A LIVE PREMATURE DELIVERY DECLARED DEAD BY SAFDARJUNG HOSPTAL

Fact Finding Report, June 2017

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Contents

ABBREVIATIONS

CEDAW-	Convention on the Elimination of all Forms of Discrimination Against Women
ICESCR -	International Covenant on Economic, Social and Cultural Rights
NFHS-	National Family Health Survey
NHM-	National Health Mission
NICU-	Neonatal Intensive Care Unit
RMC-	Respectful Maternity Care
SAARC-	South Asian Association for Regional Cooperation
UDHR-	Universal Declaration of Human Rights
WHO-	WORLD HEALTH ORGANISATION

CHAPTER 1

"Every year, about 5.2 million people die due to human errors in India. Even in the US, the figure is not less than 44,000 to 98,000. It is not lack of medical skill or knowledge of doctors, but that of team coordination and communication during an emergency that lead to medical errors. Around 70% of deaths that occur due to medical negligence can be attributed to human errors," said Dr Rakshay Shetty, a pediatric intensivist at Rainbow Hospital Bengaluru[1]

1.1 STATISTICS AND FIGURES

Child Mortality still remains a global problem. **World health Organization** updated a fact sheet in September, 2016.Theconcerning areas are as follows:

- 5.9 million Children under the age of 5 years died in 2015.
- More than half of these deaths were due to conditions that could have been prevented or treated with access to simple, affordable interventions.
- The leading causes of death in children under 5 years are preterm birth complications, pneumonia, birth asphyxia, diarrhoea and malaria.
- Approximately 45% of all child deaths are linked to malnutrition.
- Children in sub-Saharan Africa are more than 14 times more likely to die before the age of 5 than children in developed regions.[2]

India has the third highest child mortality rate among the SAARC countries in 2015. The death rate amounts to approximately 48 per 1000 live births. [3] In 2016, India ranked 49th among 225 countries regarding child mortality rate (40.50 per 1000 live births – 39.2 male deaths per 1000 births and 41.8 female deaths per 1000 births)[4].

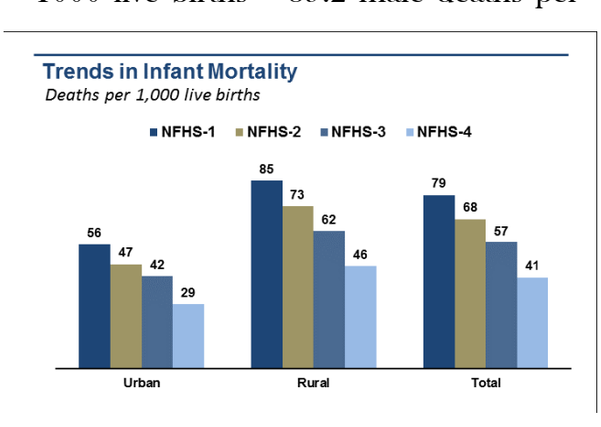


Figure 1

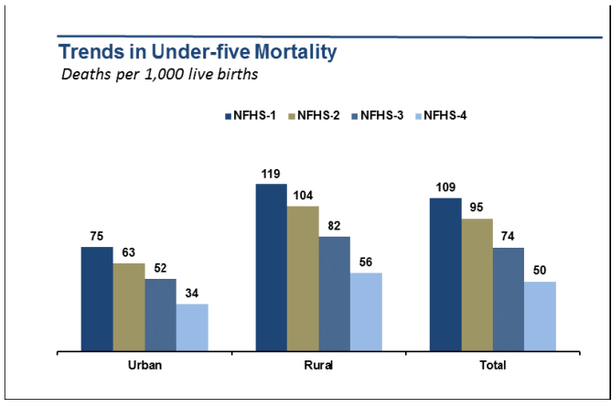


Figure 2

[1] http://timesofindia.indiatimes.com/life-style/health-fitness/health-news/Medical-negligence-70-of-deaths-are-a-result-of-miscommunication/articleshow/51235466.cms)

[2] http://www.who.int/mediacentre/factsheets/fs178/en/

[3] http://timesofindia.indiatimes.com/india/India-ranks-3rd-in-Saarc-in-child-mortality/articleshow 51147113.cms

[4] https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html

The two charts enclosed above that hail from the National Family Health Survey 4 (NFHS) (2015-2016) show the rates of infant mortality in India in both urban and rural areas.

The NFHS reports that in Delhi, from 2015-2016, the rate of infant mortality was 35 out of 1000 live births, and 40 deaths out of 1000 live births in 2005- 2006. The count rises to 47deaths per 1000 live births when it comes to Under Five mortality rate in Delhi in both 2015-2016 and 2005- 2006.

The reasons behind the high child mortality rate are largely due to prematurity and low birth weight, infections, birth asphyxia/ trauma, non communicable diseases, congenital anomalies, tetanus, measles, malaria encephalitis etc. In addition to this, children die due to medical negligence – ignorance by the doctors, hospital staff or the hospital administration.[5]

What is Medical Negligence?[6]

Persons who offer medical advice and treatment implicitly state and undertake to have the skill and knowledge to do as under:

- To undertake particular job.
- To decide whether to take a case or not ,
- To decide the treatment suitable for particular case
- To administer that treatment.

This is known as an "implied undertaking" on the part of a medical professional.
However, no human being is perfect and even the most renowned specialist could make a mistake in detecting or diagnosing the true nature of a disease.
A doctor can be held liable for negligence only if one can prove that she/ he is guilty of a failure that no doctor with ordinary skills would be guilty of if acting with reasonable care. An error of judgment constitutes negligence only if a reasonably competent professional with the standard skills that the defendant professes to have, and acting with ordinary care, would not have made the same error.
As per the notification on Code of Ethics by Medical Council of India with regard to duties of physicians to their patients,

- It is the obligation to the sick he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he discharges in the course of his professional duties.
- In his treatment, he should never forget that the health and the lives of those entrusted to his care depend on his skill and attention.
- A physician should endeavour to add to the comfort of the sick by making his visits at the hour indicated to the patients.
- A physician advising a patient to seek service of another physician is acceptable, however, in case of emergency a physician must treat the patient.
- No physician shall arbitrarily refuse treatment to a patient. However for good reason, when a patient is suffering from an ailment which is not within the

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3042727/
[6] http://www.vakilno1.com/legal-advice/law-medical-negligence-india.html

range of experience of the treating physician, the physician may refuse treatment and refer the patient to another physician.[7]

1.2 INTRODUCTION TO THE CASE:

The case at hand concerns an infant who was prematurely delivered in the 20th week, and was declared dead by the doctors after his birth, but subsequently showed some signs of life. This relief was however short-lived, as the baby eventually died after being put on a ventilator for 36 hours. A fact finding team – comprising of advocates and social health activists from Human Rights Law Network – visited the house of the deceased infant and introduced themselves to the members of the family.

1.3 METHODOLOGY

The fact finding team including Social activist and lawyer visited the place and focused on the collection of qualitative, evidence-based testimonials. The team spoke to the members of the family to garner a nuanced understanding of the case.

S.No.	Name of Person	Place Visited	Date
1.	Deepak Kumar Singh, Shadma Ahmed, Ashish Pratap Singh	Bilaspur Camp, Molarband	19.06.2017
2.	Deepak Kumar Singh, Aarushi Malik, Nupur Daudiyal	Bilaspur Camp, Molarband	26.06.2017

The team collected, collated and verified the information provided by the affected through the following methods:

a) Focus Groups

The focus group discussion through its participatory approach was conducted with the victims who were suffering as a result of the infant's death.

b) Case Studies

The team visited the home of the family of the deceased infant. This gave the researcher an insight into the situation at the ground level.

CHAPTER 2

2.1 FINDINGS

This case concerns a 22 week old premature baby who was declared dead at Safdarjung Hospital, and then was subsequently found alive on 18th June, 2017.

Shanti Devi had experienced heavy bleeding in her pregnancy one month prior to giving birth. She visited the government dispensary in Badarpur Border where she was then referred to Safdarjung Hospital, Delhi. She was asked to get admitted

[7] https://www.mciindia.org/ActivitiWebClient/rulesnregulations/codeofMedicalEthicsRegulations2002

there around 10:00 p.m. She had to get the ultrasound done and report back to the doctor with the Ultrasound report. The doctors had then mentioned that umbilical cord is upside down and that she needs to get admitted. Meanwhile the hospital authorities asked Shanti Devi's family to bring two bottles of blood for transfusion; however her family was unable to arrange for blood.

Subsequently in the next morning, surprisingly Shanti Devi was discharged and without any blood transfusion, Shanti Devi was asked to go back home and take rest. The consulting doctor did not prescribe any medicines but told Shanti Devi that once the infant starts moving in the abdomen, the bleeding would stop. However the bleeding continued and Shanti Devi health took a turn to the worse.

Bleeding continued for fifteen days. Eventually when she could take it no more, Shanti Devi visited a nearby private clinic named Get Well Clinic on 09.06.2017. Shanti Devi paid Rs. 600 for doctor's consultation and another Rs. 600 for ultrasound. The consulting doctor did share that it would be a normal delivery, and did not prescribe any medications, but however advised Shanti Devi and her family to visit some big hospital.

On 14th of June, 2017 she started to bleed heavily and her health deteriorated significantly. She went pale and was sinking. Her husband immediately called an ambulance and rushed to Safdarjung Hospital at around 06:00 p.m. Shanti Devi was accompanied by her husband Rohit and sister-in-law Uttara. There, Shanti Devi was made to wait for around 4 hours in the maternity ward before any doctor or nurse attended her. After four hours Shanti Devi was taken for ultrasound. Once the ultrasound records were available and the doctor had seen it, Shanti Devi was advised to get herself admitted.

After a long wait Shanti Devi was finally admitted to Ward No 10 (labour Room) at around 1.00a.m. Shanti Devi stayed there for three days and was administered with Glucose only once. On the third day, the lady Medical Officer in charge advised her to go through a C-Section as the infant and the umbilical cord had wound up and was upside down resulting in bleeding. Shanti Devi was told that bleeding would only stop once they remove the infant and umbilical cord. The Medical Officer also asked Shanti Devi's family to arrange for blood as Shanti Devi had lost a lot of blood and there was an urgent need for blood transfusion.

Shanti Devi's husband expressed his inability to arrange blood and requested the hospital to help him. The Medical Officer in Charge scolded Rohit and rudely asked him to take his wife to some other hospital if he could not arrange blood. Feeling helpless, Rohit called his friends from the slum and requested them to donate blood. On arrival of his friends to donate blood, the medical staff refused and asked both of them to come next day in the morning as it was getting dark. However the next day when Rohit's friends came to donate blood, the staff of the blood bank refused to draw blood as one of the friend had a cut on his hand and the other had low weight.

When blood could not be arranged, Rohit went to the blood bank to purchase blood. In the blood bank a person approached him and said he could arrange blood by donating his own blood at the cost of Rs. 3,500. Believing him Rohit handed over Rs. 2000/-. However the bank refused to take blood from him as the person was a amputee. This man also did not return the money to Rohit.

Feeling helpless, Rohit approached the blood bank officer of Safdarjung Hospital who finally provided one unit of blood from the blood bank for Shanti Devi. The doctor expressed her inability to treat Shanti Devi until she stopped bleeding. On Sunday June 18, at around 2.00 a.m. Shanti Devi had excruciating pain and was shivering. She shouted for help; however the ANM in charge scolded her and asked her to keep quiet and take rest. Rohit, on seeing his wife's pain rushed to the Medical Officer in charge and requested her to help his wife. At around 5.00a.m the Medical Officer on call saw Shanti Devi and scolded Shanti Devi and her husband and asked Rohit to shift her to a nearby room.

Finally, an infant boy was born around 05:30 a.m. on 18th of June, 2017. Though the Medical Officer in Charge had said that they would do a C-Section to remove the baby but Shanti Devi was made to go through the pain and had a difficult normal delivery.

However during Shanti Devi's delivery the Medical Officer in Charge was not present, Rohit rushed to call the Medical Officer in Charge. The Medical Officer (Archana) along with two ANMs came and delivered the infant. The doctor informed Shanti Devi and her husband that the infant was alive around 460 grams and a boy. The staff again shifted Shanti Devi along with the infant to the labour room.

Fifteen minutes later the Medical Officer in Charge came out of the labour room with Shanti and asked Shanti to take rest in the adjoining room. The Medical Officer in Charge handed over a large envelope wrapped in a piece of cloth and said that the infant is dead. Rohit on touching the packet felt it move and reported the same to the Medical Officer in Charge. The Medical Officer looked at it and dismissed Rohit's statement. When Rohit appealed again the Medical Officer scolded him and said that she is the expert and she had already checked it and the infant was dead.
Rohit in a state of shock waited in the hospital for another one and half hour, as his family members were on their way. Rohit and his family member took the infants body home while the mother remained in hospital to receive additional treatment. Before performing last rites, Rohit's mother requested to see his face. When the paper was removed they saw the infant flailing for air and gasping for breath.

Finding the baby alive the family called number 100 to report the hospital's negligence and simultaneously called for an ambulance. The police from Badarpur Police Station met the ambulance on the way to the hospital. At 10.30 a.m. 18th of June they reached Apollo Hospital, however they were unable to admit the infant as the hospital demanded a deposit of Rs. 40,000 and the family did not have any

money with them. The family again asked the ambulance to then go to Safdarjung Hospital.

On reaching the hospital Rohit took the infant to the emergency ward, where the consulting physician put a mask which was large on the infant. Subsequently the infant was shifted to Nursing Ward No. 5, where he was put in a ventilator for life support. Though Rohit waited for an hour outside the ward hoping to talk to a doctor or any health care provider, nobody turned up. At around 9.30 while waiting outside the ward, Rohit got a call from a family member who had seen news being broadcast in the television where they claimed that the infant was dead. Bewildered he tried meeting the hospital staff, but none of them were willing to meet him, and reluctantly one of them said that the infant was dead. To verify the news Rohit tried to enter into the ward to see his son but he was denied access.

The newborn infant was alive for almost one day without ventilator and another 36 hours after being put on life support. The family was unable to either see or get any news about his well being after he was put on life support; eventually they got the news that the infant had died at 4.15 p.m. on 19th June 2017. Rohit and his family were not informed immediately about the death of the infant. For the next twenty five hours they also were not given the body.
The hospital authority handed over the body to the Investigating Officer, Mr. Rajender Singh, Badarpur Police Station along with death certificate and other hospital documents. Rohit asked for the documents; however the Investigating Officer refused stating that it is of no use to him. Shanti Devi was not discharged for the next two days the hospital was reluctant to discharge her; Rohit threatened the hospital that he would call the police and the media if Shanti Devi was not discharged. Reluctantly they discharged her from the hospital.

As the incident was covered by various electronic and print media, The police in charge asked Rohit to accompany him and meet the higher authorities of Safdarjung Hospital. Rohit shared all that he and Shanti Devi had to go through, however the authorities refused to admit medical negligence. They also rudely refused to hear Rohit out and asked him to go ahead to the court and if he did go to the court then he would be the worst sufferer.
Rohit for his wife had borrowed Rs. 35,000/-from a local money lender on an interest rate of 10% per month. Rohit has also lost his job and the whole family has been trying to get over the trauma. A legal notice was sent to the Chief Medical Officer, Safdarjung Hospital, Delhi on 1st July, 2017 a legal notice, on behalf of the petitioner to share the case history, death certificate, ultrasound report, and infant death audit report.

2.2 SEQUENCE OF EVENTS:

Date	Details
April, 2017	❖ On returning from the village, Shanti informed an ASHA worker about her four month pregnancy.

May 18, 2017	❖ Shanti was taken to the dispensary in Badarpur Border. ❖ Recommended to go to Safdarjung Hospital where she was admitted for two days. ❖ No medicine provided.
June, 2017	❖ Experienced heavy loss of blood, body went pale. ❖ Patient in serious condition. ❖ Asked for arranging two bottles of blood for operation. ❖ Forced to pay bribe to a staff member in the Blood Bank.
5:30 AM, June 18, 2017	❖ Delivered baby normally.
6 AM, June 18, 2017	❖ Informed that the child had passed away. ❖ Family brings the child home to perform last rites. ❖ Family members find the child sealed in paper heavily breathing.
10 AM, June 18, 2017	❖ The infant was rushed to the hospital. ❖ Kept in emergency room for two hours, given oxygen.
12 Noon, June 18, 2017	❖ The child was kept on a ventilator.
4:15 PM, June 18, 2017	❖ The infant died.
June 20, 2017	❖ At around 5.30-6.00 p.m. the dead body was handed over to the family for last rites.
June 24, 2017	❖ Shanti Devi (mother of the dead infant) was discharged from Safdarjung Hospital.

Chapter 3

CASE STUDIES ON SURVIVAL OF PREMATURE BABIES

We came across two such incidences where a baby was born before the due delivery date but survived the situation.

3.1 CASE STUDY 1[8]

A Baby born in the 22nd week of pregnancy survived

Nirvaan, a baby born in the 22nd week of pregnancy weighing just 610 grammes, won his battle for life. After 132 days in a Neonatal Intensive Care Unit (NICU), he now weighs 3.72 kilos, and is out of intensive care. the his parents will take him

[8] http://www.thehindu.com/news/cities/mumbai/miracle-baby-nirvaan-goes-home-after-132 days/article19737755.ece |accessed on Sep 26, 2017 11:48:17 AM |

home on Sunday. Doctors at Surya Hospital in Santacruz, which treated Nirvaan, said that he is probably India's most premature baby to have survived.

Nirvaan's mother, a 34-year-old Bandra resident (who has asked not to be named) had what seemed to be a normal pregnancy, but on May 12, she suddenly went into labour. Nirvaan was born with extremely underdeveloped organs.

In the NICU, 14 doctors across specialities and over 50 nurses took care of Nirvaan around the clock. He spent six weeks on a ventilator and another six weeks on a Continuous Positive Airway Pressure machine. He also needed steroids for a month (to reduce lung inflammation and bring him off respiratory aids), antibiotics and insulin therapy (to handle rising sugar levels from the steroid treatment), multiple blood transfusions, laser treatment (he had developed retinopathy).

"He had to be closely monitored all the time," says neonatologist Dr Nandkishor Kabra. "At times, we lose our fight when such babies develop internal bleeding or air accumulation in the lungs but fortunately the baby did not develop any such complications."

Dr. Haribalakrishna Balasubramanian, neonatologist, says, "For the first six weeks, we could not say anything about the outcome. We had found very limited evidence worldwide about the survival rate of such babies. But this one was a fighter."

"Nirvaan is going home with a completely clear heart, brain and bone scan," says Dr Bhupendra Avasthi, director of Surya Hospital.

Nirvaan's name means bliss, and that's what his parents are feeling. His mother said, "Since his birth, I never let even one negative thought cross my mind about him. We have seen him gone through a lot, but finally we can now have some parental bonding that we missed out as he was in the NICU." The parents spent an estimated ☐15 to ☐20 lakh for the NICU care. His father refused to divulge the exact amount but said, "It was expensive," adding, "Those who have the resources should definitely give their babies a chance." (The above mentioned case study is reported by Jyoti Shelar September 22, 2017 22:54 IST Mumbai, published by The Hindu)

3.2 CASE STUDY 2[9]

A baby named Sakshi was born at 23rd weeks of gestation on May 5,2017 weighing 460gm was and measuring approximately 30cm from head to toe. Newborns are usually over 50cm in length. Then the infant was transferred from the delivery room to the NICU in the usual incubator as stated by the neonatologist, Dr.

[9] http://timesofindia.indiatimes.com/city/mumbai/Born-at-23-weeks-Indias-miracle-preemie-goes-home-healthy/articleshow/48930402.cms.

Haribalkrishna Balasubramanian of Surya Hospital, Santa Cruz, Mumbai where Sakshi was admitted for about 4 months in the Neonate Intensive Care Unit.

Sakshi's parents had gone through 5 miscarriages and then finally Sakshi was born. However since she was born on the 23rd month of the pregnancy, chances of her surviving was meager. But she managed to survive.

Sakshi belonged to a new group of babies dubbed "micro-preemies', as they weighed less than 900gm. "After talking to our peers and checking medical literature, we believe Baby Sakshi is the most premature baby to survive in India," said Dr Bhupendra Avasthi, a doctor at the same hospital.

Worldwide, the survival of a preterm infant born at 23 weeks is considered an achievement of sorts. "Even developed countries would not revive babies as premature as this, since the chances of survival and normal development are bleak," said Dr Avasthi's colleague, Dr Nandkishore Kabra.

The time frame between 22-24 weeks of pregnancy is generally considered the earliest that a fetus can survive outside the mother's womb. Dr Ruchi Nanavati, who heads the neonatology department of King Edward memorial Hospital, Mumbai stated, "I cannot say if this is indeed the first 23-week to survive in India, but it is admirable that a 460gm baby survived." Dr Jayshree Mondkar, who heads the neonatology department at Lokmanya Tilak Municipal General hospital, popularly reffered to as Sion Hospital, Mumbai , said, "She is likely to be among the few born under 25 weeks to look forward to a discharge from the NICU."
The newborn was given a special medicine to clear her lungs in the delivery room, and was subsequently transferred to the NICU and hooked to a ventilator within 10 minutes.

3.2 CASE STUDY 3[10]

In April 2011, a baby girl widely considered the most premature European baby ever to survive was discharged from a German hospital and returned home. The infant, Freida, and her twin, Kilian, were born more than four months early, at 21 weeks and five days. They weighed little over a pound. Soon after the birth, the infants were transferred to the ventilator without any delay.

Frieda's twin, Kilian, passed away at six weeks to heart and intestinal complications, but Frieda slowly recovered. Her doctor at the Fulda Children's Clinic, Minnesota, Dr. Reinald Repp, said there was "no indication that she will not be healthy", and described her survival as a "medical miracle".
Any premature baby is at risk for complications — the more premature, the higher the risk. So the sooner the infant is provided with proper medical attention, the more the chances of his/her survival increases.

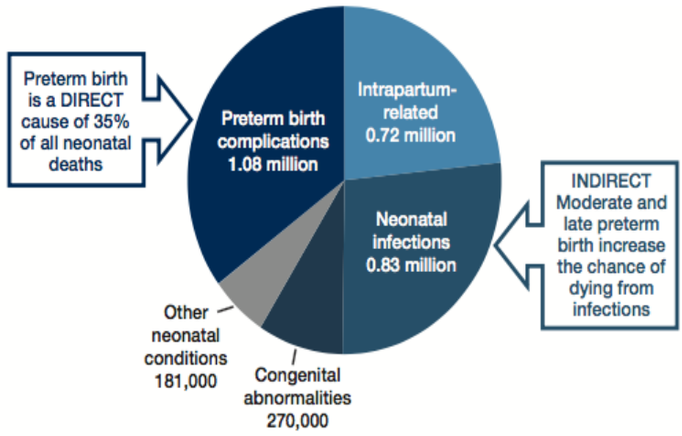
[10] http://healthland.time.com/2011/05/27/baby-born-at-21-weeks-survives-how-young-is-too-young-to-save/

3.3 OBSERVATION

According to the rules and regulations laid down by Indian Medical Association Act[11], a physician should neither exaggerate nor minimize the gravity of a patient's condition. He should ensure him or herself that the patient, their relatives or their responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

When we look at these duties of doctors towards patients, it is easy for one to conclude that the attending doctor in the concerned case of Shanti's infant not only misinformed the family regarding the death of the baby, but grossly misinformed them yet again upon the infant's actual death, where the family were not aware of her death for 36 hours.

In addition to the lack of communication, there also existed a lack of effort towards saving the life of the infant. Though preterm birth is one of the major causes of neonatal deaths[12], the power of making the decision regarding the life of an infant is not in the hands of a doctor. According to a report[13], one in four babies who are born at just 22 weeks can survive, if given active treatment like ventilation. In the case studies mentioned above, proper medical care was given to the neonatal births. The usual special care given to premature babies is resuscitating the baby. In such cases of emergency, special care is given to the person in danger. However, in the aforementioned case, not even a basic level of minimum care was provided to the infant delivered, who was barbarically packed into an envelope and a plastic sheet which made it harder for the infant to breathe.



Preterm birth is a risk factor for neonatal and postneonatal deaths
At least 50% of all neonatal deaths are preterm

When one compares case studies 1 and 2 with the concerned case, it is clearly visible that with active treatment like ventilation, this infant could have been saved by the doctor. There should have been a far greater initiative from the doctor's side.

When we look at the pre-pregnancy situation of Shanti, one can easily notice that there was a gross lack of medical assistance and guidance, despite the occurrence of complications in pregnancy. It is mentioned in one of the reports that the patient had Placenta Previa (**Placenta praevia** is an obstetric complication in which the placenta is inserted partially or wholly in the lower uterine segment. It is a leading

[11] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002

[12] March of Dimes, PMNCH, Save the Children, WHO. Born Too Soon: The Global Action Report on Preterm Birth. Eds CP Howson, MV Kinney, JE Lawn. World Health Organization. Geneva, 2012.

[13] http://www.dailymail.co.uk/news/article-3072881/One-four-babies-born-just-22-weeks-survive-given-active-treatment-ventilation.html

cause of antepartum haemorrhage (vaginal bleeding). It affects approximately 0.4-0.5% of all labours.)

This phenomenon was explained to Smt. Shanti in a very casual manner. She was told that language by informing Shanti that either the mother or the infant could survive – not both. Furthermore, no drug or medicine was provided to Shanti Ji for curing or preventing the same. In such cases of survival of either of the two, it is usually the family which decides whether to abort or continue the pregnancy; however that choice was never given to the family.
According to a guide made by the World Health Organization regarding managing complications in pregnancy[14] the suggested actions to be undertaken for vaginal bleeding in pregnancy is to perform a rapid evaluation of the women and consider the possibility of an ectopic pregnancy, thus considering abortion. However, in this case, the patient was told to go back home and rest. Even on the second visit, the doctors ignored the patient despite persistent complaints of abdominal pain.

CHAPTER 4
4.1 LEGAL DIMENSIONS

The law governing withdrawal or withholding treatment is complex. Any practice or treatment that is given with the primary intention of causing death is obviously unlawful. Parents can act on behalf of the interests of their child so long as they are acting in the best interests of the child. Howver, the case law also establishes that there is no obligation to provide treatment which would be futile or burdensome. Treatment can be withdrawn if it is not in the best interests of the child.

Civil law and negligence[15]

Negligence is the breach of a legal duty to care. It means carelessness in a matter in which the law mandates carefulness. A breach of this duty gives a patient the right to initiate action against negligence.
Persons who offer medical advice and treatment implicitly state that they have the skill and knowledge to do so, that they have the skill to decide whether to take a case, to decide the treatment, and to administer that treatment. This is known as an "implied undertaking" on the part of a medical professional.

In the case of the State of Haryana vs Smt Santra, the Supreme Court held that every doctor "has a duty to act with a reasonable degree of care and skill".
In the case of Indian Medical Association vs V P Santha , doctors in India may be held liable for their services individually or vicariously unless they come within the exceptions specified. Doctors are not liable for their services individually or vicariously if they do not charge fees. Thus free treatment at a non-government hospital, governmental hospital, health centre, dispensary or nursing home would

[14] Managing complications in pregnancy and childbirth: a guide for midwives and doctors. World Health Organization 2000, reprint 2007
[15] Article On Medical Negligence And The Law By K K S R Murthy Published In Indian Journal Of Medical Ethics DOI: Https://Doi.Org/10.20529/IJME.2007.046

not be considered a "service" as defined in Section 2 (1) (0) of the Consumer Protection Act, 1986.
However, no human being is perfect and even the most renowned specialist could make a mistake in detecting or diagnosing the true nature of a disease. A doctor can be held liable for negligence only if one can prove that she/ he is guilty of a failure that no doctor with ordinary skills would be guilty of if acting with reasonable care. An error of judgment constitutes negligence only if a reasonably competent professional with the standard skills that the defendant professes to have, and acting with ordinary care, would *not* have made the same error.

In the case of Dr Laxman Balkrishna Joshi vs Dr Trimbak Bapu Godbole, the Supreme Court held that if a doctor has adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong. Doctors must exercise an ordinary degree of skill. However, they cannot give a warranty of the perfection of their skill or a guarantee of cure. If the doctor has adopted the right course of treatment, if she/ he is skilled and has worked with a method and manner best suited to the patient, she/ he cannot be blamed for negligence if the patient is not totally cured. Certain conditions must be satisfied before liability can be considered. The person who is accused must have committed an act of omission or commission; this act must have been in breach of the person's duty; and this must have caused harm to the injured person. The complainant must prove the allegation against the doctor by citing the best evidence available in medical science and by presenting expert opinion.

Dr Janak Kantimathi Nathan vs Murlidhar Eknath Masane,in some situations the complainant can invoke the principle of *res ispa loquitur* or "the thing speaks for itself". In certain circumstances no proof of negligence is required beyond the accident itself. The National Consumer Disputes Redressal Commission applied this principle. The principle of *res ipsa loquitur* comes into operation only when there is proof that the occurrence was unexpected, that the accident could not have happened without negligence and lapses on the part of the doctor, and that the circumstances conclusively show that the doctor and not any other person was negligent.

4.2 Various National and International Guidelines:-

1. The National Health Mission's Newborn Action Plan specifically instructs health care providers to identify complications and refer them timely for safe delivery. Shanti Devi despite going to the hospital on her own for services was refused and sent back home when she should have been given a antenatal corticosteroids during preterm labour.
2. Further, the NHM has prioritized and instructed each level of care to establish a fully functional Newborn Care Corners to take care of critical deliveries and the implementation of standard clinical protocols and ensure

high quality health care for all newborns by linking entitlements under the JSSK for urban poor for all maternal newborn health services.

3. According to the World Health Organisation (WHO) Respectful Maternity Care (RMC) is a universal right of all women and newborns and is an essential component of quality care[16].
4. According to the World Health Organisation's Guideline on Pregnancy, Childbirth, Postpartum and Newborn Care there are procedures that should be followed if there are complications during pregnancy, birth and postnatal care including:

Support Care Throughout Labour

The Guidelines[17] recommend a supportive, encouraging atmosphere for birth that is respectful of the woman's wishes. Communication is key to this atmosphere including

1. Explaining all procedures, seeking permission and discussing findings
2. Keeping the woman informed on the progress of labour
3. Ensuring and respecting privacy

Quick Check

The Guideline highlights the steps that should be taken by a person responsible for the initial reception of women or babies coming into a medical clinic. They include:

1. Asking why the woman has come to the hospital
2. To look, listen and feel for bleeding vaginally, signs of looking very ill and pain.

The Guideline also indicates signs present in a pregnant woman that indicate an emergency. If the woman is bleeding or looks very ill then that is classified as an 'emergency for the woman'. She should be treated by:

1. Transferring the woman to a treatment room for Rapid assessment and management
2. Calling for help if needed
3. Reassuring the woman that she will be taken care of immediately
4. Asking her companion to stay with her

Bleeding

[16] Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors, http://www.who.int/maternal_child_adolescent/documents/mcpc-2017-brief.pdf?ua=1
[17] http://apps.who.int/iris/bitstream/10665/249580/1/9789241549356-eng.pdf

Where a pregnant woman is vaginally bleeding several steps should be taken which are:

1. Assessment of pregnancy status
2. Assessment of the amount of bleeding

Early Pregnancy: Heavy Bleeding

Where a woman is experiencing heavy bleeding (where a pad or cloth is soaked with blood in under five minutes) during early pregnancy the following steps should be taken:

1. Insert an IV line
2. Give fluids rapidly
3. Given 0.2 mg ergometrine IM
4. Repeat 0.2 mg ergometrine IM/IV if bleeding continues
5. If suspicion of possible abortion give relevant antibiotics

Early Pregnancy: Light Bleeding

Where a woman experiences light bleeding in early pregnancy this may be due to complications in pregnancy which could lead to a complicated, threatened or complete abortion or an ectopic pregnancy.

Where there is light bleeding, this may be classified as a 'threatened abortion' and the medical practitioner should

1. Observe the bleeding for 4-6 hours
    a. If there is no decrease in bleeding or vital signs, she should be referred to a hospital if not already there
    b. If there is a decrease let the woman go home
        i. Advise the woman to return immediately if bleeding continues
        ii. Follow up in two days

Late Pregnancy: Bleeding

Late pregnancy is classified as the period where the uterus is above the umbilicus. Where there is bleeding this is 'dangerous.' A practitioner should

1. Insert an IV line
2. Give fluids rapidly if there is heavy bleeding or shock
3. Refer the woman to the hospital if she is not already there

Pre Term Labour

Where a woman goes into labour before 8 completed months of pregnancy this is classified as a 'preterm labour'. The woman should be treated and advised as follows:

1. Fetal presentation should be examined
2. The woman should be encouraged to lie on her left side
3. Call for help during delivery
4. The use of magnesium sulphate is recommended for women at risk of imminent preterm birth before 32 weeks of gestation for the prevention of cerebral palsy
5. Delivery should be conducted carefully as smaller babies can pop out more quickly. Particular care should be given to the head.
6. Equipment should be prepared for the resuscitation of the newborn

Newborn Care

A newborn baby should be assessed after birth for around an hour if necessary.

5. According to the World Health Organisation Pocket Book on Hospital Care for Children there is an appropriate routine for newborns immediately after birth and after a preterm birth in particular that:
   1. Firstly, once delivered, the baby should be dried, observed and placed somewhere warm.
   2. The medical practitioner should look for breathing, crying, muscle tone and see whether the baby is the colour pink.
   a. Where these factors are not present the practitioner should take steps to clear the baby's airway and give oxygen where necessary.
   3. The heart rate of the baby should also be checked.
   4. Once these steps have been taken and the baby is not responding after a period of 20 minutes it is likely that the baby has died.

Preterm Birth

Where a baby has just been born and weighs less than 1500 grams and is less of less than 32 weeks gestation then it will be classified as a 'very small baby.' Thus the baby should, if not already, be:

1. Transferred to hospital
2. Be given extra warmth
3. Be given appropriate caloric intake

6. According to the World Health Organisation Guide for midwives and doctors on Managing Complications in Pregnancy and Childbirth

Preterm and low birth weight babies require special care. They should be transferred to appropriate services for caring for sick and small babies as early as possible[18]. Along with the above steps, others steps that should be taken include:

1. Where there is a possibility of a bacterial infection give a dose of antibiotics
2. If the baby is cyanotic (bluish) or having difficulty breathing (less than 30 or more than 60 breaths per minute, indrawing of chest or grunting) be given oxygen by nasal catheter or prongs

Newborn Resuscitation

If a newborn baby is not breathing or is gasping for breath, resuscitation should be started within one minute of birth. Steps that should be taken include

1. Keeping the baby warm
a. The baby should be transferred to a clean, dry and warm surface
b. Inform the mother the baby is having difficult
c. Keep the baby wrapped and under a radiant heater if possible
2. Open the airway
3. If still not breathing, ventilate
4. If breathing or crying, stop ventilating
5. If heart rate less than 100 per minute (HR <100/min) or breathing less than 30 per minute (RR<30/min) or severe chest drawing in
    a. Continue ventilating
    b. Arrange for immediate referral
    c. Reassess every 1-2 minutes
    d. Explain to the mother what is happening
    e. Record the event on the referral form and labour record

7. According to the World Health Organisation Palliative Care is care for patients with life-threatening illnesses and their families. It improves quality of life for patients and families who are facing problems associated with life

[18] WHO: Managing Complications in Pregnancy and Childbirth
http://apps.who.int/iris/bitstream/10665/43972/1/9241545879_eng.pdf

threatening illness[19]. It can be administered in homes, health centres, hospitals and hospices[20].

8. According to 'Between Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants' published in the New England Journal of Medicine it is possible for a baby born at 22 weeks gestation to survive. The study found that there was an overall survival rate of 5.1% of babies born at 22 weeks gestation where active treatment is given. This figure increases as each week increases; for instance, the survival rate of a baby born at 23 weeks is 23.6%.
9. According to 'Fetal Assessment near the limits of viability' published in Seminars in Perinatology 28% of obstetrician-gynaecologists considered that a fetus born at 23 weeks or less gestation was 'viable'[21].

According to various **case studies** it is possible for a baby to survive extremely preterm birth:

Baby Sashki born at 23 weeks[22]

10. Baby Sashki was born at 23 weeks gestation at Surya Hospital, Mumbai. Sashi weighed 460 grams and measured at 30cm at birth. It is believed she is the most premature baby to survive in India. She was nursed for 4.5 months in a neonatal unit before being allowed home.
11. *Alexis born at 21 weeks and six days*[23]
12. Chrissy Hutchinson's, from Manchester, Iowa, the United States, waters broke at 21 weeks and six days. She delivered her baby daughter Alexis at 22 weeks and one day. When Alexis was born she weighed 1.1 pounds (489 grams). She was treated by the hospital and remained in the neonatal unit for five months. She made a full recovery, and at the time of writing, she was a healthy five year old with some increased susceptibility to respiratory infections.

Amilia Taylor born at 21 weeks and six days[24]

13. Amilia was born in Miami, Florida the United States on October 21 2006 21 weeks and six days after conception. She weighed less than 100oz at birth and measured at 9 ½ inches. Amilia's mother went into labour at 19 weeks

[19] Palliative Care Fact Sheet http://www.who.int/mediacentre/factsheets/fs402/en/
[20] Improving Access to Palliative Care WHO Infographic http://www.who.int/ncds/management/palliative-care/Infographic_palliative_care_EN_final.pdf?ua=1
[21] Obstetrician-gynecologists' practices regarding preterm birth at the limit of viability
[22] http://timesofindia.indiatimes.com/city/mumbai/Born-at-23-weeks-Indias-miracle-preemie-goes-home-healthy/articleshow/48930402.cms
[23] https://www.nytimes.com/2015/05/07/health/premature-babies-22-weeks-viability-study.html
[24] https://www.theguardian.com/society/2007/feb/21/health.lifeandhealth

and gave birth nine days later. When Amilia was born she was breathing unassisted and made several attempts to cry. It is believed by doctors that due to the prolonged period of labour, Amilia had become distressed and produced hormones that led to her survival.

Aharon born at 22 weeks[25]

14. Aharon was born in Tel Aviv, Israel at 22 weeks gestation weighing 670 grams. He was released from hospital after five months

Frieda born at 21 weeks and five days[26]

15. Frieda was born in Fulda, Western Germany. At birth she weighed one pound (453 pounds) and measured at 11 inches. After five and a half months in hospital she was fit to leave the clinic and return home with her family. It is believed that she would not have any health complications as a result of her premature birth.

James Gill born at 21 weeks and five days in 1987[27]

16. James Gill was born in Ottawa, Canada in 1987. At the time, it was believed he was the youngest ever baby to survive after a premature delivery.
17. According to the British Royal College of Paediatrics and Child Health Framework for Palliative Care professionals working in neonatology in the United Kingdom have a duty to offer palliative care to children with life threatening illnesses and to act in the best interests of the child. A health care team that is providing palliative care to children has a duty of care with primary intention of sustaining and restoring life to the patient. Where a child cannot be restored to health there is still an 'absolute duty' to comfort the child and prevent pain and suffering.
18. Further according to the Framework a Health Care Team must have enough information about the clinical condition of the child, and any other relevant matters, before any decision is made regarding treatment. Any final decisions regarding the treatment of a child must be made with the consent of the parents. A record of communication regarding this consent and the dissemination of information to the parents must be kept.
19. According to the British Association of Perinatal Medicine Palliative care is necessary for preterm babies. Where a baby is born below 26 weeks gestation all clinical information should be reviewed so the parents and

[25] http://www.timesofisrael.com/22-week-preemie-is-youngest-ever-to-survive-in-israel/
[26] http://www.telegraph.co.uk/news/worldnews/europe/germany/8469561/Worlds-most-premature-baby-to-leave-hospital.html
[27] http://www.telegraph.co.uk/news/worldnews/europe/germany/8469561/Worlds-most-premature-baby-to-leave-hospital.html

medical team can make an informed decision about the prognosis and care of the baby[28]. The practicalities of commencing, withholding and withdrawing intensive care, and the role of palliative care, if appropriate, should be described to the parents[29].

20. Further according to the Association babies born at or below 23 weeks of gestation, are considered candidates for perinatal palliative care [30] .Any decisions regarding end of life care for a preterm infant should be made according to the best possible information on diagnosis and prognosis of the underlying condition[31].

Instances of Safdarjung Hospital Negligence

This case is not the first occurrence we have seen this year involving the medical negligence of Safdarjung Hospital. Various instances of negligence involving child birth have been reported in the news.

21. In June 2017, it was alleged by a couple that their baby boy had been exchanged for a baby girl at birth at Safdarjung Hospital[32]. It was further alleged that the hospital had inserted an intrauterine device into the mother following the birth without her permission. (As per a report published in DNA, daily news analysis on 03.06.2017 title 'Baby boy got exchanged with girl at Safdarjung Hospital' by Astha Saxena)

22. In December 2016, a mother claimed that she gave birth to twins and was only given one child after the birth[33]. It is believed that the second child was thrown in the garbage. The couple later approached Delhi Commission for Women that has issued a notice to hospital and police in the matter on 22 December, 2017. A complaint of which was lodged with the police by the father on 27 December, 2017. (As per a report published in Times of India on 06.01.2017 title 'Woman alleges baby dumped in garbage, Safdarjung hospital denies charge' PTI report).

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[28] British Association of Perinatal Medicine, The Management of Babies born Extremely Preterm at less than 26 weeks of gestation, A Framework for Clinical Practice at the time of Birth (UK)

[29] British Association of Perinatal Medicine, The Management of Babies born Extremely Preterm at less than 26 weeks of gestation, A Framework for Clinical Practice at the time of Birth (UK)

[30] Palliative Care (Supportive and End of Life Care) A Framework for Clinical Practice in Perinatal Care (British Association of Perinatal Medicine)

[31] Palliative Care (Supportive and End of Life Care) A Framework for Clinical Practice in Perinatal Care (British Association of Perinatal Medicine)

[32] http://www.dnaindia.com/delhi/report-baby-boy-exchanged-with-girl-at-safdarjung-hospital-2460046

[33] http://timesofindia.indiatimes.com/city/delhi/woman-alleges-baby-dumped-in-garbage-safdarjung-hospital-denies-charge/articleshow/56379128.cms

DENIAL OF BASIC ENTITLEMENTS: CONTRAVENING OBLIGATIONS AND COMMITMENTS ENUMERATED UNDER ARTICLE 21

Legal Violations

Medical Negligence

23. The Supreme Court has noted there is increasing pressure on hospital facilities, falling standards of professional competence and increasing complexity of therapeutic and diagnostic methods leading to medical negligence cases[34]. Combined with this pressure is growing public awareness that medical negligence can be used as a cause of action to hold medical professionals accountable[35] for their actions.

24. A doctor or other medical practitioner has a duty of care towards patients. The Supreme Court has ruled in *Laxman Balkrishna Joshi (Dr) v. Dr. Trimbak Bapu Godbole*[36] that there are clear duties that a doctor owes his or her patient and 'that a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose'. Where there is a breach of duty it will give rise to a cause of action.

25. One of the 'clear duties' established in *Laxman* is that a medical practitioner has a duty of care in the administration of treatment to the patient[37]. It should be considered whether the guilty doctor has done something or failed to do something which in the given facts and circumstances no medical professional would do when in ordinary senses and prudence[38]. Further, it should be considered whether the negligence was so manifest and demonstrative that no professional or skilled person in his or her ordinary senses or prudence would have carried out that act[39].

26. It was further established in that case that a practitioner must bring a reasonable degree of care to his or her task. The Bolam test[40] is used to establish the standard of care expected of a medical practitioner. The

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[34] M/S. SPRING MEADOWS HOSPITAL & ANR V. HARJOL AHLUWALIA & ANR [1998] RD-SC 176 (25 March 1998)

[35] M/S. SPRING MEADOWS HOSPITAL & ANR V. HARJOL AHLUWALIA & ANR [1998] RD-SC 176 (25 March 1998)

[36] Laxman Balkrishna Joshi (Dr) v. Dr. Trimbak Bapu Godbole AIR 1969 SC 128.

[37] Laxman Balkrishna Joshi (Dr) v. Dr. Trimbak Bapu Godbole AIR 1969 SC 128.

[38] Rajeev Gupta, vs Sir Ganga Ram Hospital on 19 September, 2008

[39] Rajeev Gupta, vs Sir Ganga Ram Hospital on 19 September, 2008

[40] Propounded By Mcnair J In Bolam V. Friern Hospital Management Committee (1957) 2 All ER 118 In The UK.

standard is of an ordinary skilled man exercising and professing to have that special skill. It is not expected that the practitioner has the 'highest expert skill'. This standard of care is applicable at both the 'diagnosis' and ''treatment' stage.

27. Therefore, the true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill, acting with reasonable care, would be guilty of doing[41].

28. A mistake that is tantamount to negligence cannot be pardoned as it is considered to have gone beyond the bounds of what is expected of the reasonable skill of a competent doctor[42]. Further, a gross medical mistake will always result in a finding of negligence[43].

29. Available equipment: The standard of care is to be judged in view of body of knowledge and equipment available at time of the incident[44].

30. Expert Evidence: The function of an expert is to put before the court all material together with reasons which induce him to come to a certain conclusion so that the court, though not an expert, may form its own judgment using its own observations[45].

31. Initially the person alleging the negligence has onus to make out case of negligence and after onus shifts to the doctor or hospital to satisfy there was no lack of care or diligence[46].

Hospital Liability (Vicarious Liability)

32. It was established in *Aparna Dutt v Apollo Hospital Enterprises Ltd* (2002 ACJ 954) that if any staff of a hospital is negligent in the performance of their prescribed work, the hospital will be held liable on that negligent conduct.

Cases of Medical Negligence

33. In Dr. M.L. Deb vs Smt. Rose Mary Lyngdoh, on 13 September, 2003 it was found that the act of declaring a live infant dead was not an error that would have been made by a reasonably competent doctor acting with ordinary care

[41] Dr. M.L. Deb Vs Smt. Rose Mary Lyngdoh, On 13 September, 2003

[42] M/S. Spring Meadows Hospital & Anr V. Harjol Ahluwalia & Anr [1998] Rd-Sc 176 (25 March 1998)

[43] M/S. Spring Meadows Hospital & Anr V. Harjol Ahluwalia & Anr [1998] Rd-Sc 176 (25 March 1998)

[44] Martin F. D'Souza V. Mohd. Ishfaq (2009) 3 SCC 1.

[45] Titli V. Alfred Robert Jones AIR 1934 All 273.

[46] Nizam's Institute Of Medical Science V. Prasanth S Dhananka (2009) 6 SCC 1.

and professing to have the standard and type of skill that the Appellant-Doctor held out as having[47]. It was found that the Doctor could not afford to make mistakes of such gravity as pronouncing live human beings dead and he was therefore negligent in his conduct. It was further found that given that he did not have equipment that allowed him to distinguish between a living and dead patient in his chamber, he ought not to have accepted patients into his private chamber.

34. In awarding compensation the Court took into account the mental agony of the parent's after being told their child was dead and what could have occurred had the mother of the infant not sought secondary medical advice and discovered her baby was alive.

35. In *Indu Sharma v Indraprashta Apollo Hospital,* the National Consumer Disputes Redressal Commission ordered Indraprathsa Apollo Hospital and gynecologist, Sohini Verma to pay Rs 1 crore compensation to the parents of a child suffering from disabilities due to negligence administered during his birth.

36. In *V Krishnakumar v State of Tamil Nadu and Others* (2015) 9 Supreme Court Cases 388 it was held that the respondent doctors and government hospital were negligent in their duty and deficient in their services in not screening a baby born prematurely for Retinopathy of prematurity (ROP) between 2 and 4 weeks after birth when it was mandatory to do so, particularly when the child was under their care. This finding was on the basis that the medical literature indicated that all infants born prematurely or with a birth weight of less than 1500 grams should be screened for the disease. It was further found that the respondents were negligent in not advising the parents to get the child screened. Had the baby been screened or the parents been advised, the disease would have been preventable.

37. At the government MGM Hospital in Warangal City, Telangana a newborn baby was incorrectly declared dead by hospital staff. The baby was found alive before its funeral after the parents found its foot moving. They rushed the baby to hospital for treatment however the baby later passed away[48].

Other Jurisdictions

38. In the Canadian case *Cassidy Alexis Edgier v William G Johnston 2013 SCC Online Can SC 13* the plaintiff successfully sued the obstetrician attending to

[47] Dr. M.L. Deb vs Smt. Rose Mary Lyngdoh, on 13 September, 2003

[48] http://www.freepressjournal.in/bizarre-news/newborn-declared-dead-by-warangal-hospital-found-alive-before-funeral/1095504

her birth for negligence. It was found that the plaintiff suffered from persistent bradycardia during her birth causing severe and permanent brain damage, causing quadriplegia and cerebral palsy. The doctor had breached his standard of care by failing to ensure there were surgical staff present in case of emergency caesarean section and by failing to inform the mother of the risks of a delivery by forceps

39. In the United Kingdom case *Wilsher v Essex Area Health Authority* [1981 W No.302] (Mustill LJ) it was held that the negligence of the senior registrar increased the risk factor of a premature baby developing retrolental fibroplasia, an eye condition that leads to blindness. The catheter to administer additional oxygen after the baby was born prematurely was inserted into the wrong vein, causing the baby to be saturated with oxygen, contributing to the development of the condition.

'Right to Health'

40. The right to health has been encapsulated as a fundamental, Constitutional guarantee in the numerous cases. The social justice objectives that the Supreme Court has read into Article 21 includes the Right to Health - and sets out a clear requirement of qualitative standards for the provision of healthcare facilities. Besides natural justice principles and legal precedent, international law places obligations on States to provide for quality healthcare. These international obligations have also been affirmed by the Supreme Court's Constitutional Benches over the years; further, the Supreme Court has recognized that International treaty obligations can well be enforced (unless in direct conflict with national legislation) as held by the apex court Vishaka & Ors. v. State of Rajasthan (1997) 6 SCC 241.

41. Arbitrary denial of health care services is illegal and amounts to violation of the petitioner's fundamental rights to equality under 14 & 15 of the constitution of India. It was held in Maneka Gandhi vs. UOI (1978) 1 SCC 248 that it isn't enough that our provision under a legislative act be constitutionally valid-if, in the implementation of the provision, a state action is infringing on a person's fundamental right, that the state action is ultra vires. In the present case, the denial of comprehensive abortion care and services is a violation of petitioner's right to life and right to equality.

42. In the case of Pashchim Banga Khet Mazdoor Samity v. State of West Bengal [1996 (4) S.C.C. 37], Hakim Sheikh, a member of the Paschim Banga Khet Mazdoor Samity, fell off a train and suffered

serious head injuries. He was brought to a number of state hospitals, including both primary healthcare centers and specialist clinics, for treatment of his injuries. Seven state hospitals were unable to provide emergency treatment for his injuries because of a lack of bed space and trauma and neurological services. The Supreme Court held that Article 21 of the Constitution casts an obligation on the state to take every measure to preserve life. The Court found that it is the primary duty of a welfare state to ensure that medical facilities are adequate and available to provide treatment and due to the violation of the right to life of the petitioner, compensation was awarded to him.

43. The land mark case of *Bandhua Mukti Morcha v. Union of India* [AIR 1984 SC 802]: held that "It is the fundamental right of every one in this Country, assured under the interpretation given to Article 21 by this Court in *Francis Mullen*'s case, to live with human dignity, free from exploitation. This right to live with human dignity, enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (e) and (f) of Article 39 and Article 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers, men and women, and of children of tender age..."

44. The case of Thangapandi Vs The Director of Primary Health Service, DMS Teynampet, Chennai and Ors (2011(1) MLJ 1329) is crucial in this regard. In this case owing to medical staff and doctors refusing timely medical services to a pregnant woman in labour, the woman lost her life. The Hon'ble Madras High Court held that her family be paid compensation and that-

    a. "Article 21 imposes an obligation on the state to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government Hospitals run by the State and the medical officers and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of the government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article:21"

    b. " Article: 21 of the constitution of India guarantees right to life, which includes right to get meaning full health care, especially during maternity/delivery period.."

45. The International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted by the United Nations General Assembly in 1966, entered into force in 1976 - India acceded to it in 1979.

a. Article 12:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

b. General Comment No. 14: Adopted by the Committee on Economic, Social and Cultural Rights - it elucidates the contents and nature of the Right to Health. It examines the correlation between the Rights to Health and associated rights such as Right to food, sanitation, safe drinking water etc. It also analyses the freedoms and non-discrimination inherently implied in the way Right to Health must be enforced.

46. The Convention on Elimination of All Forms of Discrimination Against Women under Article 12: (1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. (2) Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

47. The Convention on the Rights of the Child, to which India has signed and ratified, under Article 3 (1) states that the 'best interests of the child' are to be the 'primary consideration' in all actions taken against that child. Under Article 3 (2) 'State Parties shall undertake to ensure that such care and

protection as is necessary for [the child's] wellbeing'. Further, under Article 3 (3) 'State Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities' including in health.

a. Article 6 states that 'every child has an inherent right to life' and under Article 6 (2) that 'State Parties shall ensure to the maximum extent possible the survival and development of the child.'

b. Under Article 24 (1) State Parties 'recognise the right of the child to the enjoyment of the highest attainable standard of health.' Under Article 24 (2) attaining this standard includes diminishing child and infant mortality (Art 24 (2)(a)), ensuring the provision of necessary medical assistance and health care with an emphasis on primary health care (Art 24 (2)(b) and to ensure appropriate pre-natal and post-natal health care for mothers (Art 24 (2)(d)).

c. Article 19 (1) states that State Parties undertake to protect the child from injury or abuse, neglect or negligent treatment while in the care of a person who has care of the child. Article 19 (2) provides for effective procedures to undertake protective measures including investigation and follow up of instances of child maltreatment and where appropriate judicial involvement.

48. Universal Declaration of Human Rights (UDHR) under Article 25 clause (1) states that Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance.

49. *Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)*

Under Article 12 (2) of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), to which India has signed and ratified, State Parties to the Convention 'shall ensure to women appropriate services in connection with pregnancy...and the post-natal period.'

50. *Convention on Economic, Social and Cultural Rights*

Under Article 12 (1) of the Convention on Economic, Social and Cultural Rights, to which India has signed and ratified, State Parties 'recognise the right of everyone to the enjoyment of the highest attainable standard of physical

and mental health.' Further under Article 12(2)(a) steps taken by State Parties includes 'the provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child.'

52. Appropriate Health Care for Mothers and Newborns: WHO Guidelines
The World Health Organisation (WHO) highlights the importance of respectful maternity care (RMC) as a universal right of all women and newborns and as an essential component of quality care[49].

[49] Managing Complications In Pregnancy And Childbirth: A Guide For Midwives And Doctors, Http://Www.Who.Int/Maternal_Child_Adolescent/Documents/Mcpc-2017-Brief.Pdf?Ua=1