State Of Punjab vs Shiv Ram & Ors on 25 August, 2005

Equivalent citations: AIR 2005 SUPREME COURT 3280, AIR 2006 (NOC) 1209 (AP), 2005 AIR SCW 4108, 2005 AIR - JHAR. H. C. R. 2364, 2005 CRILR(SC MAH GUJ) 746, (2006) 37 ALLINDCAS 129 (SC), 2006 (37) ALLINDCAS 129, (2005) 4 ALLMR 1090 (SC), (2005) 2 CLR 526 (SC), (2005) 4 CTC 627 (SC), 2005 CRILR(SC&MP) 746, (2005) 7 JT 606 (SC), 2005 (4) ALL MR 1090, 2005 (2) CLR 526, 2005 (7) SCC 1, 2005 (6) SLT 498, 2005 (4) CTC 627, 2005 (6) SCALE 770, 2005 (8) SRJ 249, (2005) 60 ALL LR 592, 2005 CHANDLR(CIV&CRI) 421, (2005) 2 WLC(SC)CVL 500, (2005) 4 ALLCRILR 364, (2005) 4 EASTCRIC 154, (2006) 1 CIVILCOURTC 377, (2006) 1 CPR 128, (2005) 5 ANDHLD 85, (2005) 6 SUPREME 58, (2005) 1 ACJ 2084, (2006) 62 ALL LR 173, (2005) 4 ALL WC 3868, (2005) 3 ACC 717, (2005) 4 KER LT 669, (2005) 4 MAD LJ 132, (2005) 3 PUN LR 782, (2005) 4 RECCRIR 91, (2005) 6 SCJ 525, (2005) 4 RECCIVR 100, (2006) 1 ICC 104, (2005) 6 SCALE 770, (2006) 1 CIVLJ 419, (2005) 2 CURLJ(CCR) 598, (2005) 4 CPJ 14, (2006) 1 BOM CR 338

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Bench: R.C. Lahoti, C.K. Thakker, P.K. Balasubramanyan

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           CASE NO.:
Appeal (civil)  5128 of 2002

PETITIONER:
State of Punjab

RESPONDENT:
Shiv Ram  & Ors.

DATE OF JUDGMENT: 25/08/2005

BENCH:
CJI R.C. LAHOTI,C.K. THAKKER & P.K. BALASUBRAMANYAN

JUDGMENT:
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J U D G M E N T R.C. Lahoti, CJI The plaintiffs-respondents, respectively husband and wife, filed a suit against the State of Punjab, the appellant before us and a lady surgeon who was in the State Government's employment at the relevant time, for recovery of damages to the tune of Rs.3,00,000/- on account of a female child having been born to them in spite of the wife-respondent No. 2 having undergone a tubectomy operation performed by the lady surgeon. According to the plaintiffs-respondents, they already had a son and two daughters from the wed-lock lasting over 17

years. In response to a publicity campaign carried out by the Family Welfare Department of the appellant-State, respondent No. 2 with the consent of respondent No.1, underwent a sterilization operation on 1.8.1984. A certificate in this regard bearing mark of identification No. 505, duly signed by the lady surgeon who performed the said surgery, was issued to her. She was given a cash award of Rs.150/- as an incentive for the operation. On 4.10.1991, respondent No. 2 gave birth to a female child. After serving a notice under Section 80 of the Code of Civil Procedure, a suit for recovery of damages was filed on 15.5.92 attributing the birth of the child to carelessness and negligence of the lady surgeon. The plaint alleged inter alia that the respondents considered abortion to be a sin and that is why after knowing of the conception they did not opt for abortion.

The State was impleaded as defendant No. 1 and the lady surgeon who performed the surgery was impleaded as defendant No.2.

The defendants filed a joint written statement. It was submitted that there was no negligence or carelessness in the performance of the surgery. It is stated in authoritative text books of medical science that pregnancy occurring after sterilization may be attributable to natural failure. It was also submitted that the plaintiffs having learnt of the unwanted pregnancy, should have sought medical opinion and opted for medical termination of pregnancy within 20 weeks which is permissible and legal.

The parties went to trial. The plaintiff No.1, that is the husband, deposed on oath to substantiate the plaint averments. The wife, plaintiff No.2, did not appear in the witness box. On behalf of the defendants, one Dr. Sham Lal Thukral, Medical Officer, Civil Hospital, Bhatinda appeared to depose that medical science recognises failure of sterilization operations to the extent of 0.3% to 3% and the consequences of such failure can promptly be taken care of by the pregnant woman by undergoing abortion. The deponent produced five extracts (marked as Exhibits D2 to D6) from different textbooks of gynaecology in support of his statement. Original books were produced for the perusal of the court and returned. The trial court and the first appellate court have not doubted the correctness of the expert medical opinion as expressed in the textbooks cited before the Court. However, the two courts have proceeded on the reasoning that on the birth of a child to a woman who was allured into undergoing sterilization operation by the State in pursuance of its Family Planning Schemes, the State was liable to compensate for the consequences of the operation having failed. The suit was decreed for Rs.50,000/- with interest and costs. The decree for compensation passed by the trial court has been upheld by the first appellate court. The second appeal preferred by the State has been summarily dismissed.

At the very outset, the learned Additional Advocate General appearing for the State of Punjab submitted that the appellant-State was not very serious about denying the payment of Rs.50,000/- to the plaintiffs-respondents as they are poor persons, but the State was certainly interested in having the legal issue resolved. He further submitted that the filing of such suits in the civil court or complaints before the Consumer Fora, are on an increase and decrees are being passed against the State without any basis in law and, therefore, the position of law needs to be clarified and settled.

Very recently, this Court has dealt with the issues of medical negligence and laid down principles on which the liability of a medical professional is determined generally and in the field of criminal law in particular. Reference may be had to Jacob Mathew v. State of Punjab & Anr. (2005) 6 SCC 1. The Court has approved the test as laid down in Bolam v. Friern Hospital Management Committee, [1957] 1 W.L.R. 582, popularly known as Bolam's Test, in its applicability to India. The relevant principles culled out from the case of Jacob Mathew (supra) read as under:

> (1) Negligence is the breach of a duty caused by 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. The definition of negligence as given in Law of Torts, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: 'duty', 'breach' and 'resulting damage'.
>
> (2) A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions what has to be seen is 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 the standard for judging the alleged negligence.
>
> (3) A professional may be held liable for negligence on one of the 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 possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.
>
> This Court has further held in Jacob Mathew's case (supra):-
>
> "Accident during the course of medical or surgical treatment has a wider meaning. Ordinarily, an accident means an unintended and unforeseen injurious occurrence; something that does not occur in the usual course of events or that could not be

> reasonably anticipated (See, Black's Law Dictionary, 7th Edition). Care has to be taken to see that the result of an accident which is exculpatory may not persuade the human mind to confuse it with the consequence of negligence."

The plaintiffs have not alleged that the lady surgeon who performed the sterilization operation was not competent to perform the surgery and yet ventured into doing it. It is neither the case of the plaintiffs, nor has any finding been arrived at by any of the courts below that the lady surgeon was negligent in performing the surgery. The present one is not a case where the surgeon who performed the surgery has committed breach of any duty cast on her as a surgeon. The surgery was performed by a technique known and recognized by medical science. It is a pure and simple case of sterilization operation having failed though duly performed. The learned Additional Advocate General has also very fairly not disputed the vicarious liability of the State, if only its employee doctor is found to have performed the surgery negligently and if the unwanted pregnancy thereafter is attributable to such negligent act or omission on the part of the employee doctor of the State.

The learned Advocate General has brought to our notice a number of textbooks on gynaecology. We refer to some of them.

In Jeffcoate's Principles of Gynaecology, revised by V.R. Tindall, MSc.,MD,FRCSE, FRCOG, Professor of Obstetrics and Gynaecology, University of Manchester (Fifth Edition) published by Butterworth Heinemann, the following technique of female sterilization are stated:

> "Female Sterilization Techniques
>
> 1. Radiotherapy A menopausal dose of external beam irradiation to the ovaries is only attractive in so far that they sterilize without involving the woman in an operation. Their disadvantages (as stated at pages 93 and 528) are such that they are rarely used except in older women who are seriously ill.
>
> 2. Removal of the ovaries This sterilizes (provided an accessory ovary is not overlooked) but is very rarely indicated as it often results in severe climacteric symptoms.
>
> 3. Removal of the uterus This is effective but involves an unnecessarily major operation and destroys menstrual as well as reproductive function. Its chief place is in those cases where the need for sterilization is associated with disease in the uterus or cervix. But, to preclude further childbearing, it is commonly carried out as part of another operation. Examples are vaginal hysterectomy as part of the cure of prolapse, and caesarean hysterectomy. The latter is sometimes advocated, in preference to caesarean section and tubal ligation, on the grounds that it prevents future uterine disease as well as conception. Those women who have ethical objections to tubal ligation may well prefer to have a 'scarred uterus' removed. Except in special circumstances, however, caesarean hysterectomy is not justified as a sterilization procedure.

> As an elective sterilization procedure for non-pregnant women, some gynaecologists advocate hysterectomy (preferably vaginal) in preference to tubal resection. This is because it removes the possibility of the future development of uterine disease such as carcinoma of the cervix and eliminates the chance of the woman suffering menstrual and other upsets which sometimes follow less radical procedures. Hysterectomy, however, carries a much higher immediate morbidity rate than does surgical tubal resection and can be followed by other disturbances and regrets at loss of menstrual function an outward sign of femininity."

4. Resection of fallopian tubes Provided the pelvic organs are healthy, one of the best methods is to remove 1-2 cm of the middle of each tube and to bury the ligated ends separately under the peritoneum. Sometimes the cornua of the uterus are excised, together with the adjacent portions of the tubes. Excision of the whole of both tubes is not so safe because it leaves the ovum free to wander into a possible uterine fistula and fimbriectomy should never be performed.

Retention of the abdominal ostia is an advantage for it tends to ensure that ova become trapped in the occluded tubes.

Of the more simple operations on the fallopian tubes the best is the Pomeroy procedure in which a loop of tube is excised and the cut ends secured with a ligature. This method has the advantage of avoiding troublesome haemorrhage which can attend the techniques described above, requires only limited access, is speedy, and fails in not more than 0.3 per cent of cases. The technique of crushing and ligation of the tubes without excising any part of them (Madlener operation) is very unreliable, the failure rate being 3.0 per cent; it is rarely practised now.

Whatever technique be used for dividing the tubes, it is important to ligature their cut ends with plain catgut. This is much more likely to result in firm closure than is the use of unabsorbable material, or even chromic gut. Most failures are due to neglect of this medicolegally very important point.

Resection of the tubes is usually carried out abdominally and is particularly easy to perform 2-4 days after delivery when the uterus is an abdominal organ and the tubes readily accessible. It can then, if necessary, be carried out under local analgesia. Tubal resection (preferably using the Pomeroy technique) can also be performed vaginally either during the course of another operation or as the route of choice. As a method of choice it is not new as is sometimes suggested; it was regularly carried out in the 1920s."

Dealing with reliability of the sterilization procedures performed and commonly employed by the gynaecologists, the text book states (at p.621):-

> Reliability The only sterilization procedures in the female which are both satisfactory and reliable are:

resection or destruction of a portion of both fallopian tubes; and hysterectomy. No method, however, is absolutely reliable and pregnancy is reported after subtotal and total hysterectomy , and even after hysterectomy with bilateral salpingectomy. The explanation of these extremely rare cases is a persisting communication between the ovary or tube and the vaginal vault.

Even when tubal occlusion operations are competently performed and all technical precautions are taken, intrauterine pregnancy occurs subsequently in 0.3 per cent of cases. This is because an ovum gains access to spermatozoa through a recanalized inner segment of the tube.

There is clinical impression that tubal resection operations are more likely to fail when they are carried out at the time of caesarean section than at any other time. The fact that they occasionally fail at any time has led many gynaecologists to replace the term 'sterilization' by "tubal ligation" or "tubal resection" in talking to the patient and in all records. This has real merit from the medicolegal standpoint."

[underlining by us] In Shaw's Textbook of Gynaecology , after describing several methods of female sterilization, the textbook states that the most popular technique adopted in Mini-lapartomy sterilization is Pomeroy method in which the fallopian tube is identified on each side, brought out through the incision, and the middle portion is formed into a loop which is tied at the base with catgut and excised. The failure rate is only 0.4% and it is mainly due to spontaneous recanalization. The operation is simple, requires a short hospitalization, does not require any sophisticated and expensive equipment like a laparoscope, and can be performed in a primary health centre by a doctor trained in this procedure. In Madlener method, a loop of the tube is crushed and ligated with a non-absorbable suture. Failure rate is of 7% and occurrence of an ectopic pregnancy are unacceptable though it is a simple procedure to perform. There are other methods, less popular on account of their indications, which are also stated. Dealing with the topic of complications and sequelae of sterilization, the textbook states:

"Failure rate of sterilization varies from 0.4% in Pomeroy's technique, 0.3-0.6% by laparoscopic method to 7% by Madlener method. Pregnancy occurs either because of faulty technique or due to spontaneous recanalization."

In 'The Essentials of Contraceptive Technology', written by four doctors and published by Center for Communication Programs, The Johns Hopkins School of Public Health in July, 1997, certain questions and answers are stated. Questions 5 and 6 and their answers, which are relevant for our purpose, read as under:

"5. Will female sterilization stop working after a time? Does a woman who had a sterilization procedure ever have to worry about getting pregnant again?

Generally, no. Female sterilization should be considered permanent. Failure rates are probably higher than previously thought however. A major new US study found that the risk of pregnancy within 10 years after sterilization is about 1.8 per 100 women about 1 in every 55 women. The risk of sterilization failure is greater for younger women because they are more fertile than older women. Also, some methods of blocking the tubes work better than others. Methods that cut away part of each tube work better than spring clips or bipolar electrocoagulation (electric current). Effectiveness also depends on the skill of the provider.

The same US study found that 1 of every 3 pregnancies after sterilization was ectopic. If a woman who has had sterilization ever thinks that she is pregnant or has an ectopic pregnancy, she should seek help right away.

[underlining by us]

6. Pregnancy after female sterilization is rare but why does it happen at all?

The most common reason is that the woman was already pregnant at the time of sterilization. Pregnancy also can occur if the provider confused another structure in the body with the fallopian tubes and blocked or cut the wrong place. In other case pregnancy results because clips on the tubes come open, because the ends of the tubes grow back together, or because abnormal openings develop in the tube, allowing sperm and egg to meet."

In newsletter "alert" September, 2000 issue, Prof.(Dr.) Gopinath N. Shenoy writes:

> "Female sterilization can be done by many methods/techniques, which are accepted by the medical professionals all over the world. It is also an accepted fact that none of these methods/techniques are cent percent 'failure free'. This 'failure rate' may vary from method to method. A doctor is justified in choosing one method to the exclusion of the others and he cannot be faulted for his choice if his choice is based on reasonable application of mind and is not 'palpably' wrong. A doctor has discretionary powers to choose the method/technique of sterilization he desires to adopt."

[emphasis supplied] In "The New England Journal of Medicine" , owned, published and copyrighted by Massachusetts Medical Society, the result of a research carried out by a team of doctors has been published and widely circulated. 10,685 women enrolled and eligible for long term follow up and willing to cooperate and providing information were studied. The relevant part of the result of the study reads as under:

> "The median age of women at the time of sterilization was 30 years (range, 18 to 44; mean [+ SD],31+6). Most women were white and had been pregnant at least twice (Table

> 1). In all, 143 women (1.3 percent) reported pregnancies that were classified as true failure of sterilization. For 66.4 percent of these pregnancies, the classification was based on a review of medical reports by the investigators.

The remainder were classified on the basis of the woman's history alone."

In Medico-legal Aspects in Obstetrics and Gynaecology, edited by three doctors, Chapter 18, deals with Medico-legal Problems in Sterilization Operations. It is stated therein that there are several methods of female sterilization of which one that will suit the patient and the surgeon/gynaecologist should be selected. In India, Pomeroy's method is widely practised. Other methods include Madlener's, Irving's, Uchida's methods and so on. The text further states that failure is one of the undesirous outcome of sterilization. The overall incidence of failure in tubectomy is 0.4 per 100 women per year. The text describes the following events wherefrom sterilization failure usually results:

> i. Spontaneous recanalisation or fistula formation is perhaps the most common cause of failure. Though these are generally non-negligent causes of failure, it is very difficult to convince the patient if they are not informed beforehand about the possibility.
>
> ii. Undetected pregnancy at the time of sterilization is an indefensible offence. To avoid such incidence, tests to detect pregnancy should be done before sterilization operation is undertaken.
>
> iii. Imperfect occlusion of the tube is a technical loophole which may result in an unwanted pregnancy. The chance is particularly high in laparoscopic methods. If a gynaecologist fails to place ring on any one of the tube due to improper visualization, he or she must inform the patient and her husband, and some other contraceptive method should be advised.
>
> iv. Occlusion of the wrong structure(s), e.g. round ligament is a common, indefensible error which may particularly happen if the surgeon is inexperienced. This is more frequent in laparoscopic methods where even confirmation of the structure by biopsy is difficult, in case of doubt.
>
> It is thus clear that there are several alternative methods of female sterilization operation which are recognized by medical science of today. Some of them are more popular because of being less complicated, requiring minimal body invasion and least confinement in the hospital. However, none is foolproof and no prevalent method of sterilization guarantees 100% success. The causes for failure can well be attributable to the natural functioning of the human body and not necessarily attributable to any failure on the part of the surgeon. Authoritative Text Books on Gynaecology and empirical researches which have been carried out recognize the failure rate of 0.3% to 7% depending on the technique chosen out of the several recognized and accepted

ones. The technique which may be foolproof is removal of uterus itself but that is not considered advisable. It may be resorted to only when such procedure is considered necessary to be performed for purposes other than merely family planning.

An English decision Eyre v. Measday (1986) 1 ALL ER 488 is very near to the case at hand. The facts of the case were that in 1978, the plaintiff and her husband decided that they did not wish to have any more children. The plaintiff consulted the defendant gynaecologist with a view to undergoing a sterilization operation. The defendant explained to the couple the nature of the particular operation he intended to perform, emphasising that it was irreversible. He stated that the operation 'must be regarded as a permanent procedure' but he did not inform the plaintiff that there was a small risk (less than 1%) of pregnancy occurring following the operation. Consequently, both the plaintiff and her husband believed that the result of the operation would be to render her absolutely sterile and incapable of bearing further children. In 1979 the plaintiff became pregnant and gave birth to a child. The plaintiff brought an action against the defendant for damages, inter alia, for breach of contract, contending that his representation that the operation was irreversible and his failure to warn her of the minute risk of the procedure being unsuccessful, amounted to breach of a contractual term, or express or implied collateral warranty, to render her irreversibly sterile. The judge dismissed her claim and the plaintiff appealed to the Court of Appeal.

The Court held "(1) The contract undertaken by the defendant was to carry out a particular type of operation rather than to render the plaintiff absolutely sterile. Furthermore, the defendant's representations to the plaintiff that the operation was 'irreversible' did not amount to an express guarantee that the operation was bound to achieve its acknowledged object of sterilizing the plaintiff. On the facts, it was clear that the representations meant no more than that the operative procedure in question was incapable of being reversed.

(2) Where a doctor contracted to carry out a particular operation on a patient and a particular result was expected, the court would imply into the contract between the doctor and the patient a term that the operation would be carried out with reasonable care and skill, but would be slow to imply a term or unqualified collateral warranty that the expected result would actually be achieved, since it was probable that no responsible medical man would intend to give such a warranty. On the facts, no intelligent lay bystander could have reasonably inferred that the defendant was intending to give the plaintiff a guarantee that after the operation she would be absolutely sterile and the fact that she believed that this would be the result was irrelevant."

The appeal was dismissed. The Court of Appeal, upheld the finding of the trial judge that the risk of pregnancy following such a procedure to which the plaintiff was subjected is described as very small. It is of the order of 2 to 6 in every 1000. There is no sterilization procedure which is entirely without

such a risk.

Slade L J, stated in his opinion that "in the absence of any express warranty, the court should be slow to imply against a medical man an unqualified warranty as to the results of an intended operation, for the very simple reason that, objectively speaking, it is most unlikely that a responsible medical man would intend to give a warranty of this nature. Of course, objectively speaking, it is likely that he would give a guarantee that he would do what he had undertaken to do with reasonable care and skill; but it is quite another matter to say that he has committed himself to the extent suggested in the present case."

Purchas LJ, stated in his opinion that "it is true that as a matter of deliberate election the defendant did not, in the course of describing the operation which he was recommending, disclose that there was a very small risk, one might almost say an insignificant risk, that the plaintiff might become pregnant. In withholding this information it must be borne in mind, first that the defendant must have believed that the plaintiff would be sterile, second that the chances were extremely remote that the operation would be unsuccessful, third that in withholding this information the defendant was following a practice acceptable to current professional standards and was acting in the best interest of the plaintiff, and fourth that no allegation of negligence in failing to give this information to the plaintiff is pursued any longer in this case. There are, therefore, in my judgment, no grounds for asserting that the result would necessarily be 100% successful."

In Thake v Morris , [1986] 1 All ER 497 (CA) the claim for damages was founded on contract and not in torts. The Court of Appeal firmly rejected the possibility of an enforceable warranty. Neill L J said:

> "a reasonable man would have expected the defendant to exercise all the proper skill and care of a surgeon in that speciality: he would not have expected the defendant to give a guarantee of 100% success."

Nourse L J said:

> "of all sciences medicine is one of the least exact. In my view, a doctor cannot be objectively regarded as guaranteeing the success of any operation or treatment unless he says as much in clear and unequivocal terms."

We are, therefore, clearly of the opinion that merely because a woman having undergone a sterilization operation became pregnant and delivered a child, the operating surgeon or his employer cannot be held liable for compensation on account of unwanted pregnancy or unwanted child. The claim in tort can be sustained only if there was negligence on the part of the surgeon in performing the surgery. The proof of negligence shall have to satisfy Bolam's test. So also, the surgeon cannot be held liable in contract unless the plaintiff alleges and proves that the surgeon had assured 100 % exclusion of pregnancy after the surgery and was only on the basis of such assurance that the plaintiff was persuaded to undergo surgery. As noted in various decisions which we have referred to hereinabove, ordinarily a surgeon does not offer such guarantee.

The cause of failure of sterilization operation may be obtained from laparoscopic inspection of the uterine tubes, or by x-ray examination, or by pathological examination of the materials removed at a subsequent operation of re-sterilisation. The discrepancy between operation notes and the result of x-ray films in respect of the number of rings or clips or nylon sutures used for occlusion of the tubes, will lead to logical inference of negligence on the part of the gynaecologist in case of failure of sterilisation operation. (See: Law of Medical Negligence and Compensation by R.K. Bag, Second Edition, p.139) Mrs. K. Sarada Devi, the learned counsel appearing for the plaintiffs-respondents placed reliance on a 2-Judge Bench decision of this Court in State of Haryana & Ors. v. Smt. Santra, JT 2000 (5) SC 34, wherein this Court has upheld the decree awarding damages for medical negligence on account of the lady having given birth to an unwanted child on account of failure of sterilization operation. The case is clearly distinguishable and cannot be said to be laying down any law of universal application. The finding of fact arrived at therein was that the lady had offered herself for complete sterilization and not for partial operation and, therefore, both her fallopian tubes should have been operated upon. It was found as a matter of fact that only the right fallopian tube was operated upon and the left fallopian tube was left untouched. She was issued a certificate that her operation was successful and she was assured that she would not conceive a child in future. It was in these circumstances, that a case of medical negligence was found and a decree for compensation in tort was held justified. The case thus proceeds on its own facts.

The methods of sterilization so far known to medical science which are most popular and prevalent are not 100% safe and secure. In spite of the operation having been successfully performed and without any negligence on the part of the surgeon, the sterilized woman can become pregnant due to natural causes. Once the woman misses the menstrual cycle, it is expected of the couple to visit the doctor and seek medical advice. A reference to the provisions of the Medical Termination of Pregnancy Act, 1971 is apposite. Section 3 thereof permits termination of pregnancy by a registered medical practitioner, notwithstanding anything contained in the Indian Penal Code, 1860 in certain circumstances and within a period of 20 weeks of the length of pregnancy. Explanation II appended to sub- section (2) of Section 3 provides _____ "Explanation II. _____ Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman."

And that provides, under the law, a valid and legal ground for termination of pregnancy. If the woman has suffered an unwanted pregnancy, it can be terminated and this is legal and permissible under the Medical Termination of Pregnancy Act, 1971.

The cause of action for claiming compensation in cases of failed sterilization operation arises on account of negligence of the surgeon and not on account of child birth. Failure due to natural causes would not provide any ground for claim. It is for the woman who has conceived the child to go or not to go for medical termination of pregnancy. Having gathered the knowledge of conception in spite of having undergone sterilization operation, if the couple opts for bearing the child, it ceases to be an unwanted child. Compensation for maintenance and upbringing of such a child cannot be claimed.

For the foregoing reasons, we are of the opinion that the judgments and the decrees passed by the High Court and courts below cannot be sustained. The trial court has proceeded to pass a decree of damages in favour of the plaintiffs-respondents solely on the ground that in spite of the plaintiff-respondent No.2 having undergone a sterilization operation, she became pregnant. No finding has been arrived at that will hold the operating surgeon or its employer ___ the State, liable for damages either in contract or in tort. The error committed by the trial court, though pointed out to the first appellate court and the High Court, has been overlooked. The appeal has, therefore, to be allowed and the judgment and decree under appeal have to be set aside.

We have decided the question of law and held that the decree awarding the damages was totally uncalled for and had no foundation in law, and therefore, has to be set aside. The present case is an occasion, which we would like to utilize for the purpose of making certain observations on three related topics noted hereunder.

> (1) Jacob Mathew's case (2005) 6 SCC1 : a post script In Jacob Mathew this Court dealt with the liability of a medical practitioner in criminal law. Of course, the decision also discussed in detail the law of medical negligence in general and indicated the parameters of fixing liability. The distinction between the concept of negligence in civil law and negligence in criminal law was highlighted. The present case deals with the law of negligence in tort. The basis of liability of a professional in tort is negligence. Unless that negligence is established, the primary liability cannot be fastened on the medical practitioner.

Unless the primary liability is established, vicarious liability on the State cannot be imposed. Both in criminal jurisprudence and in civil jurisprudence, doctors are liable for consequences of negligence. In Jacob Mathew even while dealing with criminal negligence, this Court has indicated the caution needed in approaching a case of medical negligence having regard to the complexity of the human body which is subjected to treatment and the uncertainty involved in medical procedures. A doctor, in essence, needs to be inventive and has to take snap decisions especially in the course of performing surgery when some unexpected problems crop up or complication sets in. If the medical profession, as a whole, is hemmed in by threat of action, criminal and civil, the consequence will be loss to the patients. No doctor would take a risk, a justifiable risk in the circumstances of a given case, and try to save his patient from a complicated disease or in the face of an unexpected problem that confronts him during the treatment or the surgery. It is in this background that this Court has cautioned that the setting in motion of the criminal law against the medical profession should be done cautiously and on the basis of reasonably sure grounds. In criminal prosecutions or claims in tort, the burden always rests with the prosecution or the claimant. No doubt, in a given case, a doctor may be obliged to explain his conduct depending on the evidence adduced by the prosecution or by the claimant. That position does not change merely because of the caution advocated in Jacob Mathew in fixing liability for negligence, on doctors.

(2) How the medical profession ought to respond Medical profession is one of the oldest professions of the world and is the most humanitarian one. There is no better service than to serve the suffering, wounded and the sick. Inherent in the concept of any profession is a code of conduct, containing the

basic ethics that underline the moral values that govern professional practice and is aimed at upholding its dignity. Medical Ethics underpins the values at the heart of the practitioner-client relationship. In the recent times, professionals are developing a tendency to forget that the self-regulation which is at the heart of their profession is a privilege and not a right and a profession obtains this privilege in return for an implicit contract with society to provide good, competent and accountable service to the public. It must always be kept in mind that doctor's is a noble profession and the aim must be to serve humanity, otherwise this dignified profession will lose its true worth.

Medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. The oldest expression of this basic principle comes from Hippocrates, an early Greek Physician, born in 460 B.C. who came to be known as the "Father of Medicine" and had devoted his entire life to the advancement of medical science. He formulated a code of conduct in the form of the Hippocratic Oath, as he realized that knowledge and skill were not enough for a physician without a code of standards and ideals. He coined an oath of integrity for physicians, a code of standards and ideals to which they must swear to adhere in the practice of their profession. This continues till date to be the oath administered to doctors when they join the profession:

> "I swear by Apollo the physician, by Fsculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgement, the following Oath.
>
> To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone the precepts and the instruction. I will prescribe regimens for the good of my patients according to my ability and my judgement and never do harm to anyone. To please no one will I prescribe a deadly drug nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art. In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot."

Many versions of Hippocratic Oath are prevalent. "Light From Many Lamps" a book edited by Lilian Eichler Watson contains a little different phraseology of that oath but certainly a beautiful commentary on the significance of the Hippocratic Oath. We would like to reproduce the oath and

the commentary hereunder: (pages 181-182);

> "I do solemnly swear by that which I hold most sacred:
>
> That I will be loyal to the profession of medicine and just and generous to its members;
>
> That I will lead my life and practice my art in uprightness and honor;
>
> That into whatsoever house I shall enter, it shall be for the good of the sick to the utmost of my power, I holding myself aloof from wrong, from corruption, and from the temptation of others to vice;
>
> That I will exercise my art solely for the cure of my patients, and will give no drug, perform no operation for a criminal purpose, even if solicited, far less suggest it;
>
> That whatsoever I shall see or hear of the lives of men which is not fitting to be spoken, I will keep inviolably secret.
>
> These things I do promise, and in proportion as I am faithful to this my oath may happiness and good repute be ever mine ___ the opposite if I shall be forsworn."

[F.N.: The Hippocratic Collection, containing the best of the ancient Greek medical writings, was put together by Aristotle and has survived through the centuries. The "Hippocratic Oath" is one of the last and most inspiring passages in this Collection. There are a number of versions of the famous Oath; but the form given here is the one commonly used today; and is an adaptation of a translation from the original Greek.] "The medical profession is and always has been one of the most ethical of all professions; and this is due at least in part to the centuries-old influence of the Hippocratic Oath. This famous Oath has kept alive the high standards and ideals set by Hippocrates, and forms the basis of modern medical ethics.

Written more than twenty centuries ago, the Hippocratic Oath has inspired generations of doctors . . . and continues to do so even now. The Oath is still administered by medical schools to graduating classes; and thousands of physicians have framed copies on their walls along with their diplomas. Conscientious practitioners continue to live up to the principles and ideals set down for their profession so long ago by the "Father of Medicine."

Though it was written specifically for physicians, the Hippocratic Oath sets an enduring pattern of honor, integrity, and devotion to duty for all people, in all professions." And certainly to surgeons."

Many people argue that the original Hippocratic Oath is inappropriate in a society that has seen drastic socio-economic, political and moral changes, since the time of Hippocrates. Certain parts of the original oath such as teaching the master's sons the secrets of medicine without fees and the promise not to bring a knife to another's body but to leave it to 'practitioners of the craft' have been

rendered obsolete as the modernisation of education has led to the teaching of medical science in institutions of higher learning, and specialisation in medicine has led to physicians who specialise in a variety of fields including surgery. Similarly, the legalisation on abortion and physician- assisted suicide in certain parts of the world, has made it awkward for some medical practitioners there to carry on in the tradition of the original oath.

This has led to the modification of the oath to something better suited for our times. One of the most widely used versions is The Declaration of Geneva which was adopted by the General Assembly of the World Medical Association at Geneva in 1948. Written with the medical crimes committed in Nazi Germany in view, it is a 'declaration of physicians' dedication to the humanitarian goals of medicine.' It is also perhaps the only one to mention treating people equally, without regard as to race, religion, social standing and political affiliations:

> "I solemnly pledge myself to the service of humanity. I will give to my teachers the respect and gratitude which is their due. I will practice my profession with conscience and dignity. The health of my patient will be my first consideration. I will respect the secrets which are confided in me. I will maintain by all means in my power the honour and noble traditions of the medical profession. My colleagues will be my brothers and sisters. I will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient. I will maintain the utmost respect for human life even under threat. I will not use my medical knowledge contrary to the laws of humanity. I make these promises solemnly, freely and upon my honour."

In recent times the self regulatory standards in the profession have shown a decline and this can be attributed to the overwhelming impact of commercialization of the sector. There are reports against doctors of exploitative medical practices, misuse of diagnostic procedures, brokering deals for sale of human organs, etc. It cannot be denied that black sheep have entered the profession and that the profession has been unable to isolate them effectively. The need for external regulation to supplement professional self-regulation is constantly growing. The high costs and investments involved in the delivery of medical care have made it an entrepreneurial activity wherein the professionals look to reaping maximum returns on such investment. Medical practice has always had a place of honour in society; currently the balance between service and business is shifting disturbingly towards business and this calls for improved and effective regulation, whether internal or external. There is need for introspection by doctors individually and collectively. They must rise to the occasion and enforce discipline and high standards in the profession by assuming an active role.

(3) Need for devising a welfare fund or insurance scheme Failure of many a sterilization operation, though successfully performed, is attributable to causes other than medical negligence as we have already discussed hereinabove. And, yet the doctors are being faced with claim for damages. Some of the claims have been decreed by the courts without arriving at any finding providing a foundation in law for upholding such a claim. The state is also being called upon to honour such decrees on the principle of vicarious liability when the surgeon has performed a surgery in discharge of his duty.

Mostly such surgeries are performed on a large scale and as a part of family welfare programmes of the Government. Obviously, such programmes are in public interest. Such like decrees act as a disincentive and have deterrent effect on the surgeons performing sterilization operations. The State, flooded with such decrees is also inclined not to pursue family planning camps on large scale though in public interest.

In Javed & Ors. v. State of Haryana & Ors. (2003) 8 SCC 369, popularly known as 'Two-Child Norm' case, this Court had an occasion to deal with the problem of increasing population, the danger which it poses for the progress of the nation and equitable distribution of its resources and upheld the validity of the Haryana legislation imposing a disqualification on persons having more than two children from contesting for an elective office. The fact cannot be lost sight of that while educated persons in the society belonging to the middle-class and the upper class do voluntarily opt for family planning and are careful enough to take precautions or remedial steps to guard against the consequences of failure of sterilization, the illiterate and the ignorant and those belonging to the lower economic strata of society face the real problem. To popularize family planning programmes in such sections of society, the State Government should provide some solace to them if they, on account of their illiteracy, ignorance or carelessness, are unable to avoid the consequences of a failed sterilization operation. Towards this end, the State Governments should think of devising and making provisions for a welfare fund or taking up with the insurance companies, a proposal for devising an appropriate insurance policy or an insurance scheme, which would provide coverage for such claims where a child is born to woman who has undergone a successful sterilization operation, as in the present case.

Conclusion The appeal is allowed. The judgment and decree passed by the trial court and upheld by the first appellate court and the High Court are set aside. The suit filed by the plaintiffs- respondents is dismissed. However, as we have already stated, in view of the concession given by the learned Additional Advocate General appearing for the appellant State, the amount of Rs.50,000/- if already paid to the plaintiff-respondent shall not be liable to be refunded by way of restitution. No order as to costs.