P.B.Desai vs State Of Maharashtra & Anr on 13 September, 2013

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Bench: A.K. Sikri, A.K. Patnaik

REPORTABLE

IN THE SUPREME COURT OF INDIA

CRIMINAL APPELLATE JURISDICTION

CRIMINAL APPEAL NO. 1432/2013
(ARISING OUT OF S. L. P. (CRL.) NO. 9568 OF 2012)

Dr. P.B. DESAI …..APPELLANT

VERSUS

STATE OF MAHARASHTRA & ANR. …...RESPONDENTS

J U D G M E N T

A.K. SIKRI, J.

1. Leave granted.

2. The appellant herein, a renowned surgeon, stands convicted of the offence punishable under Section 338 r/w Section 109 of the Indian Penal Code, 1860 (hereinafter to be referred as the 'I.P.C'). This conviction was delivered by the Additional Chief Metropolitan Magistrate, 47th Court, Esplanade, Mumbai, vide judgment and order dated 05.07.2011. The -appellant was sentenced to suffer simple imprisonment (SI) till the rising of the Court and to pay Rs. 50,000/- as and by way of compensation, in default to suffer simple imprisonment for 3 months. This conviction and sentence had been upheld by the ld. Additional Sessions Judge vide judgment dated 22.03.2012 and is also confirmed by the High Court of Judicature at Bombay by way of impugned judgment dated 15.10.2012. Still not satisfied, the appellant has challenged the judgment of the High Court, by way of present appeal.

3. To give a glimpse of the episode at the outset, we may mention that one Smt. Leela Singhi (hereinafter to be referred as the 'patient'), wife of Shri Padamchandra Singhi, the complainant, was suffering from Cancer for which she was under medical treatment since the year 1977. As her condition did not improve and rather deteriorated over a period of time, in 1987 she was taken to America and was treated in Sloan Kettering Memorial Hospital in New York. However, it did not yield any positive results. The doctors in that hospital declared her beyond surgical treatment and she was sent back to India on 29.11.1987. In India, she had been under the medical supervision of Dr. A.K. Mukherjee, for a long time, who started

-administering the medication prescribed by the doctors in U.S.A. Within few days, the patient started suffering from vaginal bleeding because of which Dr. A.K. Mukherjee advised her for hospitalization. She was admitted to Bombay Hospital on 9.12.1987. After a few days of hospitalization, she was examined by the appellant who advised 'Exploratory Laparotomy (surgery)', in order to ascertain whether the patient's uterus can or cannot be removed in order to stop the vaginal bleeding.

4. Nod of a patient for Exploratory Laparotomy was duly taken who signed the consent form. Dr. Mukherjee, assisted by two other doctors, began the Exploratory Laparotomy procedure on 22.12.1987. On opening the abdomen, Dr. Mukherjee found plastering of intestines as well as profuse oozing of ascetic fluids. He immediately called the appellant who was performing other surgical procedure in another operation theatre. The appellant after seeing the condition of the patient from a distance, found that it was not possible to proceed with the operation. He advised Dr. A.K. Mukherjee to close the abdomen. Dr. Mukherjee, thus, closed the abdomen. The condition of the patient, thereafter, deteriorated due to the formation of fistula. The patient remained in the hospital for treatment of the fistula. After remaining in the hospital for about 3 months she was discharged and taken home by the complainant. But she never recovered and ultimately passed away on 26.2.1989 at Jaipur.

5. The complainant filed a complaint with the Maharashtra Medical Council against the appellant and also lodged criminal complaint against the appellant with the Director General of Police, Maharashtra. Main allegation against the appellant was that he did not take personal care and attention by preferring the operation himself. On the contrary he did not ever bother to even remain present there when Dr. A.K. Mukherjee started surgical procedure and opened the abdomen. Moreover, when Dr. Mukherjee, on opening of the abdomen, found that Cancer was at a very advanced stage and it would not be possible to proceed because there was fluid and intestines were plastered and he called the appellant for advice, even then the appellant did not examine the patient minutely. Instead, after seeing her from the entrance of the operating room, he advised Dr. Mukherjee to close the abdomen. So much so, even after the formation of the fistula and the pathetic condition of the patient, the appellant never bothered to examine or looked after her. It was alleged that the very advise of the appellant for -surgical operation, even when doctors at U.S.A. had opined to the contrary, was inappropriate. It was, thus alleged that the aforesaid acts of omission and commission amounted to professional misconduct as well as offence punishable under Section 338 of the I.P.C. Since, there was no overt act on the part of the appellant, as the surgical procedure was performed by Dr. A.K. Mukherjee, charge of abetment under Section 109 of I.P.C. was also leveled against the appellant. Dr. A.K. Mukherjee was also made accused in the said complaint. However, at a later stage, Dr. A.K. Mukherjee was dropped from the proceedings at the instance of the complainant.

6. It is on the aforesaid allegations, purportedly proved through oral and documentary evidence, that the conviction of the appellant is returned by the courts below.

7. On the complaint of the complainant, Maharashtra Medical Council initiated disciplinary action against the appellant and found him guilty of professional mis-conduct under Para 15 of the Warning Notice of the Maharashtra Medical Council's Code of Ethics and Para 3 of the disciplinary action of the Medical Council of India's Code of Ethics. It resulted in issuance of warning under Section 22(1) of the Maharashtra Medical -Council Act, 1965 vide orders dated 11.2.1991 passed by the Maharashtra Medical Council. The appellant did not challenge the findings of the disciplinary committee of the Maharashtra Medical Council and accepted the order of warning.

8. As we are, in this appeal, concerned with the validity of the conviction of the appellant under Section 338, IPC, we would like to reproduce that provision at this stage:

> "338. Causing grievous hurt by act endangering life or personal safety of others: Whoever causes grievous hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine which may extend to one thousand rupees, or with both."

9. Questions that falls for determination is as to whether the alleged role of the appellant amounts to "doing any act" and whether it was so rash or negligent as to endanger the life of the patient.-

10. Mr. Harish Salve, learned Senior Counsel appearing for the appellant, at the outset, invited the attention of this Court to the exact charge framed by the Trial Court which reads as under:-

> "Does the prosecution prove that on 22.12.1987 at about 9.00 a.m., at Bombay Hospital, Mumbai, the Accused No. 1, Accused No. 2 - Dr. A.K. Mukherjee, caused grievous hurt to the wife of complainant namely, Leela Singhi by doing an operation of abdomen taking out uterus, so rash or negligently as to endanger human life or the personal safety of wife of the complainant namely, Leela Singhi and thereby committed an offence punishable under Section 338 read with Section 109 of the I.P.C?"

11. His submission was that the specific allegations in the charge framed against the appellant as well as Accused No. 2 – Dr.. A.K. Mukherjee were that:-

a) The charge is for a specific act committed at 9.00 a.m. on 22.12.1987.

b) It is a charge against the Appellant (Accused No. 1) and Dr. A.K. Mukherjee (Acquitted Accused No. 2).

c) The charge is against the two accused under Section 338 r/w Section 109 of I.PC.

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12. Proceeding therefrom, Mr. Harish Salve, argued that the primary offender, as per the charge under Section 338 of the I.P.C, was Dr. A.K. Mukherjee, the doctor who actually performed the procedure and the appellant was charged as an abettor, using Section 109 of the I.P.C. However, Dr. A.K. Mukherjee was dropped from the prosecution at the instance of the complainant himself, on the ground that there was no evidence against him. On the contrary, the complainant in his testimony (P.W.1) gave glowing compliments to Dr. A.K. Mukherjee, praising his skills both as a doctor and a surgeon. In such circumstances, argued Mr. Harish Salve the question of abetment did not survive and, therefore, the case warranted closure even against the appellant as well, after dropping Dr. Mukherjee from the prosecution.

13. Without prejudice to the aforesaid submissions, further arguments of Mr. Harish Salve were that, in any case, the ingredients of Section 338 of I.P.C had not been established. It was merely a case of "negligence" projected by the prosecution. It could not be held, ipso facto, that the essential ingredients of the offence contained under Section 338 of I.P.C. were fulfilled. -

14. Mr. Harish Salve endeavored to demonstrate that the decision of the appellant to advise the operation, in question, namely "Exploratory Laparotomy" could not even be treated as unreasonable or an act of negligent advice. Once it was accepted that the appellant was a renowned Oncologist with great experience, his opinion to conduct the aforesaid procedure/ surgery, after examining the patient, was an expert opinion and merely because he differed from the doctors in U.S.A. on this account, negligence could not be attributed to him because of the same, much less criminal

negligence.

15. That apart, merely on the basis of negligence, it could not be held that ingredients of Section 338 of I.P.C. stood proved as it could not amount to an "act" of causing "grievous hurt", that too "rationally and negligently" thereby endangering the life of the patient. He submitted that, in the first instance, a medical professional who is called upon to treat a patient cannot possibly be charged for causing hurt, where the patient has come to the hospital for receiving treatment inter alia by virtue of Section 81, 87 and 88 of the I.P.C. and where consent for such treatment has been freely given.-

Secondly, in the context of a doctor - patient relationship, even assuming, without accepting that there could be a situation in which a doctor can be held to have committed an offence of causing hurt (either for want of consent or acting with wanton negligence in performing a procedure), it is inconceivable that a doctor can be charged of causing a hurt by not doing something. An omission by a surgeon to perform a surgery, in certain extreme circumstances, may constitute acting in a manner that no medical professional would, and thereby be a case of criminal negligence. It cannot possibly be an omission by which hurt, by way of a positive act, is inflicted.

16. Mr. Harish Salve argued that once rendering an opinion to perform such surgical procedure cannot be treated as criminal offence, in so far as actual procedure is concerned, that was not performed by the appellant. Without accepting, that it was the appellant who was to do the surgery himself, he submitted that the Courts below fell in legal error by attributing the so called omission to perform the said surgery by the appellant as an "act" within the meaning of Section 338 of the I.P.C. He pointed out that the charge as framed did not even remotely mention about the purported "illegal omission". He thus, argued that the Respondents could not base their case on- plea of "omission" as an "act". Even otherwise, in the instant case, the so called omission could not be treated as an "act" of causing grievous hurt in as much as, such an omission has to be in relation to the operation that caused the hurt. Dilating this aspect, the learned senior counsel projected the theory that illegal omissions could result in causing hurt cannot have any application to a doctor who has not performed a surgery – where the primary allegation is that the performance of the surgery constituted the infliction of hurt. Whatever may be the legal consequences of reneging on an assurance to perform a surgery, if the surgery is performed by a duly qualified professional, the surgeon who did not perform the surgery could not possibly be guilty of causing hurt. A fortiori, where the surgeon who did perform the surgery is duly qualified, and is blame free, there is no question of charging, under Section 338 of I.P.C., some other surgeon who may have been engaged to perform the surgery, but did not do so.

17. Mr. Harish Salve also sought to distract the charge of abetment under Section 109 of the I.P.C. by attempting to highlight that as per the charge framed by the Trial Court, the "act" was attributed to Dr. A.K. Mukherjee and the primary charge against the appellant was only that of abetment. With the dropping of Dr. A.K. Mukherjee from the prosecution, the charge of abetment no more survived, more so when no overt act is attributed to the appellant and there is no medical or other aspect examined to show grievous hurt resulted because of the surgery. The appellant placed reliance upon the decisions of this Court in Faguna Kant Nath v. The State of Assam (1959) 2 Suppl. SCR 1; Madan

Raj Bhandari v. State of Rajasthan (1969) 2 SCC 385.

18. Mr. B.H. Marlapalle, learned Senior Counsel appearing for the State invited the attention of this Court to the reasons recorded by the Maharashtra Medical Council in its orders dated 11.2.1991 holding the appellant guilty of misconduct. He pointed out that under the Maharashtra Medical Council Act, 1965, the proceedings against the appellant were in the nature of judicial proceedings under Sections 22 of the said Act and since these findings of the Medical Council had attained finality, there was no basis in the submission of the appellant that he had not acted negligently. He also referred to the findings recorded by the trial court and the High Court and submitted as under:

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> a) The patient Smt. Leela Singhi was admitted at the Bombay Hospital as the patient of the present accused in Room No. 1005 (MRC I Class).
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> b) She had given consent for being operated by the present accused.
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> c) It was the accused mainly who took the decision to operate the patient for exploratory surgery despite a written opinion from the doctors of USA that she was inoperable.
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> d) As per the evidence of DW.2, Dr. Gajanand Hegade, Dr. A.K. Mukherjee was the Assistant Surgeon under the present accused and it was not permissible for him to perform any procedure independently.
>
> e) The accused had accepted two different surgeries in two different operation theatres (OT 1 and OT 2) at the same time on 20.12.1987 at the Bombay Hospital and Mrs. Leela Singhi was taken in OT 2. He instructed Dr. A.K. Mukherjee to open the abdomen of Mrs. Leela Singhi and went to OT1 to attend another surgery. After Dr. A.K. Mukherjee, as per the instructions of the present accused, Dr. P.B. Desai took a cut he immediately noticed that the process was unmanageable for him and the said process was started in the absence of Dr. Desai. Dr. Mukherjee, therefore, in deperation sent for Dr. Desai to come to OT 2 and attend to Mrs. Singhi for further procedure. Dr. Desai did not turn up and, therefore, after waiting for some time -and leaving the patient, Dr. Mukherjee went to OT1 to request Dr. Desai to come and attend to Mrs. Singhi. Dr. Desai came to OT 2 and by standing at a distance of 6 feet, instructed Dr. Mukherjee to stitch the abdomen as the case was inoperable.

He did not touch the patient, leave alone stitching the abdomen by himself. The patient remained in the Hospital for over three months and for about initial one month she required dressing every one hour because of the bleeding from the stitches. This pain and suffering of the patient could have been avoided/ reduced if Dr. Desai himself had stitched the abdomen. After the wound was stitched and till the patient was discharged on 5.4.1998, Dr. Desai did not, even once, attend to Mrs. Singhi and the patient missed the healing touch of the surgeon who was authorized to operate her.

f) After the patient's husband (PW.1) started writing complaints, Dr. Desai flatly denied that Mrs. Singhi was his patient. And Dr. Desai continued the denial even till the end of the trial despite the fact that the Maharashtra Medical Council had held him guilty after a full fledged enquiry under Section 22 of the Maharashtra Medical Council Act, 1965 and warned him, so also three witnesses from the hospital i.e. PW.2, PW.3 and PW.5 were examined by the prosecution to prove that Mrs. Leela Singhi was the patient of Dr. Desai. This entire behavior of Dr. Desai during the operation stage and post operation and -post complaint/ during trial was not commensurate with his professional eminence.

19. Submissions of Mr. B.H. Marlapalle were that the aforesaid admitted facts were sufficient to establish commission of offence under Section 338 of the I.P.C., in as much as, it has been proved beyond reasonable doubts that because of the procedure with which the patient was subjected to, under the instructions of the appellant, the patient suffered grievous hurt which also endangered her life and it was he alone who was negligent and acted rashly from 20.12.1987 till the patient was discharged on 5.4.1988. He argued that it is not necessary to evaluate as to whether his decision to operate Mrs. Singhi could be said to be rash or negligent, (though it was hazardous) but surely having taken the decision to operate her, the appellant did not operate her and instead instructed Dr. Mukherjee to proceed with the first cut and Dr. Desai even abandoned the patient and went to the other operation theatre. When he came back to OT 2, he did not attend to Mrs. Singhi and stitched the cut. This was second act of rash and negligent behavior of the appellant. Thirdly, even after the operation, he never attended to Mrs. Leela Singhi till she was discharged and thus again this was another act of rash and negligent behavior. Though this could be said to be omissions of Dr. Desai, the word "doing any act" as appearing in Section 338 is required to be read with Section 32, 33 and 36 of I.P.C. The learned counsel pointed out that in every part of this Code, except where a contrary intention appears from the context, words which refer to acts done extend also to illegal omissions. Section 33 of I.P.C. states that the word "act" denotes as well a series of acts as a single act and the word "omission" denotes as well as series of omissions as a single omission. Whereas, as per Section 36 of the I.P.C. - wherever the causing of a certain effect, or an attempt to cause that effect, by an act or by an omission, is an offence, it is to be understood that the causing of that effect partly by an act and partly by an omission is the same offence. It was thus, argued that all the acts proved against the appellant and the omissions attributable to him, form the part of the same offence viz., an offence under Section 338 of causing grievous hurt by rash and negligent acts/ omissions. The said offence is not attributable to a single act or omission but it denotes a series of omissions/ acts as a single omission/ act. -

20. According to the learned State Counsel even the offence under Section 109 of I.P.C. was proved, notwithstanding the fact that Dr. Mukherjee was dropped from the proceedings. He referred to Section 107 of I.P.C. which defines Abetment of a thing - by stating that a person abets a doing of a thing who, inter alia, intentionally aids, by any act or illegal omission the doing of that thing. As per Section 109 of I.P.C. whoever abets any offence shall, if the act abetted is committed in consequence of the abetment, and no express provision is made by the I.P.C. for the punishment of such abetment, be punished with punishment provided for the offence. Thus, the offence under Section 109 is an independent offence but the punishment is related with other offence. In the instant case, with the offence punishable under Section 338, as the appellant instructed Dr. Mukherjee to open

the abdomen of Mrs. Singhi who was not authorized to do so and left the operation theatre leaving the patient in the charge of Dr. Mukherjee, the appellant abetted through Dr. Mukherjee. The words "intentionally acts" used in Section 107 (thirdly) of I.P.C. are required, to be read, in the instant case as "knowingly instructs". The prosecution case has not in any way effected because of the discharge of Dr. Mukherjee by allowing an -application under Section 321 of Cr. PC. as Dr. Mukherjee was not competent to undertake the procedure independently and he undertook the procedure solely as per the instructions of the appellant. Hence, the prosecution urged that the accused has been rightly convicted under Section 338 r/w Section 109 of I.P.C.

21. Mr. Gonsalves, ld. Senior Counsel, argued for the complainant/ Respondent No. 2, and pleaded that the conviction recorded by the Court below were perfectly justified which required no interference. He referred to the following facts which according to him, were established by sufficient and cogent evidence.

(a) The appellant alone was the doctor of the patient to whom the patient was specifically referred to by Dr. Mukherjee from the stage of examining the patient and advising surgical operation. The entire responsibility was that of the appellant even to do the surgery in as much as the patient as well as the complainant recognized only one doctor namely the appellant.

(b) The appellant took a particular decision viz., to perform Exploratory Laparotomy and this itself was "rash and negligent" act on the part of the appellant, when examined the same in juxtaposition with the advise rendered by the doctors in U.S.A.-

c) The instruction of the appellant to Dr. Mukherjee to operate, when Dr. Mukherjee was not authorized by the Complainant/ Respondent No. 2 was another act of rash and negligent nature.

d) The appellant had consciously and deliberately abandoned his patient twice – one at the time of operation and thereafter, not attending and treating her to ameliorate her pain and suffering, which was another rash and negligent act.

These acts, according to Mr. Gonsalve, were sufficient to specify the ingredients of Section 338 of I.P.C.

22. Mr. Gonsalves, also pointed out that the only defence of the appellant was that Smt. Leela Singhi was not her patient which has been proved to be false. Therefore, the appellant could not be allowed to argue to the contrary. Mr. Gonsalves also referred to the findings of the Maharashtra Medical Council, as argued by the State Counsel, to buttress his submission that the guilt of the appellant stood proved.

23. We have given our deep thoughts to the aforesaid submissions made by the learned Senior Counsel appearing for different parties. The provisions of Section 338 IPC have already been reproduced in the earlier part of this -judgment. A perusal thereof would clearly demonstrate that before a person is held guilty of the offence, following ingredients need to be established:

a) Causing grievous hurt to a person.

b) Grievous hurt should be the result of an act.

c) Such act ought to have been rash and negligent.

d) The intensity of commission of such an act ought to

endanger human life or the personal safety of others.

24. Before we find out as to whether these essential ingredients have been satisfied in the present case or not, another aspects needs discussion, viz., whether Smt. Leela was the patient of the appellant or not.

The Established Facts To find an answer to this question, let us revert to those facts which have been established by evidence. Respondent No.2 on the advice of Dr. A.K. Mukherjee admitted her in the unit of the appellant at Bombay Hospital on the basis of a note for admission given by Dr. A. Mukherjee. The operation namely "Exploratory Laprotomy Panhyxtroctomy" was advised by the appellant. At Bombay Hospital, a number of medical tests referred by the appellant including CT Scan, Blood Analysis, Blood transfusion report, -examination of urine, microscopic examination of centrifugalised deposits were done on the patient. As per the Bombay Hospital records, the patient - Smt. Leela Singhi was admitted as the indoor patient from 09.12.1987 to 4.5.1988 in Room No. 1005 under the appellant. Room No. 1005 was earmarked for the appellant and never allotted to any other patient without instructions of the appellant. The date of operation was fixed as per the convenience and on instructions of the appellant five days after his advice. The patient was examined by the appellant after preliminary investigations by Dr. A. K Mukherjee. A bill of Rs. 5000/- as the operation fee rendered by the operating surgeon Accused No 1 - the appellant, was raised by Bombay Hospital which was sent to Government of Rajasthan for payment. The documents also showed the appellant as operating surgeon. The constant reminders for the clearance of the bill were made to the Government of Rajasthan for releasing of the payment. The Respondent No. 2 had objected for charging of Rs. 5000/- in the name of the appellant for the operation which admittedly the appellant had never carried on his wife, the operation which according to the Bombay Hospital records was to be conducted by the appellant. Thereafter, Respondent No.2 made a complaint to the Board of

-Management of the Bombay Hospital regarding the behaviour of the appellant and even met the chairman of the hospital. Resultantly, the charges of Rs. 5,000/- against the appellant were waived. After the correspondence, Bombay Hospital sent a duplicate bill deleting Rs. 5,000/- which was the operation fee charges for the appellant.

We may record that the defence put by the appellant in the Trial Court was that Smt. Leela Singhi was not her patient but the same has rightly been rejected by the Courts below in view of plethora of evidence, establishing otherwise. Thus, it can be concluded that Smt. Leela was the patient of the appellant and it was his responsibility to take care of his patient.

25. The answer can also be founded on the nature of professional duty which appellant owed to the patient. Usually before the operation, consent form is required to be signed by the patient for agreeing to the risks involved. The documentary medical records of surgical operation pointed to the appellant as the operating surgeon, the oral and documentary proof both impliedly and explicitly leads to the creation of contractual agreement between the patient and the appellant. -

26. In Lambert v. California (355 U.S 225 (1957), the Supreme Court of United States seems to recognize the unfairness of imposing liability where an actor is unaware of a duty to act. Similarly the Indian Constitution mandates under Articles 20(1) & 21 of the Constitution of India that the due process of law requires that everyone who is tried under any law before court must have some awareness of, or at least a reasonable opportunity to become aware of their legal owed duty towards its recipient. In this case, at hand, the appellant was aware of his duty towards the patient - Smt. Leela as the appellant was the patient's operating surgeon. To the utter disregard of the patient, the appellant vehemently denied her to be his patient. Since the documentary evidences are conclusive in nature also all the facts which had been perused below in the courts undoubtedly point to the undeniable fact that the patient - Smt. Leela was indeed the appellant's patient.

27. Thus, brushing aside the objection of the appellant that Smt. Leela Singhi was not his patient, on the facts of this case we proceed to find out whether conviction u/s 338 is sustainable or not.

28. For time being we keep aside the first element, viz. whether the surgical procedure of opening the abdomen of the patient resulted in

-grievous hurt. That is dealt with at appropriate stage. Before that we discuss the preliminary submission as to whether this act can be attributed to the appellant. Vehemence in the submission was that there is no "overt" act on the part of the appellant. Therefore, question arises, in the context of second ingredient, as to whether "omission to act", would also be covered by the expression "act" occurring therein.

29. Whether "act" includes "omission"? Though this aspects needs elaboration alongwith discussion with regard to other ingredients as these are inextricably mixed up and can't be discussed in isolation and, therefore, we have proceeded in that manner at appropriate stage. Here, we are narrating the legal position only. In this behalf, we may point out that there may be various circumstances where "act" would include "omission to act" as well. This is so recognized even in Sections 32, 33 & 36 of I.P.C.

These provisions are reproduced below:

> "32. Words referring to acts include illegal omissions. - In every part of the said code, except where a contrary intention appears from the context, words which refer to acts done extend also to illegal omissions. -
>
> 33. "Act", "Omission". - The word "act" denotes as well a series of acts as a single act: the word "omission" denotes as well a series of omissions as a single omission.

36. Effect caused partly by act and partly by omission. -

Wherever the causing of certain effect, or an attempt to cause that effect, by an act or by an omission, is an offence, it is to be understood that the causing of that effect partly by an act and partly by an omission is the same offence."

30. The legal understanding of omission is indispensable at the juncture. An omission is sometimes called a negative act, but this seems dangerous practice, for it too easily permits an omission to be substituted for an act without requiring the special requirement for omission liability such as legal duty and the physical capacity to perform the act. Criminal liability for an omission is also well accepted where the actor has a legal duty and the capacity to act. It is said that this rather fundamental exception to the act requirement is permitted because an actor's failure to perform a legal duty of which he is capable, satisfies the purposes of the act requirement or at least satisfies them as well as an act does. Specifically these two special requirements for omission liability help to exclude from liability cases of -fantasizing and irresolute intentions, important purposes of the act requirement.

31. However, a failure to act, by itself does nothing to screen out mere fantasies. It is the actor's failure to act in the light of his capacity to do so that suggests the actor's willingness to go beyond mere fantasizing and to have the harm or evil of the offence occur. Even then, however, the screening effect seems weak; "letting something happen" simply does not carry the same implication of resolute intention that is shown in causing something to happen by affirmative action. While an actor's failure to perform a legal duty provides some evidentiary support for the existence of an intention to have the harm or evil occur, the force of the implication is similarly weak. Inaction often carries no implication of intention unless it is shown that the actor knows of his or her duty to act and the opportunity to do so.

32. Liability for an omission requires a legal duty to act; a moral duty to act is not sufficient. The duty may arise either from the offence definition itself or from some other provision of criminal or civil law. A duty arises from the former when an offence is defined in terms of omission. This is the -situation where the legislature has made it an offence. A legal duty to act may also be created by a provision of either criminal or civil separate from the offence charged. For example, a duty under the Maharashtra Medical Council's Code of Ethics and Maharashtra Medical Council Act, 1965.

33. Since there is no moral difference between (i) a positive act and (ii) an omission when a duty is established, it is to be borne in mind that cases of omissions, the liability should be exceptional and needs to be adequately justified in each instance. Secondly, when it is imposed this should be done by clear statutory language. Verbs primarily denoting (and forbidding) active conduct should not be construed to include omissions except when the statute contains a genuine implication to this effect. Thirdly, maximum penalties applied to active wrongdoing should not automatically be transferred to corresponding omissions; penalties for omissions should be re- thought in each case. Indeed, the Indian Penal Code, 1860 does include explicitly the liability due to omissions. And even Indian courts have affirmed so. In the case of Latifkhan (1895) 20 Bom 394, wherein the law imposes a duty to act on a person, his illegal omission to act renders him liable to punishment. While dealing

with the imposition of liability for -omission, certain considerations are required to be kept in mind. Does section 338 of the I.P.C recognize that the particular offence may be committed by omission? Some category of offences may, some may not; Does it include medical profession? If the offence is capable of being committed by omission, who all were under a duty to act? Who owed the primary duty? What are the criteria for selecting the culprit? Where the definition of the crime requires proof that the actor caused a certain result, and can he be said to have caused that result by doing nothing? These questions cannot be completely separated and sometimes few or all three of them would arise in the same material which follows. Each of them, perhaps, also gives rise to yet another question: Is actor's conduct properly categorized as an omission, or an act? Indeed section 338 of the I.P.C does recognize unambiguously that the particular offence can be committed by omission. More so, the medical profession is included in it. The offence under section 338 of the I.P.C is capable of being committed by omission.

34. We reiterate that we have stated, explained and clarified the meaning of expression "act" occurring in Section 338 IPC, to include acts of omission as well. Its applicability in the instant case has been discussed elaborately at the relevant portion of this judgment so as not to lose the continuum.

35. As we find that "omission" on the part of the appellant would also be treated as "act" in the given circumstances, the issue is as to whether this act of omission was rash & negligent. This is a pivotal & central issue which needs elaborate and all pervasive attention of the court. To create the edifice, brick by brick, we intend to proceed in the following order:

1. The Doctor-Patient Relationship.

2. Duty of care which a doctor owes towards his patient.

3. When this breach of duty would amount to negligence.

4. Consequences of negligence: Civil and Criminal.

5. When criminal liability is attracted.

6. Whether appellant criminally liable u/s 338 IPC, in the present case?

(1) The Doctor- Patient relationship

36. Since ancient times, certain duties and responsibilities have been cast on persons who adopt the sacred profession as exemplified by Charak's Oath (1000 BC) and the Hippocracic Oath (460 BC).

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37. It is the responsibilities that emerge from the doctor-patient relationship that forms the cornerstone of the legal implications emerging from medical practice. The existence of a

doctor-patient relationship presupposes any obligations and consequent liability of the doctor to the patient.

38. It was Talcott Parsons, a social scientist, who first theorized the doctor-patient relationship. He worked on the hypothesis that illness was a form of dysfunctional deviance that required re-integration with social organism. Maintaining the social order required the development of a legitimized sick role to control this deviance, and make illness a transitional state back to normal role performance. In this process, the physician, who has mastered a body of technical knowledge, on a functional role to control the deviance of sick persons who was to be guided by an egalitarian universalism rather than a personalized particularism. While this basic notion has remained robust, over a period of time there have been numerous qualifications to the theory of Parsons. For instance, physicians and the public consider some illnesses to be the responsibility of the ill, such as lung cancer, AIDA and obesity.

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39. It is not necessary for us to divulge this theoretical approach to the doctor-patient relationship, as that may be based on model foundation. Fact remains that when a physician agrees to attend a patient, there is an unwritten contract between the two. The patient entrusts himself to the doctor and that doctor agrees to do his best, at all times, for the patient. Such doctor-patient contract is almost always an implied contract, except when written informed consent is obtained. While a doctor cannot be forced to treat any person, he/she has certain responsibilities for those whom he/she accepts as patients. Some of these responsibilities may be recapitulated, in brief:

> (a) to continue to treat, except under certain circumstances when doctor can abandon his patient;
>
> (b) to take reasonable care of his patient;
>
> (c) to exhibit reasonable skill: The degree of skill a doctor undertakes is the average degree of skill possessed by his professional brethren of the same standing as himself.

The best form of treatment may differ when different choices are available. There is an implied contract between the doctor and patient where the patient is told, in effect, “Medicine is not an exact science. I shall use my experience and best judgment and you take the risk that I may be wrong. I guarantee nothing.”-

(d) Not to undertake any procedure beyond his control: This depends on his qualifications, special training and experience. The doctor must always ensure that he is reasonably skilled before undertaking any special procedure/treating a complicated case.

(e) Professional secrets: A doctor is under a moral and legal obligation not to divulge the information/knowledge which he comes to learn in confidence from his patient and such a communication is privileged communication.

Conclusion: The formation of a doctor-patient relationship is integral to the formation of a legal relationship and consequent rights and duties, forming the basis of liability of a medical practitioner. Due to the very nature of the medical profession, the degree of responsibility on the practitioner is higher than that of any other service provider. The concept of a doctor –patient relationship forms the foundation of legal obligations between the doctor and the patient.

In the present case, as already held above, doctor-patient relationship stood established, contractually, between the patient and the appellant.

(2) Duty of Care which a doctor owes towards his patient.-

40. Once, it is found that there is 'duty to treat' there would be a corresponding 'duty to take care' upon the doctor qua/his patient. In certain context, the duty acquires ethical character and in certain other situations, a legal character. Whenever the principle of 'duty to take care' is founded on a contractual relationship, it acquires a legal character. Contextually speaking, legal 'duty to treat' may arise in a contractual relationship or governmental hospital or hospital located in a public sector undertaking. Ethical 'duty to treat' on the part of doctors is clearly covered by Code of Medical Ethics, 1972. Clause 10 of this Code deals with 'Obligation to the Sick' and Clause 13 cast obligation on the part of the doctors with the captioned "Patient must not be neglected". Whenever there is a breach of the aforesaid Code, the aggrieved patient or the party can file a petition before relevant Disciplinary Committee constituted by the concerned State Medical Council.

(3) When this breach of duty would amount to negligence?

41. When reasonable care, expected of the medical professional, is not rendered and the action on the part of the medical practitioner comes within the mischief of negligence, it can be safely concluded that the said doctor -did not perform his duty properly which was expected of him under the law and breached his duty to take care of the patient. Such a duty which a doctor owes to the patient and if not rendered appropriately and when it would amount to negligence is lucidly narrated by this Court in Kusum Sharma and others v. Batra Hospital and Medical Research Centre and Others; (2010) 3 SCC 480. The relevant discussions therefrom are reproduced hereinbelow:

> "45. According to Halsbury's Laws of England, 4th Edn., Vol. 26 pp. 17-18, the definition of negligence is as under:
>
> 22. Negligence.—Duties owed to patient. A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give; and a duty of care in his administration of that treatment. A breach of any of these duties will support an action for negligence by the patient."

> 46. In a celebrated and oft cited judgment in Bolam v. Friern Hospital Management Committee (Queen's Bench Division) McNair, L.J. observed:
>
> (i) A doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular
>
> -art, merely because there is a body of such opinion that takes a contrary view.

"The direction that, where there are two different schools of medical practice, both having recognition among practitioners, it is not negligent for a practitioner to follow one in preference to the other accords also with American law; see 70 Corpus Juris Secundum (1951) 952, 953, Para 44. Moreover, it seems that by American law a failure to warn the patient of dangers of treatment is not, of itself, negligence McNair, L.J. also observed:

> Before I turn to that, I must explain what in law we mean by 'negligence'. In the ordinary case which does not involve any special skill, negligence in law means this:
>
> some failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this man exercising and professing to have that special skill. ... A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."
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> (4) Breach of Duty to Take Care: Consequences

42. If the patient has suffered because of negligent act/ omission of the doctor, it undoubtedly gives right to the patient to sue the doctor for damages. This would be a civil liability of the doctor under the law tort and/ or contract. This concept of negligence as a tort is explained in Jacob Mathews v. State of Punjab and Another 2005(6) SCC1, in the following manner:

> "10. The jurisprudential concept of negligence defines any precise definition. Eminent jurists and leading judgments have assigned various meanings to negligence. The concept as has been acceptable to Indian jurisprudential thought is well stated in the Law of Torts, Ratanlal & Dhirajlal (24th Edn., 2002, edited by

Justice G.P. Singh).

> Negligence is the breach of a duty caused by the omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. Actionable negligence consists in the neglect of the use of ordinary care or skill towards a person to whom the defendant owes the duty of observing ordinary care and skill, by which neglect the plaintiff has suffered injury to his person or property.... The definition involves three constituents of negligence: (1) A legal duty to exercise due care on the part of the party complained of towards the party complaining the former's conduct within the scope of the duty; (2) breach of the said; and (3) consequential damage. Cause of -action for negligence arises only when damage occurs; for, damage is a necessary ingredient of this tort."

43. Such a negligent act, normally a tort, may also give rise to criminal liability as well, though it was made clear by this Court in Jacob's Case (supra) that jurisprudentially the distinction has to be drawn between negligence under Civil Law and negligence under Criminal Law. This distinction is lucidly explained in Jacob's Case, as can be seen from the following paragraphs:

> "12. The term "negligence" is used for the purpose of fastening the defendant with liability under the civil law and, at times, under the criminal law. It is contended on behalf of the respondents that in both the jurisdictions, negligence is negligence, and jurisprudentially no distinction can be drawn between negligence under civil law and negligence under criminal law. The submission so made cannot be countenanced inasmuch as it is based upon a total departure from the established terrain of thought running ever since the beginning of the emergence of the concept of negligence up to the modern times. Generally speaking, it is the amount of damages incurred which is determinative of the extent of liability in tort; but in criminal law it is not the amount of damages but the amount and degree of negligence that is determinative of liability. To fasten liability in criminal law, the degree of negligence has to be higher than that of negligence enough to fasten liability for damages in civil law. The essential ingredient of mens -rea cannot be excluded from consideration when the charge in a criminal court consists of criminal negligence. In R. v. Lawrence Lord Diplock spoke in a Bench of five and the other Law Lords agreed with him. He reiterated his opinion in R. v. Caldwell3 and dealt with the concept of recklessness as constituting mens rea in criminal law. His Lordship warned against adopting the simplistic approach of treating all problems of criminal liability as soluble by classifying the test of liability as being "subjective" or "objective", and said:
>
> (All ER p. 982e-f) "Recklessness on the part of the doer of an act does presuppose that there is something in the circumstances that would have drawn the attention of an ordinary prudent individual to the possibility that his act was capable of causing the kind of serious harmful consequences that the section which creates the offence was intended to prevent, and that the risk of those harmful consequences occurring

> was not so slight that an ordinary prudent individual would feel justified in treating them as negligible. It is only when this is so that the doer of the act is acting 'recklessly' if, before doing the act, he either fails to give any thought to the possibility of there being any such risk or, having recognised that there was such risk, he nevertheless goes on to do it."
>
> 13. The moral culpability of recklessness is not located in a desire to cause harm. It resides in the proximity of the reckless state of mind to the state of mind present when there is an intention to cause harm. There is, in other words, a disregard for the possible consequences. The consequences entailed in the risk may not be wanted, and indeed the actor may hope that they do not occur, but this hope nevertheless fails to inhibit the taking of the risk.

Certain types of violation, called optimising violations,

-may be motivated by thrill-seeking. These are clearly reckless.

14. In order to hold the existence of criminal rashness or criminal negligence it shall have to be found out that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent. The element of criminality is introduced by the accused having run the risk of doing such an act with recklessness and indifference to the consequences. Lord Atkin in his speech in Andrews v. Director of Public Prosecutions4 stated: (All ER p. 556 C) "Simple lack of care such as will constitute civil liability is not enough. For purposes of the criminal law there are degrees of negligence, and a very high degree of negligence is required to be proved before the felony is established." Thus, a clear distinction exists between "simple lack of care" incurring civil liability and "very high degree of negligence" which is required in criminal cases. In Riddell v. Reid4a (AC at p. 31) Lord Porter said in his speech — "A higher degree of negligence has always been demanded in order to establish a criminal offence than is sufficient to create civil liability."

15. The fore-quoted statement of law in Andrews has been noted with approval by this Court in Syad Akbar v. State of Karnataka5. The Supreme Court has dealt with and pointed out with reasons the distinction between negligence in civil law and in criminal law. Their Lordships have opined that there is a marked difference as to the effect of evidence viz. the proof, in civil and criminal proceedings. In civil proceedings, a mere preponderance of probability is sufficient, and the -defendant is not necessarily entitled to the benefit of every reasonable doubt; but in criminal proceedings, the persuasion of guilt must amount to such a moral certainty as convinces the mind of the Court, as a reasonable man, beyond all reasonable doubt. Where negligence is an essential ingredient of the offence, the negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment."

44. Thus, in the civil context while we consider the moral implications of negligent conduct, a clear view of the state of mind of the negligent doctor might not require strictly. This is for the reason the law of tort is ultimately not concerned with the moral culpability of the defendant, even if the

language of fault is used in determining the standard of care. From the point of view of civil law it may be appropriate to impose liability irrespective of moral blameworthiness. This is because in civil law two questions are at issue: Was the defendant negligent? If so, should the defendant bear the loss in this particular set of circumstances? In most cases where negligence has been established, the answer to the second question will be in the affirmative, unless the doctrine of remoteness or lack of foresee ability militates against a finding of liability, or where there is some policy reason precluding compensation. The question in the civil context is, therefore, not about moral blame, even though there will be many cases where the civilly liable defendant is also morally culpable.

(5) Criminal Liability : When attracted

45. It follows from the above that as far as the sphere of criminal liability is concerned, as mens rea is not abandoned, the subjective state of mind of the accused lingers a critical consideration. In the context of criminal law, the basic question is quite different. Here the question is: Does the accused deserve to be punished for the outcome caused by his negligence? This is a very different question from the civil context and must be answered in terms of mens rea. Only if a person has acted in a morally culpable fashion can this question be answered positively, at least as far as non strict liability offenses are concerned.

46. The only state of mind which is deserving of punishment is that which demonstrates an intention to cause harm to others, or where there is a deliberate willingness to subject others to the risk of harm. Negligent conduct does not entail an intention to cause harm, but only involves a deliberate act subjecting another to the risk of harm where the actor is aware -of the existence of the risk and, nonetheless, proceeds in the face of the risk. This, however, is the classic definition of recklessness, which is conceptually different from negligence and which is widely accepted as being a basis for criminal liability.

47. The solution to the issue of punishing what is described loosely, and possibly inaccurately, as negligence is to make a clear distinction between negligence and recklessness and to reserve criminal punishment for the latter. If the conduct in question involves elements of recklessness, then it is punishable and should not be described as merely negligent. If, however, there is nothing to suggest that the actor was aware of the risk deliberately taken, then he is morally blameless and should face, at the most, a civil action for damages.

(6) Whether the appellant criminally liable under Section 338 IPC, in the present case?

48. We have to keep in mind that by the impugned judgment, the appellant is convicted of an offence under Section 338 read with Section 109 of I.P.C. Therefore, the relevant question to be decided is as to whether, the -acts of omission and commission, imputed to the appellant, are sufficient to hold that all the ingredients of Section 338 of the I.P.C. stand satisfied.

49. The section explicitly lays down that only that ‘act’ which is “so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished....”. Thus the section itself carves out the standard of criminal negligence intended to distinguish between those whose failure

is culpable and those whose conduct, although not up to standard, is not deserving of punishment.

50. One of the several questions which arise in the factual situation at hand is this: Whether the appellant-doctor, who acted negligently, manifested such a state of mind which justifies moral censure? This is conceivably best answered by identifying what was nature of act owed by the appellant towards the patient.

51. In the case at hand, the concern revolves around the acts of omission and commission which amounted to an "act" so rashly or negligently as to have had endangered the life of Smt. Leela constituting an offence punishable under Section 338 of the I.P.C. Since, there was no overt act on the part of the appellant - as the surgical procedure was performed by Dr. -A.K. Mukherjee, charge of abetment under Section 109 of I.P.C. was also leveled. . Dr. A.K. Mukherjee was also made accused in the said complaint. However, at a later stage, Dr. A.K. Mukherjee was dropped from the proceedings at the instance of the complainant.

52. We would also like to make another aspect very explicit. The appellant was leveled a specific charge which was framed against him. The prosecution was required to prove that particular charge and not to go beyond that and attribute "rash and negligent" acts which are not the part of the charge. Culpability is specifically related to the "act" committed on 22.12.1987 at about 9 a.m. in the hospital viz., the act of performing surgical procedure. It is, thus, this act alone, and nothing more, for which the appellant and Dr. Mukherjee were charged and the appellant is supposed to meet this charge alone.

53. In this scenario, the first and foremost question that needs to be determined is as to whether the advise of the appellant that 'Exploratory Laparotomy' be conducted on the patient was inappropriate, and if so, amounted to wanton negligence, giving rise to criminal liability, in as much -as the opening of the abdomen of the patient, even by Dr. Mukherjee, was the consequence of that advise.

54. No doubt, such an opinion was given in the teeth of the advise of the doctors in the U.S.A where the patient was examined earlier. However, only because of this reason, it would not automatically follow that the view expressed by the appellant was blemished. The two experts in medical field may differ on decision to undertake the surgical operation. But for the sake of life which, any way was struggling to live is the respect to doctors in their position to operate the patient or not. We have to keep in mind the critical condition of the patient at that time. She was sent home by the American doctors as inoperable. She was advised to take certain medicines. These medicines were being administered by Dr. Mukherjee. However, further complications arose in the meantime as vagina started bleeding which was not coming to a halt. Obviously, it was terminal stage for the patient. It is in this situation, opinion of the appellant was sought. The dilemma of a doctor in such a scenario can be clearly visualized viz., whether to leave the patient as it is or to take a chance, may be a very slim chance, to save or at least to try to prolong the life of the patient. It was not -an easy choice. Overcoming this difficult situation, the appellant took the bold decision viz. that surgical operation was worth taking a risk, as even otherwise, the condition of the patient was deplorable. The appellant has even given his justification and rationale for adopting this course of action. The

appellant states that the decision to operate was taken having regard to the following circumstances:

> (a) The patient was suffering from metastatic breast cancer for ten long years and the said cancer was spreading to other parts of the body. As such the patient was unable to follow her ordinary pursuits irrespective of the surgical procedure advised by the appellant herein.
>
> (b) The patient was repeatedly suffering from vaginal bleeding and bodily pain and as such the patient was unable to follow her ordinary pursuits irrespective of the surgical procedure advised by the appellant herein.
>
> (c) The formation of a fistula is a complication which may or may not arise out of surgical procedures and the advice for surgical procedure was tendered with a view to alleviate her suffering rather than endanger her life. -

55. During trial, Dr. Gajanand Hegade (DW.2) has endorsed the opinion of the appellant and has gone to the extent of saying that it was the best possible option for the treatment of the patient. Moreover, Dr. Mukherjee has also accepted/ agreed that the advise tendered by the appellant on the basis of CT Scan Report, and, that the call to operate was "unanimous". Thus, even Dr. Mukherjee endorsed the opinion which appears to be his opinion as well. In this scenario, it cannot be said that advise of the appellant for taking the surgical procedure was an act of wanton negligence. Dilemma of a doctor, in such circumstances, is beautifully explained by this Court in Kusum Sharma (Supra), in the following words:

> "89(V) In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.
>
> (VI) The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/ her suffering which did not yield the desired result may not amount to negligence.-
>
> (VII) Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.

56. It also needs to be emphasized, as contended by Mr. Harish Salve, that the experts from New York are not oncological surgeons. Dr. Ernest Greenberg is a physician while Dr. Brokunier is a Gynecologist. On the other hand, even as per the complainants own version, the appellant is a renowned oncologist and surgeon.

57. At this juncture, an important observation is needed. When such a decisional shift is taken against the line of other doctors who had earlier treated the patient, the appellant was required to give personal attention to the patient during the operation. He was, even otherwise, contractually bound to do so.

58. While the two experts might differ on the level of risks involved in the critical surgical operation but for the sake of life which in anyway was struggling to live, is a mild respite to doctors in their decision to operate the -patient or not. A long catena of medical cases on this theme does provide relief to doctors. One of the many indispensable duties which is of utmost importance is that when such a decisional shift is taken by a doctor against the line of renowned doctor who had earlier treated the patient, that doctor must exercise required personal attention to the patient during the operation. On this aspect, the Medical council of Maharashtra, while reprimanding, reasoned that Dr. P.B Desai, instead of merely advising surgery which was inspite of the opinion of cancer specialists from U.S.A, ought to have voluntarily taken more interest and personally seen the situation faced by Dr. A.K Mukherjee which he did not do so. Since the appellant has not challenged the findings of the Medical Council who had found him guilty of misconduct, those findings does provide the legal fortification and along with the oral and documentary evidences adduced before court below speaks much on the professional duty which the appellant owed to the patient.

59. Thus, one thing is crystal clear. Failure to act on the part of the appellant, in conducting surgical procedure, and not taking care thereafter as well, established his negligence in tort law i.e. in civil domain. We refer to and rely on the judgment of this Court in Jacob's Case once again, where -the Court explained as to under what circumstances professional can be liable for negligence. It is necessary for this purpose that one of the two findings, as set out therein, should be established.

"18. In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised with reasonable degree of care and caution. He does not assure his client of the result. A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, -he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising

ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practises. In Michael Hyde and Associates v. J.D. Williams & Co. Ltd. Sedley, L.J. said that where a profession embraces a range of views as to what is an acceptable standard of conduct, the competence of the defendant is to be judged by the lowest standard that would be regarded as acceptable."

60. No doubt, in the present case the appellant not only possesses requisite skills but also an expert in this line. However, having advised the operation, he failed to take care of the patient. Thereafter, at various stages, as observed by the courts below, he was held to be negligent by the Maharashtra Medical Council and thus found to be guilty of committing professional misconduct.

61. Thus, it was the appellant's "duty" to act contractually, professionally as well as morally and such an omission can be treated as an "act". We again clarify that undoubtedly, within the realm of civil liability, the appellant has breached the well essence of "duty" to the patient. -

62. Having reached this conclusion, we proceed to the next stage viz., the criminal liability of the appellant. However, we once again emphasize that the question of criminal liability has also to be examined in the context of Section 338 of I.P.C. which is the real issue. To recapitulate some important aspects, we have concluded that decision of the appellant advising Exploratory Laparatomy was not an act of negligence, much less wanton negligence, and under the circumstances it was a plausible view which an expert like the appellant could take keeping in view the deteriorating and worsening health of the patient. As a consequence, opening of the abdomen and performing the surgery cannot be treated as causing grievous hurt. It could have been only if the doctors would have faltered and acted in rash and gross negligent manner in performing that procedure. It is not so. At the same time, his act of omission, afterwards, in not doing the surgery himself and remaining absent from the scene and neglecting the patient, even thereafter, when she was suffering the consequences of fistula, is an act of negligence and is definitely blame worthy. (though that is not the part of criminal charge) However, we are of the opinion that the omission is not of a kind which has given rise to criminal liability under the given circumstances.

63. As already noted above, we are conscious of the fact that when the appellant decided to operate on the patient against the U.S doctor's advice, the level of attention expected from the appellant towards the patient was immense and undivided kind. The operating surgeon along with the fellow junior doctors was supposed to conduct operation. The junior doctor rendered his complete and undivided assistance to the patient but the appellant abstained.

64. However, the important and relevant point is: Had the appellant undertaken the surgical procedure by himself, the result would have been different? Or, to put it otherwise, whether opening of abdomen by Dr. Mukherjee and not by the appellant who was supposed to do it, made any difference? In the given case, we do not find it to be so.

65. To appreciate, we need to reiterate certain facts. On opening the abdomen, Dr. A.K. Mukherjee found plastering of intestines as well as profuse oozing of ascetic fluids. He immediately called the appellant who -was performing other surgical procedures in another operation theatre. The

appellant after seeing the condition of the patient, albeit, from the distance found that it was not possible to proceed with the operation. He advised Dr. A.K. Mukherjee to close the abdomen. Dr. Mukherjee, thus, closed the abdomen. Significantly, Section 109 IPC was also pressed into service at the time of framing of the charge on the premise that Dr. Mukherjee caused grievous hurt and omission on the part of the appellant to not to personally intervene in the operation of the patient amounted to abetment. However, the position which emerges is that the junior doctor rendered complete care. He did not falter in his act of cutting open the abdomen. It is only at that stage, it was found, that there was a lot of discharge from fistula and surgery was not possible. The appellant advised Dr. Mukherjee to close the abdomen. No doubt, he did not do it himself but it is not the case of the prosecution that Dr. Mukherjee did not do it deftly either. It is because of the deplorable condition of the patient, the surgery could not be completed as on the opening of the abdomen other complications were revealed. This would have happened in any case, irrespective whether abdomen was opened by Dr. Mukherjee or by the appellant himself. On the contrary, the

-complainant's own case is that Dr. Mukherjee's performance was not lacking; nay, it was of superlative quality.

66. The appellant's omission in not rendering complete and undivided legally owed duty to patient and not performing the procedure himself has not made any difference. It was not the cause of the patient's death which was undoubtedly because of the acute chronic cancer condition. In such a scenario, it is enough to keep off the clutches of criminal law.

67. The negligent conduct in the nature of omission of the appellant is not so gross as to entail criminal liability on the appellant under section 338 of the I.P.C. It is to be kept in mind that the crime as mentioned in section 338 I.P.C requires proof that the appellant caused the patient's condition to the acute stage. Can he be said to have caused such a result, by his omission to act? We do not find it to be so.

68. In the common law case R v Adomako [1994] 3 WLR 288 wherein, Lord Mackay LC set the test for gross negligence in manslaughter:

> "On this basis in my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime. This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal."

69. For the aforesaid reasons, we have no option but to conclude that though the conduct of the appellant constituted not only professional misconduct for which adequate penalty has been meted out to him by the Medical Council, and the negligence on his part also amounts to actionable wrong in tort, it does not transcend into the criminal liability, and in no case makes him liable for offence under Section 338, IPC as the ingredients of that provision have not been satisfied. We, therefore, allow this appeal and set aside the impugned judgments of the courts below. No costs.

.....J. [A.K. Patnaik] New Delhi.

September 13, 2013 .....J. [A.K. Sikri]