards realising health for all. The following factors weigh heavily against the patients venturing into pursuing health justice in the juridico-legal institutions.

- Requirement of medical expert’s testimony to prosecute medical doctors and hospitals in cases of criminal negligence
- Presumptions of having no negligence in doctors puts the burden of proof on the suffering patient or survivor
- Contributory negligence as a mitigating factor is an easy defence that courts admit favouring doctors
- Burden of proof on the plaintiff to prove causal linkages to the lack of due care
- The medical councils which adjudicate complaints on professional misconduct of doctors in their capacity as quasi-judicial institutions, are constituted only of doctors. They do not follow the open court system, are often hostile to complainants and invariably end up exonerating doctors as indicated by the abysmally low rate of finding the doctors guilty. Even when some doctors are found guilty of misconduct, the punishment imposed is often symbolic and tokenistic.

As the analysis in this section has indicated, contrary to putting in place the measures for the reform of the medical profession and the medical practice, the jurisprudence has buttressed the impunity of the medical profession. In addition, it has constricted the avenues available for citizens for redressal against the medical profession.
3.3 Domains of Health Care Services and Litigations

3.3.3.3 Brief Summary of the Legal Doctrine Concerning Health Care of Social Elites and Patient Rights

*Health Care of Social Elites*

(1) Self-preservation of life is necessary concomitant of right to life and includes medical treatment;
(2) Meaningful life and quality of life is part of right to life;
(3) Right to life—casts corresponding duty on the State to create congenial conditions for good health;
(4) Article 47 [of the Constitution of India] casts duty on the welfare-state for the health of citizens;
(5) Right to health, medical aid and [medical] care are fundamental rights guaranteed under Article 21 read with Article 39(e) of the Constitution;
(6) Government is under a constitutional mandate to improve public health.

*Patient Rights and Medical Profession*

(1) The unauthorised practice and adverse impact on the patient are an unfair trade practices;
(2) Providing medical service not qualified to offer, is violation of the mandatory statutory provisions and is a breach of legal duty;
(3) Non-exercise of reasonable care and skill—is ‘negligence per se’—and is liable under the Constitutional mandate and law of tort;
(4) ‘Medical service’ is consumer ‘service’;
(5) Doctrine of legitimate expectation casts duty on doctors for the ‘duty of care’ for patients;

3.3.4 Thematic Cluster 4: Public Health Measures

In this section two overlapping themes within the overarching paradigm of public health are considered, viz. public health measures and health care services. The former cover issues such as regulation on smoking, sale, and consumption of liquor, use of helmets while driving two-wheeler motor vehicles and regulating vehicular pollution. The latter cover issues of primary health centres etc. In these litigations the fundamental right to health has been employed as a strong ground to argue for adequate public health measures to be put in place. Although there is no further refinement of jurisprudence, these litigations illustrate the contextual interpretation and application of the settled jurisprudence to several issues that are integral to public health.
3.3.4.1 **Accentuating Public Health Measures**

Of the 41 litigations considered for analysis, 25 petitions are litigated in HCs and 16 in SCI. This section deals with litigations on various intersecting public health issues such as regulating tobacco, usage of helmets, access to food, and agricultural policies that impact health. They also demonstrate the scope of health care jurisprudence and its contribution to the discourse on right to health care.

**Regulation of Smoking and Tobacco Sales**

India is a signatory to WHO Framework Convention of Tobacco Control (FCTC) (World Health Organisation n.d.). The Central government enacted Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA) in 2003 and its rules were framed in 2004. Since then, civil society has filed several PILs using this legal framework for issues such as seeking a ban on public smoking, restriction of government participation in tobacco promotion events, prohibition of sale of tobacco products around educational institutions, restraining surrogate advertising, and, restricting the sale and distribution of ‘pan masala’ and ‘gutka’ containing tobacco as ‘food items’.

Apart from the application of the health care jurisprudence in this domain, the politics that plays out in engaging courts narrates an interesting story on the intersections of power—both economic and political—and the judicial institutions. The power of the court has been used both by the industry and the civil society to further their respective goals. However, this research opens up avenues to probe further

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230Murli S Deora v. Union of India and others (2001) 8 SCC 765; [WP(C) 316 of 1999].

231The Institute of Public Health v. The State Government of Karnataka and Ors. (Vide Order dt. September 17, 2010) W.P. No. 27692/2010 GM-RES-PIL (The High Court of Karnataka, India); petition prayed for restraining the Tobacco Board, a statutory body constituted under the Tobacco Board Act 1975 from participating in the Global Tobacco Network Forum 2010.

232The Cancer Patients Aid Association v. The State of Karnataka and Ors. (March 29, 2011) W.P. No. 17958/2009 GM-RES-PIL (The High Court of Karnataka, India); World Lung Foundation South Asia v. Ministry of Health and Family Welfare, India. (February 2, 2011) W.P. (C) 7540/2010 (The High Court of Delhi, India); Kerala Voluntary Health Services v. Union of India et al. (March 26, 2012) WP No. 38513 (The High Court of Kerala India).

233R. Arul v. The Secretary to Government, Health, and Family Welfare Department and Ors. (November 27, 2012) W.P. No.26527 (The High Court of Madras, India).

234Indian Dental Association UP State and another v. State of UP and another. (September 17, 2012) (PIL) No. – 19126 of 2012.

235For example: Supreme Court: Ankur Gutkha v. Indian Asthma Care Society and Ors. (April 3, 2013), SLP(C) No.16314/2007, SCI; Miraj Products Pvt. Ltd. v. Indian Asthma Care Society and Ors. (February 17, 2011) SLP (Civil) No(s). 19467-19469/2007, SCI; Union of India v. ITC Ltd. India. (September 29, 2008) Diary No. 28322, SCI High Cours: Amarsinh Z Choudhari v. State of Gujarat and Ors. (December 22, 2010) Special Civil Application No. 4848 of 2009 (HC of Gujarat); Berrys Hotel (MOCHA), et al v. Municipal Corporation of Greater Mumbai, et al. (August 11, 2011) WP-L-1531-2011, HC Bombay; Concepts and More v. Bruhat Bengaluru Mahanagara Palike et al. (March 8, 2012) WP No. 16820, HC Karnataka; Ghoi Foods Private Limited v. UOI, India.(May 7, 2012) WP No. 3131, HC Madhya Pradesh; M/S Omkar Agency v. The Union of India
into the line of interpretation and the nuances of application of the constitutional principles by courts and what drives the final outcomes of these litigations. Such research needs to delve into the art, skills, philosophy and perspectives of the judiciary that goes into the interpretation and application of these principles to these highly political issues that are presented as legal briefs in the court of law.

Two industry petitions challenged the constitutional validity of COTPA 2003 and some of the Rules framed in 2004.236 The petition by the Central Government to transfer these petitions to the SCI was rejected by the Bombay HC which ordered an injunction on the Act and Rules.237 In this case the raiding and seizing of gutka stock under the Food Safety Act by the Commissioner of Food safety was challenged by business barons as unconstitutional.238 In 2015, SCI transferred all the pending petitions from various HCs (about 50) to the HC of Karnataka (Bangalore). The HC of Karnataka, however, disposed off all these petitions without any noticeable order in favour of public health.

Regulating Vehicular Pollution for Improving Public Health

In *Smoke Affected Residents v. Municipal Corporation of Greater Mumbai*239 petitioners prayed for control and reduction of auto emissions from vehicles. The Bombay HC in its orders reinforced the duty to improve public health and issued a series of orders that included directions for all transport vehicles to run on cleaner fuels. Meanwhile, SCI too had issued wide ranging orders in similar petitions for the regulation of vehicular pollution under the mandate in Article 47 of the Constitution of India for reducing vehicular pollution.240

Wearing Protective Helmets

In two HCs, viz. Andhra Pradesh and Allahabad,241 petitions were filed challenging the imposition of wearing helmets. In *T.V. Rajagopala Rao v. Additional Director of the Central Government Health Scheme*,242 the provision of wearing helmets was
validated as part of right to life and under Section 129 of Motor Vehicles Act while declaring it to be a beneficial legislation for saving life from injuries.

Public Health Governance and Sale of Alcohol

In many unsuccessful petitions challenging the government’s role in the sale of alcohol and seeking a prohibition on the sale of alcohol, the reasoning of public health protection and the legal doctrine of health care were employed. The courts, however, took a stringent technical view of the matter as belonging to the policy domain where courts will not interfere in addition to it being non-justiciable as part of DPSP. The court also refused to admit it under the article 32 of the Constitution. However, as such matters continued appearing in the SCI, in a recent PIL to ban sale of alcohol around highways, the court finally banned sale of all alcohol within 500 metres of National and State highways all over the country (excepting Sikkim and Meghalaya), including the restaurants and licensed bars and wine shops. The SCI took note of the issue of drunken driving and increasing vehicular accidents that are related to the availability of alcohol around the highways. The judgment, however, is contested for its practicality (Editorial 2017).

Right to Food and Nutrition Security

People’s Union for Civil Liberties v. Union of India and Ors is a well celebrated PIL in the history of India and demonstrates the jurisprudence of continuing mandamus, as the SCI continued issuing important orders over a period of 17 years. In this comprehensive case the right to life and right to health care jurisprudence were extensively employed. In the backdrop of the malnutrition and starvation related deaths, SCI affirmed the right to food as quintessential to the articulation of necessary to ‘the fundamental right to life with human dignity’ enshrined in Article 21 of the Constitution of India. (Human Rights Law Network n.d.) The apex court orders on the PDS, midday meals, rural employment, drought relief, enhanced pension as social security to the elderly were intended to provide food and nutrition to people, all contributing to the realisation of right to health. This is one of the most successful civil society litigations filed before the SCI in the post-independent era on several issues intersecting health and health care. ‘Since inception of the case in 2001, 427 affidavits have been submitted by the petitioner and respondents and 71 IA’s (interlocutory applications) have been filed and 21 main or important orders issued’ (Human Rights Law Network n.d.).

Regulation on Genetically Modified Organisms (GMOs) for Protection of Public Health

New trade policies and the interest of transnational companies in the agriculture industry led to the introduction of GMOs in India. Among others, critical concerns on environmental and biosafety and impact on the health of the populations were

243Smt. Mala Banerjee v. State of West Bengal and Ors. 2008 (1) CHN 979 Calcutta; Krishna Bhat v. Union of India (1990) 3 SCC 65.
244People’s Union for Civil Liberties v. Union of India and Ors Writ Petition (Civil) 196/2001.
raised in this litigation. The Genetic Engineering Approval Committee (GEAC) had recommended to withhold approval to all applications for GM crops. In the applications that came to seek approval of SCI, the Court considered the ground of right to life and right to health under Article 21 as forming the core of the argument. In the orders that ensued, conditions were laid down and GEAC was asked to publish guidelines for approval keeping in mind public health and biosafety. Conditions for the field testing of GMOs included putting the data on toxicity and allergenicity in the public domain for enabling effective regulation and transparency and taking safety measures to avoid contamination. An expert committee was formed to submit a report within three months of the order (2012).

Other Public Health Issues

Several other issues were brought before the apex court on the grounds of safeguarding public health, albeit unsuccessfully. Such issues included challenging the policy on imposing compulsory iodisation of salt replacing the voluntary iodisation; public health impacts in constructing dams and environmental damage; demolitions of houses in slums and its adverse health impacts; issue of liability of corporations for people’s health and damages to be paid as in Bhopal Gas tragedy; demanding shelter by urban poor; containing dog bite as a public nuisance for public health.

Some of these litigations bring out the intersectionality of the determinants of health and health care and their impact on the health of the populations. The status of health and wellbeing is determined by various other social-economic and environmental factors that necessitates pursuing social citizenship in the wider dimensions of health—known as the social determinants of health—that includes social security and wellbeing (CSDH-WHO 2008). These two, viz. health care and determinants of health, are mutually reinforcing and significantly convey that any gain in one domain can only be sustained by such gains in the other, or vice versa. On the other hand, setbacks any one can nullify the gains in the other. The principle of intersectionality, enunciated in the Alma Ata Declaration, has convincingly proposed the mutuality of various determinants of health (World Health Organisation and UNICEF 1978).

Often, in several petitions that challenged the State policies contravening the wider dimensions of health and wellbeing, courts have taken very ambivalent positions. Such ambivalence is reflected in their stated inability to direct the State to legislate

245 Aruna Rodrigues v. Union of India (2012) 5 SCC 331.
246 Academy of Nutrition Improvement v. Union of India (2011) 8 SCC 274.
247 Narmada Bachao Andolan v. Union of India (2000) 10 SCC 664.
248 Olga Tellis and Others v Bombay Municipal Council (1985) 2 SCR 51; Ahmedabad Municipal Corporation v. Nawab Khan Gulab Khan, (1997) 11 SCC 123.
249 Charan Lal Sahu v. Union of India (1990) 1 SCC 613.
250 Ahmedabad Municipal Corporation v. Nawab Khan Gulab Khan (1997) 11 SCC 123 (right to shelter – pavement dwellers); Sodan Singh v. NDMC (1989) 4 SCC 155: petition on evictions, categorization of people and allotment of place – right to trade is not under 21, but 19 (g).
251 Sanjay Phophaliya v. State of Rajasthan and Ors. AIR 1998 Raj 96; 1997 (3) WLC 431; 1997 (2) WLN 112 Rajasthan.
any law in tune with Article 47 or to invalidate a law infringing the right to health, or in the view that passing orders was tantamount to making policy which was not the intent of Article 32 of the Constitution.

3.3.4.2 Health Care Services

Health care system or health services system is central to the understanding of public health care. The blueprint of India’s health care system was proposed to be crafted adopting an allopathic medical system organised through the network of primary health care centres with adequate referral system in a district. Such a model was proposed by Bhore Committee incidentally right at the time of Indian independence Govt of India (1946). This was contemporaneous to the Beveridge report in England (1945) which played a monumental role in shaping the health care system in England, much known as the National Health Service (NHS). In addition, India also subscribed to the Alma Ata Declaration, which vouched for strengthening people’s health through a primary health care model, intended to be closer to the people while being very cost-effective. However, the analysis in this book (vide Chaps. 1 and 2) and several litigations poignantly indicate the lack of political will in strengthening such a system. The litigations that are considered in this section, summarise the critical issues that point to the glaring gaps in an ailing public health care system.

Of the 41 litigations analysed here, 18 are from SCI and 23 are from various HCs. Some of these litigations overlap with other themes and belong to the 38 litigations that are considered in two domains separately for analysis. They are considered here for a synthesis as they raise systemic issues including health care infrastructure and services. Some of the systemic deficiencies and inadequacy of services that these litigations raise include collecting, storing, and supplying blood, access to mental health services, availability of food and nutrition, negligence of medical care in custody, and availability of medical aid to the visually impaired. Some other petitions include the issues of policy gaps as well with varied gains and include policy issues of sterilisation, hysterectomies and drug pricing. Sexual violence that formed the subject matter of a litigation illustrates the varied issues that come before the courts with public health and health rights aligned subject matters.

252 Common Cause v. Union of India, (1998) 2 SCC 367 [WP(c) 91 of 1992; Date of judgment: 04/01/1996].
253 Rakesh Chandra Narayan v. State of Bihar and Ors. 1989 SCC Supl. (1) 644.
254 Peoples’ Union of Civil Liberties v. Union of India Writ Petition (civil) 196 of 2001.
255 Supreme Court Legal Aid Committee v State Of Bihar (1991) 3 SCC 482, 1991 ACJ 1034; Poonam Sharma v. Union of India AIR 2003 Delhi 50.
256 Indian Council of Legal Aid and Advice v. Union of India, (2000) 10 SCC 542.
257 Rama Kant Rai v. Union of India [W.P (C) No 209 of 2003]; Devika Biswas v. Union of India [WP (C) 95/2012]; All India Drug Action Network v. Union of India (2011) 14 SCC 479; All India Drug Action Network v. Union of India (2011) 14 SCC 479.
258 CEHAT v. Government of Maharashtra challenging the two-finger test.
outcomes of these litigations vary substantially. The application of jurisprudence in matters related to health care services is summarised in this section.

Demanding Adequate Health Care Centres and Appropriate Infrastructure

Employing the jurisprudence of health care that emerged grounding itself on the foundations of right to life and public health—referring to Articles 21 and 47 of the Constitution of India—, several litigations were filed in the HCs of various states. They raised the issues concerning the lack of health centres, inadequate infrastructure, unhygienic conditions in the existing hospitals, and the unavailability of appropriate services.

Two petitions in diverse socio-political settings and independent of each other, raised the issue of the need of PHC in rural areas and health infrastructure in semi-urban areas. In one of the unique cases, an Ex-sarpanch (Sarpanch is the elected president of a gram panchayat) of Pachhikote Grama Panchayat in Odisha (Orissa) approached the HC to direct the respondent government to establish a PHC at Pachhikote village within Korei block in the district of Jeypore. The HC of Orissa developed the jurisprudence around the need of healthy life to achieve great things in life and to build a healthy society. The court noted as follows:

> [t]he Government is required to assist people, and its endeavour should be to see that the people get treatment and lead a healthy life. Healthy society is a collective gain and no Government should make any effort to smother it. Primary concern should be the primary health centre and technical fetters cannot be introduced as subterfuges to cause hindrances in the establishment of health centre (Ibid.).

The HC directed that a PHC should be started in the Grama Panchayat building and continued there till the new building is completed for running of the health centre. Apparently, this is the only case in which a judgement on establishing a PHC is passed to uphold the right to health. In a similar vein, an advocate in Uttar Pradesh raised the issue of the requirement of well-equipped urban health centres in Allahabad district, invoking the Articles 21 and 47 of the Constitution of India. This case was decided in 1999 with no clear directives. Together, these litigations depict the conditions of the health care system in the mid-1990s. The jurisprudence linked the citizens’ rights to the Constitutional framework of welfare-state. In K. Garg v. State of Uttar Pradesh, the court reiterated: ‘this is a welfare State, and the people have a right to get proper medical treatment’ (Paragraph 5). Finding the petitioner’s allegations to be true, the court acknowledged that government hospitals in Allahabad were in ‘very bad shape’ and needed ‘drastic improvement’. The Court directed the State of UP to set up a committee to investigate the affairs of government hospitals.

Several other petitions highlighted the issues of unhygienic conditions and inadequate infrastructure in health centres and hospitals. These petitions grounded their petitions on the jurisprudence developed in the Municipality of Ratlam case, where the Article 47 of the Constitution of India was unequivocally stated as the principle.

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259 Mahendra Pratap Singh v. State of Orissa AIR 1997Or 37.
260 S.K. Garg v. State of Uttar Pradesh and Ors. 1999 (1) AWC 847 Allahabad.
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of public health governance [Vide Sect. 3.2.1]. Applying the jurisprudence, viz. statutory duty and constitutional obligation of the statutory bodies and the duty of public bodies for governance, HCs, in these petitions ordered for removal of public health nuisance. Additional orders were issued to improve infrastructure, hygiene, and sanitation in public hospitals.261

The litigations on reproductive health services, in particular, singularly highlighted the malfunctioning of PHCs even while there was unspent money or diversion of funds allocated under the NRHM.262 Such malfunctioning of the health system at the village level consequently resulted in serious violations of women’s health rights in the centrally administered programmes such as sterilisation or maternal health services.263 As discussed in this chapter, the litigation outcomes by way of systemic changes vary across health care thematic domains. However, a salient feature became expressly manifest through the litigation process that despite a laudable and considerably sound jurisprudence, the courts did not [want to] engage themselves either in fixing accountability in the public health care system or in enforcing their own orders to fulfil such an objective. Notably, this has resulted in persisting gaps in the public health care infrastructure and health services.

Public Sector Enterprises and Health Care

Several public sector enterprises or undertakings such as railways, armed forces, tea gardens and beedi sector, run their own health care services for employees under their jurisdiction. A few petitions on railway services provide a peek into such arrangements. The practice of sending medical teams in railway coaches, for example, had been discontinued on account of under-utilisation. Drawing court’s attention, a petition264 prayed for adequate medical facilities at Railway Stations/Platforms, including the availability of life-saving drugs/medicines. In this case, the court creatively linked the fundamental right to movement (Article 19), right to life (Article 21) and public health governance (Article 47), to declare railways as ‘State’ having the obligation of the duties cast under Article 47.

[R]ailway Board to provide for effective medical facilities during the course of journey through rail transport for convenient and safe movement of people from one place to the other as a measure ensuring improvement in public health, standard of living and also for protection of life and liberties of people (Ram Dutt Sharma v. State of Rajasthan and Others, Paragraph 13).

261Citizens Action Committee, Nagpur vs. Civil Surgeon, Mayo (General) Hospital, Nagpur and Ors AIR 1986 Bom 136; Suo Moto v. State of Rajasthan, Rajasthan High Court, AIR 2005 Raj 82; The Registrar, Aurangabad.

262Fact finding reports & petitions Centre for Health and Resource Management (CHARM) v. State of Bihar & Ors., High Court of Patna W.P. (C) 7650/2011 and Dunabai v. State of Madhya Pradesh; For instance, the scam unearthed in Uttar Pradesh was diverting about 5000 crore of rupees from NRHM to other works.

263Sandesh Bansal v. Union of India, High Court of Madhya Pradesh at Indore W.P. 9061/2008; Promotion and Advancement of Justice, Harmony, and Rights of Adivasis (PAJHRA) v. State of Assam, Gauhati High Court W.P. 21/2012; Shri Rinsing ChewangKazi v. State of Sikkim &Ors., High Court of Sikkim PIL No. 39/2012.

264Ram Dutt Sharma v State of Rajasthan And Ors. AIR 2005 RAJ 317.
Constitutional Obligation of Private Charitable Hospitals to Provide Free Health Services

In India, apart from the public health care system, people also access the private-commercial health facilities and private charitable hospitals. The latter are supported by the State through incentives and concessions to provide free and subsidised health care to citizens. Hence, notwithstanding all the limitations, it can be presumed that the citizens’ right to access health care extends also to the private charitable hospitals within the scope provided by the legal framework. This provision was used by citizens to claim health care services to the poor. In *Social Jurist v. Govt of NCT of Delhi and Others*, the HC of Delhi widened this issue of allocating free beds to poor patients beyond the scope of one hospital questioned in the petition to all hospitals built on land provided by government at a concessional rate under the Governments Grant Act, 1895 (the Act) and the Delhi Development Authority (Disposal of Developed Nazul Land) Rules, 1981 (the Rules). Such concessions included the precondition of providing free treatment to a limited percentage both in-patient (IPD) and out-patient departments (OPD). The petitioner’s prayer to the court was to direct the concerned authorities to act against defaulting hospitals. The orders in this litigation laid down certain principles for charitable hospitals established through government grant and reinforced the State’s power to impose conditions on private hospitals including the duty to treat and clarified the meaning of free treatment.

Several concessions were granted to these hospitals which the court considered ‘advantageous situation because of the help or allotment of vital assets’. Based on this and providing a wider interpretation under Article 21 read with Article 47 of the Constitution of India, the court mandated these hospitals to provide free care, stating ‘…The principle of equality, fairness and equity would command these hospitals to discharge their obligations of free patient treatment to poor strata of Delhi’ (*Social Jurist v. Government of NCT of Delhi*, Paragraph 94). It also mandated super speciality hospitals to have free emergency services so that any patient could be given first aid treatment before being sent to an appropriate hospital. The meaning of free treatment was clarified in the order as inclusive of all facilities to be free of charge including services, treatment, consumables, and non-consumables (Box 3.11).

In *the Supreme Court Young Advocates Forum v. Union of India and others*, known as the Apollo Hospital case, Delhi HC directed the State to reserve 33 percent beds and 40 percent out-patient services for the poor in private hospitals built on the largesse provided by the government. Similarly, *All India Lawyers Union v. Government of NCT of Delhi and Ors.*, the issue of largesse provided to the private entities and non-compliance by the private parties to those conditions was raised. The Government of the National Capital Territory of Delhi (GNCTD) had provided a vacant Players Building to a multi-speciality hospital (IMCL), subject to providing free medical care to patients, both in-patient and out-patient care, one third and

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265 *Social Jurist v. Government of NCT of Delhi and Ors.* 140 (2007) DLT 698 High Court, Delhi.
266 *Supreme Court Young Advocates Forum v. Union of India and others*, Delhi High Court, 99 (2002) DLT 290.
267 *All India Lawyers Union v. Government of NCT of Delhi and Ors.* WP(C) No.5410/199 Delhi.
40 percent, respectively. Later, the IMCL did not comply with this condition and challenged the very concept of ‘free care’ as not applying to

Box 3.11 Free Medical Care in Charitable Hospitals (Social Jurist v. Government of NCT of Delhi)
The Court made a balancing act in this petition when the argument of financial non-viability of providing free care was provided in defense and limited the percentage of free and complete treatment of patients to 10 percent IPD and 25 percent OPD patients. A special committee was constituted by the Court to overlook the creation and maintenance of this pool as well as to monitor compliance with the rest of the conditions imposed by it. (Ibid., Paragraph 63) The Court also held that if any hospital was found not complying with the conditions and the directions issued by it, the head of such a hospital would be liable to be proceeded against in accordance with law. The Court constituted an Inspection Committee to carry out inspections at the twenty hospitals dealt with in the petition. It was granted the power to ‘revive this petition…against the defaulters under the Contempt of Courts Act’.

it as a public limited company. The lawyers’ association impleaded in this case. In the jurisprudence developed in this litigation, the HC of Delhi has laid down the following principles:

1. The private party is a State instrumentality by virtue of the agreement: By agreeing to be a partner with the State in the matter of health care, with stipulations about free health care to the specified extent, IMCL had taken onto itself the mantle of State instrumentality (Paragraph 30).

2. State has the mandate to regulate, for assuring basic health care to all citizens: Health care is essential concomitant to quality of life. Its demand and supply cannot therefore be left to be regulated solely by the invisible hands of the market. The State must strive to move towards a system where every citizen has assured access to basic health care, irrespective of their capacity to pay (Paragraph 43).

3. Writ of mandamus maintainable against any authorities, instrumentalities of the State, private parties performing public function, under the wider powers of the Article 226 of the Constitution of India

4. Free treatment is comprehensive: The expression ‘free medical diagnostic and other facilities’ must be interpreted to mean ‘treatment not only in the nature of providing admission and accommodation to the hospital, diagnosis and investigation but free medicines and consumables also’ (Paragraph 57).

In another case on allocation of government land reserved for public purpose to construct a private hospital in Karnataka,268 the SCI constructed its judgment on the jurisprudential principle of ‘statutory/legislative intent’. Referring to the statutory object of the Bangalore Corporation, the court reiterated that it aimed to promote and

268Bangalore Medical Trust vs B.S. Muddappa And Ors [1991] 4 SCC 54.
enhance quality of life and healthy growth and development of the city of Bangalore. It will be achieved by providing maximum space for the benefit of the public at large for recreation, enjoyment, ventilation, fresh air, and protection of health of the public at large. Hence allotting land reserved for public purpose to a private party to construct hospital was held violative of the legislative intent.

3.3.4.3 Summary of the Key Jurisprudence Applied in the Thematic Domain of Public Health Measures

The litigations demanding adequate health care and infrastructure and to regulate those components vitiating public health originated from diverse civil society actors. Most of them were context specific and addressing specific issues at hand. Collectively, these provide a sense of the application of the existing health care jurisprudence to these specific issues. Key jurisprudence in the themes discussed in this section is summarised here.

Public Health Measures

1. In a welfare-state it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health;

2. Article 47 [of the Constitution of India] casts a fundamental duty on the State to improve public health, and to endeavour to prohibit consumption of intoxicating substances which are injurious to health;

3. Article 21 of the Constitution makes provision for safeguarding the life of a person wearing a helmet. It is in consonance with the provisions of Article 21 of the Constitution of India. The provision is neither arbitrary nor unreasonable;

4. The right to food is necessary to uphold Article 21 of the Constitution of India, which guarantees the fundamental right to ‘life with human dignity’.

Health Care Services

1. Article 21 of the Constitution, as interpreted in a series of judgments of the Supreme Court, has the legal effect that no hospital can refuse medical treatment to a person on the ground irrespective of his poverty or inability to pay;

2. ‘Healthy environment’ principle includes people’s right to live in a healthy environment’;

3. Railways is a ‘State’ under Article 12 of the Constitution. Accordingly, Articles 19 and 21 read with Article 47 [of the Constitution of India] oblige the Railway Board to provide for effective medical facilities during the course of journey, as a measure ensuring improvement in public health, standard of living and also for protection of life and liberties of people;

4. It is the duty of the State under Article 47 to provide the citizens proper health care. The State cannot deny a citizen of the medical treatment while s/he is travelling in a train;

5. The right of the State to impose conditions on the [private] hospitals to make it accessible to citizens is upheld on the grounds of Article 47 and Article 21;
The right to access health care extends to health services in the private charitable hospitals within the legal framework of India;

The expression ‘free medical diagnostic and other facilities’ must be interpreted to mean treatment not only in the nature of providing admission and accommodation to the hospital, diagnosis and investigation but free medicines and consumables also;

The private party is a ‘State instrumentality’ by virtue of the agreement to participate in public programmes. State has the mandate to regulate for assuring basic health care to all citizens;

Writ of mandamus is maintainable against any authorities, instrumentalities of the state, private parties performing public function, under the wider powers of the Article 226 of the Constitution of India.

### 3.4 A Brief Synthesis

The key principles of jurisprudence in health care laid down in India’s Apex Court point to a further progression of jurisprudence of personhood (right to life) and access to justice as integral to dignity and personhood. They reinforce the underlying principles of the Constitution of India itself, viz. the concept of welfare-state and State’s ‘public duty’ which is oftentimes described as an absolute duty with no exceptions. Such a duty is enunciated in the jurisprudence in several terms such as ‘removing public nuisance’, ‘creating a healthy environment’, ‘enhancement of quality of life’, and ‘protection of health and public at large’. The analysis in the chapter unambiguously points to the fact that the right to health care is unequivocally laid down as a fundamental right. With 67 percent cases litigated in the SCI, the firm imprint of the apex court in the jurisprudence is visible across the rights constituencies. The evolution of health care jurisprudence over the last five decades also vouches for the fact of it being incontrovertible and irreversible.

Health care jurisprudence is founded on the foundations laid in the environmental rights, rights of workers and movement for civil liberties. The argument of welfare-state is well founded in the judgements concerning workers’ right to health and medical care. This is built on the principles of considering welfare in broad terms as ‘the legislative intent’ in many of the legislations concerning workers. The welfare of the workers, social security, right to dignity, protecting their health and strength are considered part of the welfare-state concept and the legislative intent. Historically, the churnings on workers’ rights issues were spearheaded through workers’ unions in public sector undertakings. Therefore, the argument that the State as the principal employer was bound by public duty to provide medical and health care became unassailable in constructing the edifice of SRHC. Civil liberties and progressive criminal jurisprudence, on the other hand, which took cognisance of the violations of health and medical care of under-trials, prisoners and arrestees, provided critical reinforcement in making ‘health care jurisprudence’ relevant to segments other than
the organised workforce as well. Realising the right of medical care to these vulnerable sections, imprints a stamp of definitiveness on the declaration of health care as integral to the fundamental right to life. The litigation on hazardous drugs forms an important piece of health care jurisprudence within the health care domains, wherein the SRHC was alluded to as a fundamental right. It formed the springboard for other health care related litigations that were subsequently filed.

The relative ease of establishing such jurisprudence in the rights domains of workers and civil liberties, can be fairly attributed to the centrality of welfare-state and the accountability of public servants and institutions to Constitutional governance. The issue of violations by non-State actors and private-commercial entities and subjecting them to Constitutional governance, however, is emerging as another barrier that civil society must cross. The liability of the private-commercial health care establishments is yet to find a substantive space in the jurisprudential discourse of SRHC.

Among other considerations, the ability in the civil society actors or the aggrieved to manoeuvre courts on health care related matters brings the issue of social class into the forefront. As most of the petitions strongly indicate, the patients or the aggrieved from the marginalised communities had no wherewithal required for the legal mobilisation. The thematic domain of social elites and patient rights indicate that the socially privileged class had the competence to access to private health care and to mobilise legal institutions to redress their grievances. Being higher ranked government employees provided them the ecosystem of influence, power of networking among themselves and the capability to engage experts to raise issues of complete reimbursement of financial expenditure for medical care, room rent during the hospitalisation, excess of expenditure for medical care in the private hospitals, and appropriate remedial action on undue delay in reimbursement. Being an elite class, they were able to consistently bring petitions into courts. Consequently, the medical services to government employees are spelt out clearly as ‘entitlements’. Their status also enabled them to resolve the issue even moving beyond the HC into the SCI. The optimum utilisation of the health care jurisprudence, with a fair degree of success in litigations, is visible in the domain of social elites. As a class, they left no stone unturned to claim their rights. Contrastingly, it is not the same for citizens from underprivileged classes who are the primary subjects in the major portion of health care domains that we discussed in this book. Hence the role of socially sensitive ‘organic individuals’ drawn from the civil society belonging to the middle class professionals or civil society alliances emerges as very critical to broach and advance the rights of the marginalised.

Right to life (i.e. personhood jurisprudence) and the framework of the welfare-state form the fulcrum of health care jurisprudence. The framework of constitutional governance itself stands on the philosophical edifice of the welfare-state that

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For example, vide Government of Karnataka 1963, which is amended from time to time with major amendments in 2006; Clause 10(1) states: ‘A Government servant shall be entitled free of charges to medical attendance by the authorized medical attendant. Medical Officers shall not be allowed to charge any fees for Government Servants for whom they are appointed medical attendant.’ [emphasis added].
submits itself to constitutional duties and obligations. In the case of our discussion, we attribute such subjection to the mandate of Articles 21 and 47, among others, to secure SRHC to its citizens.

The changing character of the State from being a welfare-state to that of promoting health care as a business together with the oscillating positions of the judiciary on the State vis-a-vis the rights of people, indicate among other things, the predicament of such a jurisprudence vis-a-vis the political philosophy of the State and the paradoxes that the judiciary embed in the jurisprudence, which in the long run result in negating each other. The courts have emphasised that the State cannot shirk its obligation to provide medical facilities which would be ex-facie violative of Article 21. Courts have considered, in some occasions, the limitations of resources as one of the arguments for not providing medical facilities to its citizens including its employees. (See, Ram Lubhaya Bagga case). On the other hand, the jurisprudence analysed also amply finds the paradoxical and contradictory statements. For example, one judgement states: ‘Cannot direct the State to legislate law in tune with Article 47 nor can it invalidate a law on the ground that the same is in conflict with the said Article’ and that the ‘interpretation of Statute should not frustrate the goals set out in the Directive Principles of the Policy of the States’. In another judgement it is stated, ‘To make the State accept a particular policy, desirable and necessary as the policy might be, is not the function of Article 32 of the Constitution. Article 32 of the Indian Constitution is not the nest for all the bees in the bonnet of ‘public spirited persons’. The paradoxes and contradictions in several judgments in the same domain of health care or across thematic domains of litigations, leave ample scope for its variant interpretation in its application by the executive. As noted by scholars, it affirms the subjectivity that is involved in interpreting the Constitution and its application to the issues of violations of SRHC of citizens.

The area of policy making by judicial orders is a contested space determined by the doctrine of separation of powers. Courts, while generally accepting the State’s prerogative to make or change its policies, are often caught in the dilemma of asserting their power of judicial review and respecting the doctrine of separation of powers. The analysis finds some glimpses of the delicate art of navigating through this puzzle that courts exercised by way of articulating rights of citizens, even as it took care not to negate the State’s prerogative in policy making. In a Constitutional governance such as in the case of India, due to the power vested in the constitutional courts, the jurisprudence itself forms the part of the domestic policy and law. Through a sharp application of jurisprudential acumen, the judiciary has incrementally refined the canvas of health care policy by incrementally sharpening the articulations on SRHC. However, executing its orders and monitoring the policy implementation for effectively realising SRHC has remained elusive which needs an in-depth analysis, which will be done in the subsequent chapters (Vide Chaps. 4 and 5).

Considering the global and local socio-political contexts determined by the COVID19 pandemic at the time of writing this book, one cannot but underscore and reaffirm the importance of positing health as justice and the quintessential need for a robust public health care system to deliver health care as a fundamental right. The centrality of the welfare-state too is poignantly recognised during this time,
even in the avowed capitalist countries, who have invested enormous resources to contain and treat the COVID19 infections. Instead of situational and relative articulations on the obligations of the welfare-state—as we have seen in certain parts of the jurisprudence analysis -, the health care jurisprudence must unwaveringly declare the absolute centrality of the welfare-state for SRHC to be a reality.

Considering the health care jurisprudence as one whole, its positive and progressive dimensions hypothetically outweigh the constraints that are seen in parts. The articulations of SRHC and the jurisprudential principles laid down, in essence, are progressive and as a body of legal principles, encapsulate within it, the potential and far reaching insights for unassailably establishing the SRHC as a fundamental right.

Paradoxically however, regardless of having a progressive jurisprudence in hand, aggrieved patients are still grappling within the confines of the unchanging health care and justice systems. As seen in the domain of patient rights and medical negligence, the weight of the parts of jurisprudence have outdone the gains of the totality of jurisprudence, by making it virtually impossible for patients to produce convincing evidence even as they are handcuffed to prosecute the violators, most importantly, the private-commercial health care institutions. With the unbridled expansion of the private-commercial health care sector, violations of patient rights have emerged as the most serious concern in India. Despite the body of legal principles pointing towards its fundamental rights character, patients continue to experience the violations of their rights and are struggling to get justice. The complexities in pursuing health justice within the paradigm of the prevailing health care and justice systems, need critical examination to decode such paradoxes and predicaments. The mechanisms available for such patients are discussed and critically examined in chapter four. It is followed by a theoretical discourse in chapter five, on the exchange of power and actors that intersect in positing the possibility of health justice.

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