

(2002) 03 BOM CK 0084

In the Bombay High Court

Case No : Criminal Application No. 761 of 2000

Praful B. Desai (Dr.)

APPELLANT

Vs

Jyoti Raghunath and others

RESPONDENT

Date of Decision : 06-03-2002

Acts Referred:

Criminal Procedure Code, 1973 (CrPC) — Section 190, 200, 202, 482
Penal Code, 1860 (IPC) — Section 109, 338, 34, 415, 417

Citation : (2002) 03 BOM CK 0084

Hon'ble Judges : A.B. Palkar, J

Bench : Single Bench

Advocate : V.R. Manohar and Mrs. Rashmi D. Chandrachud instructed by Gagrath and Co, for the Appellant; Shreeram V. Shirsat for Respondent No. 1 and K.K. Kapoor, Assistant Public Prosecutor for State, for the Respondent

Final Decision : Allowed

Judgement

A.B. Palkar, J.—This is an application u/s 482 of the Criminal Procedure Code. Applicant, who is arraigned as accused No. 2 in the complaint filed by respondent No. 1 Smt. Jyoti Raghunath and her husband, is, even according to the statement in the complaint, a well known and reputed surgeon and specialised in the treatment of cancer. Original complainant No. 2 K. W. Raghunath was suffering from indifferent health having mild fever with indigestion. The ailment included discomfort, pain, and indigestion. He consulted his family Doctor Dr. N. R. Save and continued treatment prescribed by Dr. Save till March 1996. As the treatment did not lead to any satisfactory results, he was referred to one Dr. Banka who was initially arraigned as Accused No. 1, but subsequently deleted as per order of the learned Sessions Judge dated 20-1-2000, whereby the learned Sessions Judge set aside the order taking cognizance of offence passed by the learned Magistrate against Dr. Banka in Revision Application No. 527 of 1998.

2. Although the complaint is lengthy it would be necessary to refer to principal allegations so far as the present applicant is concerned. When Mr. Raghunath was

referred to Dr. Banka, he was examined and certain medical tests were conducted including Endoscopy and Multiple Biopsies. Dr. Banka diagnosed that the Raghunath was suffering from carcinoma of fundus including lower end of Oesophagus. Dr. Banka found that this growth is near the foodpipe and advised surgery. Thereafter Mr. Raghunath was referred to the present applicant, a well-known cancer surgeon, attached to Bombay Hospital. Raghunath was referred to Dr. Desai by Dr. Banka to get operated and believing on the suggestions and assurances of Dr. Banka, Raghunath consented for the operation. He was not at any time told that the operation to be performed was exploratory laparotomy which, according to the complaint is an operation to be performed in order to ascertain whether other operation can or should be performed. According to Raghunath the test reports clearly showed that it was an inoperable case and the intended surgery will prove detrimental to his health. Had he been informed earlier to the operation that it was exploratory laparotomy, he would not have consented in view of the express medical reports. Therefore, according to Raghunath, accused by not disclosing and willfully concealing the facts that the case was inoperable one and by giving a contrary opinion induced him to submit to the operation, and thereby committed offence of cheating punishable u/s 420 of the Indian Penal Code.

3. He was admitted to Bombay Hospital on 16-4-1996. Thereafter the Applicant/accused and his team of doctors prescribed various tests such as X ray, blood test, HIV test, Urine test, Excreta test, CT scan, sonography etc. When Raghunath was taken to Dr. Desai, he did not bother to examine the patient nor did he bother to peruse the reports and directed one Dr. Gangwal to take him to operation theatre and his approach was perfunctory and casual. Dr. Desai told him not to worry as the cancer is located near the food pipe and can be removed by surgery and he would be alright within a couple of weeks. Relying on this, he consented to the operation. The operation was performed on 25-4-1996 from 9 a.m. to 11 a.m. at the Bombay Hospital. Complainant Raghunath was taken to the operation theatre when he was in fully conscious condition. It is his emphatic assertion that he did not see Dr. Desai till he was given anesthesia and even after he retained consciousness he did not see Dr. Desai and therefore he strongly believe that Dr. Desai never operated upon him and the entire process was carried on some junior doctors. He came to know for the first time that it was an exploratory laparotomy when disclosed by Dr. Gangwal on 8-8-1996.

4. After the operation he was not given even a drop of water or other liquid for five days and on the 6th day he was given little water which resulted in deterioration of his health to such an extent that he could not get up from the bed even for urination. Thereafter within 10 days he was given first cycle of chemotherapy. Two more cycles were given by an interval of 21 days and thereafter, he took further chemotherapy treatment elsewhere as no accommodation was available when he went to Bombay Hospital for further cycle of chemotherapy. He was not informed any particular date on which he should visit Bombay Hospital and was in fact refused treatment by the said hospital on

the ground of non-availability of accommodation. The Applicant never bothered to see him after the operation and follow-up treatment. Therefore, according to the complainant, he was operated for carrying on experiment and was treated as guinea pig.

5. Later on he consulted Dr. Mukarjee and Dr. Ashok Mehta who studied the case papers and told him that the doctors have committed rash and negligent act by advising and performing such operation. The doctors ought to have told him that the real operation (curative) is possible on ascertaining the condition (extent of spread of cancer) by conducting exploratory laparotomy and thus the accused has committed offence punishable under sections 338 and 420 of the Indian Penal Code.

6. On this complaint a show-cause notice was issued which order came to be set aside by the Sessions Court. Thereafter process was issued and the order as against Dr. Banka was set aside by the Sessions Court as stated earlier.

7. The applicant has contended in the application that he is an internationally known surgeon and also known for his pioneering work in the field of cancer and was Medical Director of Tata Memorial Hospital and Cancer Research Institute and is presently Professor Emeritus at Tata Memorial Hospital and has been practicing as consulting surgeon for 42 years. Mr. Raghunath also moved the State Consumer Dispute Redressal Forum and filed a complaint to Medical Council. Due to this simultaneous proceedings before different forums, the applicant suffered mental torture and anxiety and has therefore, approached this Court challenging the complaint and issuance of process by the Magistrate.

8. In short according to the applicant, the complaint even if taken as it is, does not disclose any offence. The entire act of the applicant, his decision of performing exploratory laparotomy was in the best interest of the patient. The patient and his near relatives were informed that it is an exploratory laparotomy. Exploratory Laparotomy is not an operation performed for deciding as to whether actual resection is possible and advisable. It is performed when other tests do not positively disclose the spread of cancer and its extent. It is a medically recognized practice to explore by surgery and if possible to resects the malignant growth at the same time i.e. in the same operation and not for deciding whether another operation is possible or advisable. Complaint is wanting in bonafides and is a frivolous and vexatious litigation. Complainant has deliberately suppressed facts. He has chosen to annex few documents to the complaint without bringing the entire set of medical papers on record. Operation was performed with express consent for exploratory laparotomy.

9. Complainant has also filed an affidavit of Dr. Mehta in support of the complaint Dr. Ashok Metha has stated that in his considered opinion it was not a case for exploratory laparotomy as the spread of cancer revealed by the investigation papers was to such an extent that surgery was not advisable.

10. Arguments were heard at length. On behalf of the applicant. Mr. V.R.

Manohar, senior Counsel, contended that this is a classic case which shows to what extent professional jealousy can lead persons to instigate somebody to file an entirely false, concocted, frivolous and vexatious complaint causing defamation and mental torture to a well-known and internationally acclaimed surgeon, who has been serving to the cause not only of treatment or cure of a deadly disease like cancer but also of research in the field. On such a complaint, the supporting affidavit and documents produced no cognizance of any offence could have been taken. The order of the learned Magistrate has resulted in miscarriage of justice and this Court in exercise of inherent powers must intervene in order to secure the end of justice and put to an end the enormous harassment, mental torture and defamation suffered by the applicant..

11. As against this, on behalf of the Respondents Mr. Shirsat supported the order contending that no reasons are required to be given while issuing process. In spite of this, the learned Magistrate had issued notice to show cause and thereafter passed a reasoned order. If the accused is confident that he has not committed any offence, why he is shy of facing a trial.

12. Number of judgments have been cited by either side. However, since the law relating to powers of High Court u/s 482, Criminal Procedure Code is well settled, I would refer to only few of them. In my view an extensive reference to the authorities on the subject of negligence by medical experts is necessary.

13. In the case of Smt. Nagawwa Vs. Veeranna Shivalingappa Konjalgi and Others, , the Supreme Court after accepting the proposition that once the Magistrate exercises his discretion, it is not for the High Court or the Supreme Court to substitute its discretion to that of the Magistrate, specifically pointed out the instances in which the order of issuing the process can be quashed or set aside :

(1) Where the allegations made in the complaint or the statement of the witnesses recorded in support of the same taken at their face value make out absolutely no case against the accused or the complaint does not disclose the essential ingredients of an offence which is alleged against the accused.

(2) Where the allegations made in the complaint are patently absurd and inherently improbable so that no prudent person can ever reach a conclusion that there is sufficient ground for proceeding against the accused;

(3) Where the discretion exercised by the Magistrate in issuing process is capricious and arbitrary having been based either on no evidence or on materials which are wholly irrelevant or inadmissible; and

(4) Where the complaint suffers from fundamental legal defects, such as want of sanction, or absence of a complaint by legally competent authority and the like.

14. In the case of Dr. Anand R. Nerkar Vs. Smt. Rahimbi Shaikh Madar and others, , this Court (Coram : M. P. Saldanha J.) referred to the tests laid down by the Supreme Court in Nagawwa's case (supra) and pointed out:

Having regard to this position, it is necessary to observe that in cases where a professional is involved and in cases where a complainant comes forward before a Criminal Court and levels accusations, the consequences of which are disastrous to the career and reputation of the adverse party such as a doctor, the Court should be slow in entertaining the complaint in the absence of complete and adequate material before it. It is always open to the learned Magistrate to direct an enquiry through the police so that all relevant aspects of the case are looked into before process is issued. Alternatively, it is a salutary procedure adopted by some of the Magistrates in Bombay City that notice is issued to the accused so that he is afforded an opportunity of placing before the Court the relevant material which the complainant himself omitted to disclose. It must be realised in the present context that a professional whose career and reputation can be seriously damaged through the commencement of a criminal proceeding can never be adequately compensated in the public mind, even if he is acquitted of a charge at a later point of time. The duty cast on the trial Magistrate u/s 202 of the Code of Criminal Procedure is not to be understood as being confined to ascertain as to whether the complainant and the witnesses have mechanically averred that the accused has committed an offence, but it presupposes that a judicial mind will apply itself to the case made out as a whole and conclude as to whether there is sufficient justification to hold that an offence has been committed. The establishment of a prima facie case, therefore, indicates that on the face of the record all ingredients that would constitute the commission of an offence are before the Court. Where there exist serious lacunae in the case made out and where the possibilities and probabilities of an adverse conclusion are remote, it would not be justified in holding that a prima facie case has been made out." In the case of *Nirmaljit Singh Hoon vs. State of West Bengal*, reported in 1973 SCC (Cri.) 521, the Supreme Court has pointed out in para 22 as under:

Under section 190 of the Code of Criminal Procedure, a Magistrate can take cognizance of an offence, either on receiving a complaint or on a police report or on information otherwise received. Where a complaint is presented before him, he can u/s 200 take cognizance of the offence made out therein and has then to examine the complaint and his witnesses. The object of such examination is to ascertain whether there is a prima facie case against the person accused of the offence in the complaint, and to prevent the issue of process on a complainant which is either false or vexatious or intended only to harass such a person. Such examination is provided therefore to find out whether there is or not sufficient ground for proceeding.

Normally this Court does not interfere with the discretion exercised by a Magistrate in taking cognizance of offence. However, in the instances pointed out above, it becomes the duty of the Court to interfere at this stage and to put an end to the harassment suffered by the accused on the basis of false, frivolous and vexatious complaint or on the basis of complaint which taken as it is, does not disclose the offences alleged.

15. In the case of Philips India Ltd. vs. Kunju Punnu & Anr., reported in 7975 Mh.L.J. 792, a Division Bench of this court has dealt with liability in case of negligence of Doctors. The Division bench pointed out in unmistakable terms that a mistaken diagnosis by a doctor is not necessarily negligent diagnosis. A practitioner can be held liable if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part regard being had to the ordinary levels of skill in the profession. In the case before the Division Bench the patient had complaints of digestive trouble and was given treatment by doctor and when he returned after a week with complaints of fever, cold and headache he was again treated but after four or five days, when he was again brought with complaint of high fever, he was kept at the company's dispensary. In the evening when the doctor found red pigmentation on his body, he was advised pathological tests and was taken to the nursing home of Dr. Grant who examined him and treated him for bacteraemia. He approved the treatment given by the earlier Doctor (defendant No. 7). Nobody suggested that he was suffering from small pox. There was no small pox epidemic. He was removed to Sassoon Hospital as he was unable to bear the charges of the Nursing Home and later on to a Infectious diseases Hospital, where he died. As there was no evidence to show that the patient was taken to defendant, any doctor of ordinary skill and competence would have diagnosed disease of the patient as small pox and treated him for that disease. In para 14, the Division Bench made reference to an English decision, (Blyth vs. Birmingham Waterworks Company (1856) 11 Exch. 781) and quoted :

...Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.

After referring to the judgment of Lord Wright in Lochgelly Iron and Coal Co. vs. M. Mullan ((1925) 94 LJKB 791), the court pointed as below :

Doctors owe to their patients a duty in tort as well as in contract. It is expected of such a professional man that he should show a fair, reasonable and competent degree of skill; it is not required that he should use the highest degree of skill, for there may be persons who have higher education and greater advantages than he has, nor will he be held to have guaranteed a cure. Although the standard is a high one, a medical practitioner should not be found negligent simply because one of the risks inherent in an operation of that kind occurs, or because in a matter of opinion he made an error of judgment, or because he has failed to warn the patient of every risk involved in a proposed course of treatment.

16. Learned Counsel Mr. Manohar also relied on a judgment in the case of Maynard vs. West Midlands Regional Health Authority, (1985) 1 All. E. R, 635. In order to appreciate the law enunciated therein, it is material to know the facts of that case. Two consultants employed by the defendants health authority who

were treating plaintiff for, chest complaint thought that she was suffering from tuberculosis, but also considered possibility that she might be suffering from Hodgkin's disease. Accordingly before obtaining the result of the test which would have determined whether she was suffering from tuberculosis, they decided to perform an exploratory operation to determine whether she was suffering from Hodgkin's disease. One of the consultants carried out the operation, which showed her infact suffering from tuberculosis and not Hodgkin's disease. However, as a result of the operation, plaintiff suffered damage to a nerve affecting her vocal cords resulting in her speech getting impaired. Such a damage being an inherent risk of the operation, plaintiff prayed action for negligence against defendant health authority claiming that the consultants have been negligent. The House of Lords in appeal held :-

Where a plaintiffs claim was based on an allegation that the fully considered decision of two consultants in the field of their special skill was negligent, it was not sufficient for the plaintiff to show that there was a body of competent opinion which considered that that decision was wrong if there also existed a body of professional opinion, equally competent, which supported the decision as being reasonable in the circumstances. Furthermore, it was not sufficient for the plaintiff to show that subsequent events demonstrated that an operation need not have been performed if the decision to operate was reasonable at the time, in the sense that a responsible body of medical opinion would have accepted it as being proper. It had to be recognised that differences of opinion and practice existed in the medical profession and that there was seldom any one answer exclusive of all others to problems of professional judgment and therefore although the court might prefer one body of opinion to the other that was not a basis for a conclusion that there had been negligence on the part of the defendant doctor. On the evidence, the Court of Appeal had been right to reverse the Judge's finding of negligence and the appeal would accordingly be dismissed." (Emphasis supplied) It is further pointed out by reference to an earlier decision at page 638, as under: "In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men....

The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care....

(Emphasis supplied).

It is pointed out categorically in this judgment by the House of Lords that at the trial and in the Court of appeal there were two issues - "causation and negligence". The judge decided both in favour of the plaintiff/appellant. The Court of Appeal had no hesitation in upholding the judge on causation but reversed him on negligence. Thus it is that the only issue now is negligence. On this the judge's conclusions were that the operation was unnecessary, wrong,

and in the circumstances unreasonable and a breach of the duty of care. He found that Dr. Ross instigated the operation and that Mr. Stephenson in failing to object to it and in sharing the decision was also in breach of his duty of care. The Judge accepted the evidence of Dr. Hugh-Jones, the appellant's principal expert witness, that it was almost certainly a case of tuberculosis from the outset and should have been so diagnosed, and that it was wrong and dangerous to undertake the operation. His detailed findings against Dr. Ross were that he should not have used the operation where the right diagnosis was almost certainly tuberculosis and that he should at the very least have waited for the pathological reports on the sputum, which in fact turned out to be positive. Dr. Ross's defence that because of the risk of Hodgkin's disease he could not delay was rejected by the judge on the grounds that a delay of four to six weeks, upto ten at maximum, would not have mattered and that the fear of Hodgkin's disease being present was not a reasonable fear in the circumstances. The judge recognized that the defence had called a formidable number of distinguished experts, amongst whom it was legitimate to include Dr. Ross and Mr. Stephenson themselves, all of whom expressed a contrary view to his and approved the course of action taken in deferring diagnosis and performing the operation. The judge accepted not only the expert of all the medical witnesses called before him but also their truthfulness and honesty. But he found Dr. Hugh-Jones an outstanding witness, clear, definite, logical persuasive and preferred his opinion and evidence. The House of Lords observed as below :

My Lords, even before considering the reasons given by the majority of the Courts of Appeal for reversing the finding of negligence, I have to say that a judge's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another. Failure to exercise the ordinary skill if a doctor (in the appropriate specialty, if he be a specialist) is necessary.

(Emphasis supplied).

17. Another judgment relied on by the learned Counsel for the applicant is in the case of *Whitehouse vs. Jordan*, reported in (1980) 1 All.E.R. 650. To appreciate the legal discussion, the facts are also relevant. Defendant, a senior hospital registrar, was in-charge of the delivery of the plaintiff as a baby following a high risk pregnancy. After the mother had been in labour for 22 hours the defendant (doctor) decided to carry out a test to see whether forceps could be used to assist the delivery. In doing so the defendant followed a suggestion by his head of department, a consultant professor of obstetrics, in his case notes on the mother. The defendant pulled on the baby with forceps five or six times and then

fearing for the safety of the mother and child he carried out a Cesarean section quickly and competently. The plaintiff was born with severe brain damage and, acting by his father, brought an action in negligence against the defendant alleging want of professional skill and care by pulling too hard and too long on the forceps and so causing the brain damage. The Court of appeal held:

(i) An error of clinical judgment by a medical practitioner did not of itself amount to negligence in the legal sense. Accordingly (Donaldson U. Dissenting) even if the finding that the defendant had pulled too hard and too long with the forceps was accepted, that did not constitute a finding of negligence, for the defendant's decision to continue pulling on the forceps was merely an error of clinical judgment or (per Lord Denning MR) was not, on the evidence, improper at all (see p.p. 658 a to h and 9 661 h j. post) : dictum of Denning LJ in *Roe vs. Ministry of Health* (1954) 2 All. E.R. 139 applied.

(ii) (Donaldson LJ dissenting) in any event the court was entitled to and would, reverse the judge's finding that the defendant had pulled too hard and too long with the forceps because that finding was based on an unjustified interpretation of the professor's report and the mother's evidence, especially as the latter contradicted the evidence of the doctors who were present at the delivery and the rest of the mother's evidence had been rejected by the judge, and (per Lawton LJ) because, in this particular instance, the appellate Court was entitled to disregard the trial Judge's assessment of the reliability of a witness (see p 657 h.p 658 h.p. 660 d e and p 661 e. post); *The Hontestroom* (1927) AC 37 applied.

Per Curiam. An inference of negligence should not necessarily be drawn from the fact that a baby is born with brain damage sustained in the course of delivery (see p. 658 a. p 661 h and p 663 e. post).

(Emphasis supplied).

While discussing the judge's findings the Court pointed out that the key sentence of the judge was "In getting it wedged or stuck, or unwaged or unstuck, Mr, Jordan caused asphyxia which in turn caused the cerebral palsy. In this respect Mr. Jordan fell below the very high standard of professional competence that the law requires of him". The Court further observed :

The first sentence suggests that, because the body suffered damage, therefore Mr. Jordan was at fault. In other words *res ipsa loquitur*. That would be an error. In a high-risk case, damage during birth is quite possible, even though all care is used. No inference of negligence should be drawn from it.

In the second sentence the judge required Mr. Nordan to come up to the very high standard of professional competence that the law requires. That suggests that the law makes no allowance for errors of judgment. This would be a mistake. Else there would be a danger. In all cases of professional men, of their being made liable whenever something happens to go wrong. Whenever I give a

judgment, and it is afterwards reversed by House of Lords, is it to be said that I was negligent? That I did not pay enough attention to a previous binding authority or the like? Every one of us every day gives a judgment which is afterwards found to be wrong. It may be an error of judgment but it is not negligent. So also with a barrister who advises that there is a good cause of action and it afterwards fails. Is it to be said on that account that he was negligent? Likewise with medical men. If they are to be found liable whenever they do not effect a cure, or whenever anything untoward happens, it would do a great disservice to the profession itself. Not only to the profession but to society at large. Take heed of what has happened in the United States. Medical malpractice cases there are very worrying. 1 especially as they are tried by juries who have sympathy for the patient and none for the doctor, who is insured. The damages are colossal. The doctors insure but the premiums become very high: and these have to be passed on in fees to the patients. Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risk involved. In the interests of all, we must avoid such consequences in England. Not only must we avoid excessive damages. We must say, and say firmly, that, in a professional man, an error of judgment is not negligence. To test it, I would suggest that you ask the average competent and careful practitioner: Is this the sort of mistake that you yourself might have made? If he says: "Yes, even doing the best I could, it might have happened to me, then it is not negligent. I saying this, I am only reaffirming that I said in *Hatcher vs. Black* (a case I tried myself). *Roe vs. Ministry of Health* and *Hucks vs. Cole*. Perhaps I may remind you of the saying of John Bradford over 450 years ago. On seeing some criminal taken to execution he exclaimed: "But for the Grace of God, there goes John Bradford. So now if this judgment against Mr. Jordan stands: all the doctors in English will say: But for the Grace of God, there go I.

Applying this test and even accepting that judge's view that Mr. Jordan pulled too hard and too long, it was not negligent. It was at worst an error of judgment. The Court even expressed: "Let it not be thought that I am wanting in sympathy for the mother. It was a most grievous thing for her. But it is not a thing which will be cured by money damages. Everyone will rally round to help her as they have already done during these last ten years. She should be grateful for all that has been done for her without laying blame on the doctors. I would allow the appeal accordingly.

(Emphasis supplied).

18. Another landmark judgment to which my attention was drawn by the learned Counsel for the applicant is reported in (1985) 1 All. E. R. 643 -*Sidaway vs. Bethlem Royal Hospital Governors*. The facts of this case in brief were that the plaintiff, who suffered from persistent pain on her back and shoulders, was advised by a surgeon employed by the defendant hospital governors to have an operation on her spinal column to relieve the pain. The surgeon warned the

plaintiff of the possibility of disturbing a nerve root and the possible consequences of doing so but did not mention the possibility of damage to the spinal cord even though he would be operating within three millimeters of it. (Emphasis supplied). The risk of damage to the spinal cord was very small (less than 1%) but if the risk materialized the resulting injury could range from the mild to the very severe. The plaintiff consented to the operation, which was carried out by the surgeon with due care and skill. However, in the course of the operation the plaintiff suffered injury to her spinal cord which resulted in her being severely disabled. She brought an action against the hospital governors and the surgeon's estate (surgeon having died in the mean time) claiming damages. In the course of his judgment, the Court applied to Bolam test and said:

The Bolam test is far from new; its value is that it brings up to date law and re-expresses in the light of modern conditions in which the art of medicine is now practiced an ancient rule of common law. The original rule can be traced to the maxim "*spondet peritiam artis et imperitia culpae adnumeratur*". It goes back to the origin of *assumpsit*; it applied to all artificers and was firmly founded in case (moderniter negligence) although it may be of interest to note that as long ago as 1767 in *Slater vs. Baker* 2 Wils 359, 95 ER 800 a suggestion that where injury was caused by surgery the form of action lay in *trespass vi et armis* was rejected with scant sympathy by the Court of Kings Bench.

The Court further pointed out that those members of the public who seek medical or surgical aid would be badly served by the adoption of any legal principle that would confine the doctor to some long established, well tried method of treatment only, although its past record of success might be small, if he wanted to be confident that he would not run the risk of being held liable in negligence simply because he tried some more modern treatment, and by some unavoidable mischance it failed to heal but did some harm to the patient. This would encourage defensive medicine with a vengeance. The merit of the Bolam test is that the criterion of the duty of care owed by a doctor to his patient is whether he has acted in accordance with a practice accepted as proper by a body of responsible and skilled medical opinion. There may be a number of different practices which satisfy this criterion at any particular time. These practices are likely to alter with advances in medical knowledge. Experience shows that, to the great benefit of humankind, they have done so, particularly in the recent past. That is why fatal diseases such as smallpox and tuberculosis have within living memory become virtually extinct in countries where modern medical care is generally available. It is further pointed out:

In modern medicine and surgery such dissection of the various things a doctor has to do in the exercise of his whole duty of care owed to his patient is neither legally meaningful nor medically practicable. Diagnosis itself may involve exploratory surgery, the insertion of drugs by injection (or vaccination) involves intrusion on the body of the patient and oral treatment by drugs, although it

involves no physical intrusion by the doctor on the patient's body, may in the case of particular patients involve serious and unforeseen risks.

(Emphasis supplied).

In the course of the judgment the Court has further pointed out:

No doubt, if the patient in fact manifested this attitude by means of questioning, the doctor would tell him whatever it was the patient wanted to know; but we are concerned here, with volunteering unsought information about risks of the proposed treatment failing to achieve the result sought or making the patient's physical or mental condition worse rather than better. The only effect that mention of risks can have on the patient's mind, if it has any at all, can be in the direction of deterring the patient from undergoing the treatment which in the expert opinion of the doctor it is in the patient's interest to undergo. To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on matters should be treated in just the same way. The Bolam test should be applied.

(Emphasis supplied.)

19. Another landmark judgment is the one reported in (1954) 2 QBD 66, *Roe vs. Minister of Health & another*. The facts of the case material to understand the law propounded are that two patients in hospital were operated on the same day. Both the operations were of a minor character, and in each case nupercaine, a spinal anaesthetic, was injected by means of a lumbar puncture by a specialist anaesthetist assisted by the theatre staff of the hospital. The nupercaine had been contained in sealed glass ampoules which had been stored in a solution of phenol. After the operations both patients developed severe symptoms of spastic paraplegia, caused by phenol, which had percolated into the ampoules through invisible cracks or molecular flaws, resulting in permanent paralysis from the waist down. Actions for damages for personal injuries were brought by both of the patients against the Minister of Health as successor in title to the trustees of the hospital. The trial Judge found for the defendants rejecting the contention of the plaintiffs that the doctrine *res ipsa loquitur* applied. On appeal it was held that applying the test of what was the standard of medical knowledge in 1947 in respect of the detection of the presence of the phenol in the ampoules, at the time of the operations, neither the anaesthetist nor any member of the hospital staff had been guilty of negligence, and the appeal failed.

20. Lord Denning L.J. in his judgment observed:

It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against, especially in cases against hospitals and doctors. Medical science has conferred great

benefits on mankind, but those benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right.

(Emphasis supplied).

It is further pointed out that:

One final word. These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure. I agree with my Lord that these appeals should be dismissed.

(Emphasis supplied).

21. In *Bolam vs. Friern Hospital Management Committee*, reported in (1957) 1 W.L.R. 582, it was held that a Doctor who had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question was not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique.

22. These principles are also relevant when one has to consider a case of criminal negligence. In my view the principles would apply to criminal cases a fortiori.

23. After taking into consideration the legal position which has to be kept in mind while considering cases of this type, it is also necessary to get acquainted with the medical aspect in respect of the disease and exploratory surgery. Mr. V. R. Manohar, learned Senior Counsel for the applicant with his ability and industry, drew my attention to certain medical journals and authorities. In a book titled as "Abdominal Operations" by Rodney Maingot, F.R.C.S. London, 4th Edition, on the chapter "Tumours of the Stomach" at page 302, there is discussion regarding this particular aspect. Under the head "Carcinoma of the Stomach", the author says :

Carcinoma of the stomach can be cured only by gastrectomy, and by this method alone can the patient's life be saved. All nonsurgical methods of therapy, including deep x-rays and radium, have a mortality of 100 per cent. Furthermore, cure is only possible when the disease is recognized early and resection is radical.

As only some 40 per cent of cancers of the stomach lend themselves to curative resection, it is obvious that no improvement is possible in the present situation until these cases are referred to the surgeon at a much earlier period in the illness than they have been hitherto.

The fight against cancer is a fight for earlier diagnosis and thus for earlier radical treatment.

After all, unless the diagnosis's made early, no technical skill will avail the patient with a carcinoma of the stomach. The fact that longtime survivors of gastrectomy for gastric cancer have usually had longer duration of symptoms in no way supports the contention of Mac Donad and Cotin (Surg., Gynec. & Obst., 98 : 148, 1954) that the concept that early diagnosis of cancer of the stomach may improve end-results is not only fallacious but is in fact the reverse of the truth.

(Emphasis supplied).

It is further pointed out on the same page :

The exploratory rate has increased 33 per cent (from 60 to 80 per cent), the respectability rate about 50 per cent (from 37 to 55 per cent), and the 5 year survival rate about 200 per cent (from 5 to 14 per cent). At the same time, the hospital mortality rate has fallen from about 16 to about 8 percent. Of all patients who underwent the resection 31.6 per cent were living 5 years after operation; 23.2 per 10 year after operation; 17.2 per cent 15 years after operation; and 12.2 percent 20 years after operation. The presence of metastasis is a dire omen in respect of prognosis. The 5 year survival rate of the group without metastasis is 48,5 per cent, whereas for the group with metastasis it is 18.6 per cent; the 10 year survival rate for those without metastasis is 36.9 per cent, while for those with metastasis it is 12.8 per cent. (Berkson et al. Proc. Mayo Clin., 27:137,1952).

(Emphasis supplied).

It is also important to note at this stage the observation on page 303, which are as under;

At operation it is sometimes difficult to decide whether or not a large, fixed, infiltrating growth is respectable, and, again, it is often difficult to decide which cases should be subjected to total or subtotal gastrectomy. In cases of cancer of the stomach a challenge to surgical courage should always be accepted. Surely, decision is one of the attributes to strength.

At page 320, it is pointed that out of 219 patients operated in 72 cases exploration only was carried out, that is to say that after exploration no resection could be carried out.

(Emphasis supplied).

24. In American Journal of surgery Vol. 104, issue of Sept. 1980 there is discussion on Therapeutic Significance of Noncurative Gastrectomy for Gastric Cancer with Liver Metastasis, wherein it is stated:

Liver metastasis is found in about 5 to 7 percent of patients with primary gastric cancer (1-3), and it has been reported that the postoperative survival time of patients subjected to non-curative gastrectomy is longer than that of patients receiving laparotomy alone (1.3.6.). On the basis of these reports, non-curative gastrectomy is now being performed routinely at our hospital in patients with gastric cancer with liver metastasis. This therapeutic significance of this type of treatment is evaluated herein and the histologic characteristics of gastric cancer with liver metastasis are described.

Summary is given at the end of the article as under:

The therapeutic significance of non-curative gastrectomy for gastric cancer with liver metastasis was evaluated and the histologic characteristics of such cancer examined. The mean post-operative survival time of patient with liver metastasis limited to one lobe or a few scattered metastases to both lobes without peritoneal metastasis or direct cancer invasion to other organs was significantly prolonged by noncurative gastrectomy. Differentiated adenocarcinoma, including papillary adenocarcinoma, and intravenous cancer invasion were found to be the histologic characteristics of gastric cancer with liver metastasis.

25. In a book titled "EPIDEMIOLOGY" by Devita, Hellman, Rosenberg, 5th Edition, at page 1021, there is an article on Cancer of Stomach, wherein it is stated:

Wanebo and coworkers have reported on the results of a tumor registry survey in 1982 and 1987 of 18,365 patients. Of all patients with gastric cancer, 72.4% were explored and 77% of these had gastric resection. Other organs resected during operation included omentum in 41% of patients, spleen in 23%, esophagus in 29%, and 7% for both the colon and the pancreas. When these organs were resected they were involved by tumor in 41% for omentum, 45% for colon, 75% for esophagus, 38% for pancreas, and 10% for spleen. Pathologically, in the entire cohort, about 18% were stage I, 16% were stage II, 36% were stage III and 30% were stage IV.

(Emphasis supplied).

While summarising it is pointed out at page 1033 as under :

In summary, retrospective reports indicate that the routine use of extended lymphadenectomy for potentially curable gastric cancer can be performed safely and may result in improved survival compared with a more limited D-I resection. Two small single-institution prospective randomized trials with a limited number of patients do not support the routine use of extended D-2 gastrectomy. The advanced stage of disease at surgery in most patients remains the key determinant of survival, and the presence of peritoneal, hepatic, or unresectable

modal metastases portends a dismal prognosis despite of D-2 resection. The routine application of lymphadenectomy is currently being evaluated in several random assignment trials in Europe.

26. In the light of this situation, it would be proper to consider the present case. Respondent/org. Complainant Raghunath has relied on the affidavit of Dr. Mehta, who had admittedly not seen or examined him at the crucial stage when he was advised exploratory laparotomy. This doctor was consulted in December 1996 i.e. when his health condition was deteriorating after the laparotomy. He claims to have reviewed the reports of the investigation and treatment which included Gastro intestinal endoscopy done by Dr. Banka and biopsy reportedly showing adenocarcinoma, the CT. Scans of 23-4-1996 reported by Dr. Inder Talwar of Bombay Hospital and Medical Research Centre, the ultra sonography of abdomen of 22-4-1996 performed by Dr. Ambriah K. Dalai of the Bombay Hospital. According to Dr. Mehta, the Bombay Hospital Medical record of investigation states that pre-operative investigations showed that he had adenocarcinoma of fundus of the stomach extending into the lower end of the esophagus and through the stomach in the pancreas. The left gastric and paraeortic lymphnodes were reportedly enlarged and there were multiple metastatic deposits in the liver. The left supraclavicular node were also enlarged. All these reports indicated that the cancer which had started in the stomach had spread not only locally in the stomach but had also spread to the regional lymphnodes and pancreas. According to him the cancer of stomach with such extensive spread cannot be considered suitable for resection. Determination of the extent of disease is of assistance in making decisions regarding therapeutic intervention. Any suspicious lesions (lymphnode or liver detected on physical examinations and investigations should be biopsied prior to laparotomy, liver biopsy performed under CT control or ultra sonographically guided should be considered for patients with suspicious CT scans surgical intervention. He has further stated that from the past records it appears that Mr. Raghunath developed temperature. Dr. Mehta has the audacity to say that Mr. Raghunath should have received two bottles of blood. This statement is made when he had no opportunity to examine Mr. Raghunath after operation in the condition in which according to him, the blood transfusion was necessary. He further states that chemotherapy in such advanced cancer is of no significant help and more often than not causes side effects which leads to general debility especially if it is exhibited before recovery from operation as was done in Raghunath's case.

27. Now apart from anything else, let us consider the basic import of this affidavit, if any, from this statement of Dr. Mehta, it is obvious that according to him, the case of Mr. Raghunath was neither a case for surgery nor a case for chemotherapy treatment nor for exploratory laparotomy. I wonder what treatment Dr. Mehta would have given to this patient had the patient approached him in that condition. Therefore, obviously on the face of it, this is an afterthought statement made with intention best known to the Doctor. Does he mean to say that he would not have advised any treatment? as Mr. Raghunath

could be operated. He could also not be given chemotherapy, and consequently no treatment could be prescribed. It is obvious that Dr. Mehta would not advice any patient that there is no treatment neither surgery nor chemotherapy and the patient should take only pain killers and wait for death. Therefore, the statement is made for some other reasons.

28. Now what is made out in the complaint. Once Mr. Raghunath says that Dr. Desai was negligent in taking a decision of exploratory laparotomy. He was negligent in performing operation. At the same time he has the audacity to say that Dr. Desai did not perform the operation. He does not know who performed it. He has not collected information even through his relatives or doctors who had discussion with him afterwards as to who performed the surgery. He is bold enough to say that Dr. Desai did not perform operation, and some junior must have performed it. It was rightly contended by Mr. Manohar that this type of assertion in the complaint is unknown to criminal law. Once you charge a person for negligently performing the operation then at the same you cannot say that he did not perform operation and negligence was in entrusting it to some other doctor for which neither the complainant has personal knowledge nor has he sought reliable information. The intention is obviously to involve the doctor in a case of criminal negligence somehow or the other.

29. The medical records show that the patient was a chronic smoker and alcoholic for 20 years. He was aged about 57 years. He was admitted on 16-4-1996 in Bombay Hospital and investigation carried out for exploratory laparotomy and treatment advised was chemotherapy five doses. Operation and findings; Exploratory laparotomy, stomach infiltrations into pancreas, liver metastases, adenocarcinoma of stomach. The report of Dr. Talwar dated 23-4-1996 regarding C.T. Scan of Abdomen is as below :

Plain and contrast CT study of the abdomen has been performed after administration of oral contrast medium.

There is an irregular inhomogeneously enhancing mass seen at the fundus of the stomach. The mass is seen to extend into the lower esophagus (Images 17, 18, 19). The fat planes between the mass and the left lobe of liver is not well defined. Nodular inhomogenously enhancing lesions are seen medial to the fundus in the region of the porta. These are seen contiguous with the growth, but may represent metastatic lymphnodes also.

The liver does not reveal any focal abnormality. The intrahepatic biliary and portal venous radicals are normal.

The gall bladder, spleen, pancreas, both the kidney and adrenals are normal.

There is no evidence of para-aortic lymphadenopathy.

Conclusion.

An irregular, inhomogeneously enhancing mass arising from the fundus of the

stomach and extending into the lower esophagus is consistent with a malignant neoplasm of stomach.

Soft tissue mass seen posterior to the left lobe of liver and periportal region is either a metastatic lymphadenopathy or a contiguous spread.

(Emphasis supplied).

The Report clearly shows that even the Neuro-Radiology and C.T. Scanning Department head Dr. Talwar did not find any evidence of paranoiac lymphadenopathy. He has clearly stated that regarding nodular lesions from medial to the fundus in the region of the porta and that though these are seen contiguous with the growth may represent metastatic lymphnodes also which shows that he was not sure whether they represent metastatic lymphnodes. He has clearly stated that the liver does not reveal any focal abnormality. The intrahepatic biliary radicles and portal venous radicles are normal. The left lobe of liver and periportal region is either a metastatic lymphadenopathy or contiguous spread. If on this report Dr. Mehta has asserted that prior investigations revealed the spread of cancer to different parts on which decision could be taken that no exploratory laparotomy is required and therefore, taking such a decision amounts criminal negligence, then it is obvious that his opinion is biased. It appears that he has based his opinion on the data made available by exploration and for some ulterior motive he is now making statement against the record for reasons best known to him. (Emphasis supplied). The legal position is that even if his opinion is acceptable, that is no ground to hold the surgeon who took the decision for exploratory laparotomy guilty of negligence.

30. Another aspect of the matter is that Complainant Raghunath is not even aware as to what is meant by exploratory laparotomy, inasmuch as he has mentioned in the complainant that according to him, it was an operation for the purpose of deciding whether any further operation should be performed or that it was an experiment. The medical authorities referred to clearly show that exploratory laparotomy is an operation performed in order to explore possibility of resection and not only in exceptional cases like Mr. Raghunath but in number of cases resection could not be performed and exploring the possibility" of resection was of no use and the part of the body had to be closed. These were the case in which only exploratory operation was done.

31. In the same complaint the complainant stated that he was told that the cancer is located near food pipe. It was revealed so. Because the spread of cancer was not known definitely from investigation reports. His further assertion that he was told that it was an operable case and it can be removed by performing surgery and he would become alright after a couple of weeks is on the face of it a false statement. The case papers disclosed that he was in an advanced stage of malignancy. Doctors were not sure regarding certain factors noted during investigation and in such a situation by a man of the skill and reputation of Dr. Desai, it is not probable that such a sentence would be uttered.

I have not heard any doctor having advised any cancer patient that he would be alright within a couple of weeks. This advise is not given even to persons who have cancer diagnosed at preliminary stage.

32. Even at the initial stage of entertaining a complaint, the Court is required to look into this aspect of the matter as to whether on the face of it the allegations made in the complaint can be accepted atleast prima facie. The complainant probably wants us to believe that the doctors thought that he was suffering from a disease like cough, cold or bronchitis or some fever of which he would be cured within a couple of weeks. It shows the falsity of the complaint and the audacity with which such assertions are made in the complaint.

33. Coming to the contention of the complainant that he would not have consented if he was aware of exploratory laparotomy. The case papers show falsity of the statement. It is specifically mentioned that exploratory laparotomy was carried with express consent obtained on the case papers. The consent of his wife, who is also a complainant along with him, and now the only complainant, as Mr. Raghunath is no more, has in her own hand signed the writing wherein it is stated, "we are aware of the patients disease and the type of surgery he will undergo. We hereby gives consent to the surgery under anesthesia with due risk because of patient"s age 57 years...."

34. The complainant has also stated that for five days he was not given even a drop of water. It was a stomach operation. Case papers show that he was given intravenous fluids for four days and thereafter he was given liquids orally. Had the complainant been not given any liquid orally or by intravenous injection, would he survived is a big question. What he means to say by making such an allegation in the complaint is difficult to appreciate. If only intravenous fluid was given, it was the part of treatment based on a conscious decision and in the interest of the patient.

35. Complainant is not aware what is exploratory laparotomy. What is asserted in the complaint is against the medical science. He is not sure as to what allegations he wants to make because once he states that Dr. Desai did not perform the operation. His assertion that he was not given water or liquid for five days is falsified by the case papers which are relied on by him. The assertion of his witness that prior investigation report disclosed the extent of spread of cancer to different organs is also falsified by the same reports on which Dr. Mehta claims to have relied. All this shows that the complaint is full of allegations which are not only unreliable but on the face of it false and concocted. It appears that there is some other force behind the complaint and that is why the learned Counsel for the applicant asserted that it is difficult to imagine, to what extent professional jealousy can go, although no particular person was named at any stage nor is being intended to by the Court while making reference to this argument.

36. There is one more aspect. Prior to the filing of the complaint, the

complainant had issued a notice to the applicant Dr. Desai and this notice was replied in detail and as a matter of fact had the complainant sent notice due to his our anxiety or under some misapprehension, the reply to the same produced on record should have set the controversy at rest. In the notice he has asserted that on 25-4-1996 his relatives were told that it was an exploratory laparotomy whereas in the complaint he says that he came to know that it was an exploratory surgery on 8-8-1996 when Dr. Gangwal disclosed it. The assertion is therefore on the face of it untenable. He has further stated in the notice that though it was informed to his relative, he was not told because they feared that it might upset him. In a detailed reply sent to the complainant, the applicant has explained the entire situation. Notice appears to have been given after consultation with some medical and legal experts. However, reply was sent by the applicant in his own handwriting which appears to have obviously been sent without consulting any lawyer and in order to make clear the facts as probably that time applicant was not expecting that litigation would follow. In this reply it is clearly stated that investigations such as Chest X-ray, Scan, blood test etc. are usually done to examine spread of the disease to important organs like Liver, Lungs, Bones etc. in which case surgery is usually avoided if it shows spread to distant organs. In the case of Mr. Raghunath, the Lungs, and Liver on the CT Scan were normal which is in conformity with the report of Dr. Talwar. In some cases surgery is advised even in the presence of spread to prevent obstruction to swallowing or bleeding which can occur due to the growth in the food pipe or stomach. It is further stated that resection of the growth is the best form of palliation and comfort for an advanced cancer. The final decision to remove the growth however, is always made at the time of the actual operation. Areas of spread and type of spread seen at surgery cannot always be delineated even by the most modern technology of CT Scan or MRI Scan, and hence the final decision is always at the time of surgery. Even an advanced looking cancer can be removed in more than 50% of cases. It is therefore a good surgical principle to offer a chance with exploratory surgery and then decide the issue on the operating table. The reply of the applicant is thus in conformity with the medical experts and their articles cited above. Therefore, what Dr. Desai has done is that he was required to do according to the existing medical practice and in the best interest of the patient. It is also brought to the notice of the complainant by this reply that in 20 to 25% of cases the actual spread is more than what the scans have indicated and then one has to do the minimum and retreat as appropriate surgical strategy from patient's safety point of view. This is what we have seen in the medical books referred to by the learned Counsel. The law also recognizes that it is ultimately the decision of the surgeon and it is not a decision to be taken by someone looking into the papers afterwards. The law has gone to the extent that even if the decision is wrong, there is no negligence either civil or criminal. In the present case, it is obvious from the record that it was a case of a correct and bold decision and was an attempt to save the life of the patient, if possible or to palliate the sufferings and pain if nothing else could be achieved. Chemotherapy was the treatment advised, as resection was not possible. Had

the resection been possible, the same would have been done followed by Chemotherapy. All these facts having been brought to the notice of complainant at appropriate stage, he rushed to the Court, probably as he was misguided.

37. The allegations in the complaint, even if taken as they are along with medical reports on which complainant has relied, then even after considering the statement of Dr. Mehta and its merits as discussed above. I am of the considered opinion that the complainant has failed miserably to make out a prima-facie case of any criminal offence, especially the offences charged i.e. criminal negligence punishable u/s 338 and cheating punishable u/s 417 and 420 of the Indian Penal Code. The complainant was informed that it was a exploratory laparotomy, consent was obtained, his relatives were told about the risk involved. It was done in the best interest of the patient and was an attempt either to save his life or atleast to prolong it as much as possible.

38. So far as the offence of cheating punishable u/s 420, Indian Penal Code is concerned, it is not even alleged that the accused have charged anything beyond the hospital bills. Whatever is paid to the applicant is by the hospital from out of the bills as per their usual practice. Coming to section 415 Indian Penal Code, the only portion that can be referred to is the second part which is to the effect that "or intentionally induces a person so deceived to do or omit to do anything which he would not do or omit if he were not so deceived, and which act or omission causes or is likely to cause damage or harm to that person in body, mind, reputation...." At the cost of repetition, it is necessary to state that even according to the complainant's case taken at its best, what was done or omitted to be done was that the complainant was not told that it was exploratory laparotomy which was to be performed, which on the face of it is falsified by the case papers. Another aspect of the matter is that immediately after the surgery, complainant was informed by his relative that exploratory laparotomy was done. In this connection, it is also necessary to bear in mind that when a surgical operation is to be undertaken the doctors are required to take consent after informing the patient the risk involved. It is advisable and necessary to leave it to the doctors as to what exactly and in what words the things are to be disclosed to the patient. Once the caution of risk involved is given, I do not think that there is any further duty cast on the medical profession. Every surgery does involve some risk. The doctor performing the operation is doing it in the best interest of the patient with the aim either to give a complete cure and if that is not possible to palliate the sufferings and pain and give some relief to the patient. If as a result of surgical operation the patient does not get the relief as expected, would that be sufficient to charge the doctor with negligence that too criminally. This has been amply discussed in the various authorities I have already referred to above. The patient of the type of the complainant, who was a long time smoker and alcoholic for 20 years having suffered a serious disease like cancer at the age of 57 cannot be believed when he says that he was given promise of complete cure by the doctor. He may not have been explained all the details of surgery but the risk factor was fully explained to the relatives. At such

a crucial juncture, it is always the decision of the relatives. It is easy for a patient to say afterwards that I would not have consented to surgery in a particular manner. Had the spread not been found to be so extensive as was found after exploration? the affected portion would have been resected. It was a decision of the doctor to explore the possibility of resection as the earlier tests including CT Scan, X-ray, Ultrasonography did not disclose positively either that there was spread or its extent and whether it was malignant. Whatever was seen could not positively be said to be spread of cancer even from CT Scan. Even different biopsies did not lead to such a positive conclusion and in the situation faced by the patient (complainant Raghunath) doctors were left with no option but to explore the possibility of resection by this type of surgery and that alone was done in the best interest of the patient. It was the best possible decision that could be reached in the situation faced. The law as already discussed has gone to the extent of saying that even if decision is wrong or is found to be wrong by somebody at a later stage or there is medical opinion that such decision should not have been taken, that does not mean that the doctor was negligent more so criminally negligent.

39. There was no question of the applicant inducing the patient for any ulterior motive. No experiment was to be carried out. The patient was to be given treatment if not for complete cure, at least for palliation. We must bear in mind that the fight against cancer is going on at all levels by the Doctors, scientists and researchers are trying to do maximum possible to help patients. There has been in recent past a radical change in the treatment and merely because patient suffered as a result of surgery or chemotherapy the doctor cannot be imputed with an intention of inducing the patient to submit to surgery or treatment for some ulterior motive. This is a case in which the patient had no alternative than to undergo the surgery advised and when an explanation was sought from the applicant, the doctor did inform the patient in the best possible terms, the necessity of undergoing an operation. The statements made in the reply and the arguments of the learned Counsel are supported by different medical authorities. The question of complainant being cheated by inducing him to give consent to the operation does not arise. The process appears to have been issued as a result of complete non-application of mind. Even otherwise the offence of causing grievous hurt by negligence and offence of cheating cannot be simultaneously alleged as the condition of mind of the offender in both the cases is totally different.

40. The Court is duty bound to consider the issue of protecting an honest professional acting in the best interest of the patient. More important is the interest of the society at large. If persons in medical profession known for their skill and ability in the field are always required to work under a tension that after a particular decision to operate or to give a particular treatment, they are likely to be involved in some litigation at the hands of the patients or their relatives either misguided or unscrupulous, if I may say so, then it is bound to affect adversely the interest of the society at large as even known experts in the field

would hesitate to take a bold decision which is necessary in the best interest of the patient and no doctor even if he is a genius would dare a non-traditional step in the treatment which would adversely affect the progress. The fruits of progress in medical science we are enjoying and future generations are going to enjoy would normally come from such decisions of the doctor thinking on entirely unknown lines. It would stall the progress and discourage new approach. Therefore, the interest of the society at large are at stake and must be protected so that even so far unknown methods of diagnosis and treatment are given a chance and are introduced in regular practice. The tendency of filing after-thought complaints on advice of some so-called expert is required to be discouraged, nay it must be nipped in bud and therefore, such complaints must be examined by the Magistrates with full application of mind. It is not material whether Magistrate passes a speaking or non-speaking order. He must apply his mind, and consider what are the allegations in the complaint, whether the allegations considered on the entire background are sufficient to make out a prima-facie case to take cognizance of a criminal offence, if not, it is his duty in law to dismiss the complaint at the very threshold and thereby to put an end to the harassment of the men in profession. I am not at all impressed by the argument, why applicant is shy of facing trial and let there be a trial? Such an approach amounts to escaping from the duty which the law enjoins the Courts. The High Court must intervene and prevent miscarriage of justice, and consequent harassment to innocent professionals. Refusal to exercise its inherent powers by the High Court even in such an extreme case would be tantamount to abdicating this solemn duty and encouraging unscrupulous elements in the society to wreak vengeance on the professionals who have reached the pinnacle of success by sheer intellect and toil and that would result in highest misuse of the process of law.

In this view of the matter. I am of the considered view that this petition must be allowed and the order issuing process must be quashed and justice must be secured thereby.

41. Petition is allowed. The order dated 25-6-1998 passed by the Metropolitan Magistrate, 23rd Court, Esplanade, Mumbai in C. C. No. 14/Misc./97 (No. 78/S/98) issuing process against the applicant under sections 338, 420, 109 read with 34 Indian Penal Code is quashed and set aside and the complaint is dismissed.