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REVIEW ARTICLE

Between Black and White: A Comparative Analysis of the Black Coat and the White Coat in Law and Medicine

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ABSTRACT

The medical and legal professions, symbolized respectively by the white coat and the black coat, represent two of the most respected and socially significant vocations. While their primary objectives differ - healing in medicine and justice in law - both professions are grounded in ethical responsibility, public trust, and professional accountability. This article undertakes a comparative analysis of these professions, examining their ethical frameworks, standards of care, decision-making processes, and mechanisms of liability. It further explores the medico-legal interface through landmark judicial pronouncements, particularly in the domain of medical negligence and professional misconduct. The study highlights both convergence and divergence between these professions and emphasizes the necessity for interdisciplinary awareness in an era of increasing litigation and patient rights consciousness.

KEYWORDS

• Medical ethics • Legal ethics • Medical negligence • Professional liability • Medico-legal interface • Duty of care • Black coat • White coat

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INTRODUCTION

The symbolism of the white coat and the black coat is reflected in the professional attire of doctors and lawyers; it represents two distinct yet intersecting paradigms of service. The white coat signifies healing, compassion, and scientific inquiry, while the black coat embodies justice, advocacy, and the rule of law. Both professions have historically been regarded as "noble," owing to their commitment to social welfare and ethical conduct.

Despite their differing objectives, medicine and law share a profound commonality: both professions deal directly with human life, dignity, and rights. Both have defined duties towards those seeking their services. Both recommend preventive measures to the general public. Both require good communication skills and secure documentation. Both are non-committal about outcomes, which depend on some unknown factors not under their control. In contemporary society, the interaction between these professions has intensified, particularly in the context of medical negligence, patient autonomy, and legal accountability. This evolving interface necessitates a deeper understanding of its similarities and differences.

Nature and Objectives of the Two Professions

The medical profession is fundamentally oriented toward preserving life and alleviating suffering. Its practice is rooted in scientific knowledge, clinical expertise, and a humanitarian ethos. Medicine is an ever-evolving science, and multiple known & some unknown factors influence the outcome of the patients' treatment. The physician's role extends beyond mere treatment to encompass empathy, reassurance, and ethical decision-making in situations often marked by uncertainty.

In contrast, the legal profession is concerned with the administration of justice and the resolution of disputes. Lawyers function within a structured framework of statutes, precedents, and procedural rules. Their role is inherently adversarial, requiring them to represent clients zealously while maintaining fidelity to the court and the legal system. The outcome of a dispute depends on the facts & circumstances of the case as well as how well the pleadings have been drafted, evidence has been presented, and the skills of the advocate in arguments before the adjudicating judge. Despite all this, the outcome is not always predictable. There are ambiguities in the law that may be interpreted differently under different circumstances. There are many situations where the lower court judgment is set aside in the higher court and may be again reversed in the still higher court. These serve as constitutional checks & balances, but the dispensation of justice not only gets delayed but also adds to the unpredictability and uncertainty of the outcome.

The divergence in objectives is evident: the doctor seeks to cure and care, while the lawyer seeks to plead and argue. Yet, both professions require a high degree of intellectual rigor, specialized training, and adherence to ethical norms. Importantly, both operate in domains where their decisions can profoundly impact human lives.

There is a difference in the timelines of the events they deal with. Whereas the doctor generally deals with the problem in real-time, when the problem is active & happening, the lawyer deals with the situation that has arisen generally from a past event. The doctor deals with the situation prospectively, while the lawyer participates in the retrospective legal scrutiny. The doctor has to make a quick assessment & take a quick decision, while the lawyer has time to study the problem, examine the options, consult the books, discuss with experts, and prepare the course of action. In both cases, the outcome depends partly on the professional competence and partly on 'other' factors. The other factors in medicine include the patients' variable body responses & the will of God. The other factors in law include the interpretation of the case by the judge & the will of God. Whereas the doctors generally work within their professional jurisdiction, the lawyers generally deal with all subject matters. However, there are subject matter experts in both professions – more in medicine than in law. In medicine, the patient can seek treatment from any hospital anywhere in the world, but for legal recourse, the territorial jurisdiction and the type & hierarchy of court are restricted as defined by statute. Of course, the client in legal disputes has the liberty to engage any lawyer from anywhere he likes.

Ethical Foundations

Ethics form the cornerstone of both professions,

though their emphasis and application differ. Medical ethics, deeply influenced by the Hippocratic tradition, prioritize beneficence and non-maleficence. The physician is expected to act in the best interests of the patient, often placing patient welfare above all other considerations. Respect for patient autonomy and confidentiality further underscores the ethical framework of medical practice.

Legal ethics, on the other hand, revolve around duties to the court, the client, and the justice system. Advocates are required to represent their clients competently and diligently, even when personal beliefs may conflict with the client's instructions. This introduces a unique ethical tension, which is absent in medical practice, where the patient's welfare remains paramount.

The contrast is particularly striking in situations involving moral ambiguity. A doctor cannot ethically harm a patient, even if requested, whereas a lawyer may defend an accused individual irrespective of personal views & knowledge, provided the defence adheres to legal principles. In medicine, the outcome of the patient's treatment does not directly affect another person. However, in law, the outcome of the case of his client generally affects the opposite party – directly or indirectly, favourably or adversely. Thus, while both professions emphasize integrity and trust, their ethical priorities diverge in practice.

Professional Duties and Standard of Care

The concept of duty of care is central to both professions. In medicine, a doctor owes a duty to the patient from the moment a professional relationship is established. This duty encompasses a prudent effort to provide an accurate diagnosis, appropriate treatment, and careful administration of medical/surgical interventions.

The standard of care expected of a medical practitioner has been articulated through the Bolam principle, which holds that a doctor is not negligent if his conduct is consistent with that of a responsible body of medical professionals[1]. This principle was judicially recognized in India in several judgments[2], where the Supreme Court emphasized that negligence must be distinguished from mere error of judgment, difference of opinion, or choosing one of the several recognized options of treatment.

In the legal profession, the duty of care manifests as the obligation to provide competent representation. Lawyers must exercise reasonable skill and diligence in advising their clients on the contentious issues and representing them diligently in court. Failure to do so may result in allegations of professional negligence, though such claims are less frequently litigated compared to what happens in medical negligence.

Both professions have their respective regulatory councils for keeping a check on professional misconduct. Medical council (State medical councils and National Medical Commission) and the Bar Council (at State level & National level) take up the professional misconduct issues related to their members as per their defined rules.

The similarity lies in the expectation of reasonable competence rather than perfection. However, the consequences of breach differ significantly, with medical negligence often involving irreversible physical harm. When a patient suffers harm from perceived medical negligence, he often approaches a lawyer for relief. On the other hand, when a lawyer's client suffers a defeat in a litigation, with or without a perceived negligence of his lawyer, it does not generally lead him to a doctor. Yes, occasionally the litigation defeat may result in depression, etc., necessitating medical help, but generally a defeat in litigation results in an appeal in a higher court or compliance with the court judgment, which will still need the services of a lawyer.

A doctor, apprehensive about litigation, orders excessive diagnostic tests, 'for safety's sake' and liberal referrals for indirect corroboration of his line of treatment, to avoid potential liability. While this approach reduces the legal risk, it increases the financial burden on the patient. More than that, the doctor-patient relationship suffers. Moreover, gradually, instead of the clinical sense, he depends on and, in a way, treats the reports rather than the patient. Anything that encourages defensive medicine is not good for society.

Vignette 1: Defensive Medicine vs Legal Fear

A 40-year-old male patient presented with epigastric pain and sour eructation off & on for about a month, with a history of some relief with Digene gel as prescribed by his family doctor. The MD physician does routine blood investigations, X-ray chest, USG & ECG. These being normal, the doctor referred him to a Cardiologist and a Gastroenterologist for their expert opinion. The cardiologist got some more blood tests, 2D-ECHO, and a TMT. These were found to be normal. The gastroenterologist did an upper GI endoscopy and found mild gastric erosions. He prescribed Pantoprazole for 4 weeks & advised a review endoscopy after that. Having spent Rs. 35,000, he was disappointed and decided to go back to his family doctor. No, he did not come back to appreciate his clinical sense. He actually blamed him for unnecessary referrals to friends, possibly for some fee-splitting. He lamented that the so-called experts did not do any physical examination on him nor did they explain to him the details about his ailment, the treatment plan, and the prognosis. They did not explain the necessity of the investigations prescribed, nor what their clinical sense was as a super specialist. He, in his wisdom, switched to Ayurveda therapy.

This vignette illustrates the phenomenon of defensive medicine, a growing concern in India following the expansion of medical liability under consumer law. It demonstrates how legal frameworks can indirectly influence clinical decision-making, sometimes to the detriment of patient-centric care. The family doctor has protected himself by referring him to the MD physician, who, after some investigations, preferred to refer him to some super specialists, as a medicolegal shield for himself.

Decision-Making Processes

Decision-making in medicine is often characterized by urgency and uncertainty, as patients typically approach a doctor when they are ill and perceive their illness as the worst suffering. Physicians are often compelled to make critical choices based on incomplete information, balancing risks and benefits, while considering patient preferences. The dynamic nature of clinical situations means that even well-reasoned decisions may lead to adverse outcomes.

Legal decision-making, in contrast, is more structured and deliberative. Lawyers have the advantage of time to analyse facts, research legal precedents, discuss with peers, and construct arguments. Judicial decisions are typically based on evidence presented and legal reasoning, allowing for a more systematic approach.

This distinction underscores a fundamental difference: while doctors operate in real time, often under pressure, lawyers work within procedural timelines that allow reflection and analysis. Consequently, the margin for error and its implications vary considerably between the two professions.

In medicine, between the efforts of the treating team and the outcome, the variable human response, some unknown factors, or the will of God may bring surprises. However, in law, between the efforts of the legal team and the outcome, the judge decides one way or the other, based on his appreciation of the facts & circumstances, his interpretation of the legal arguments, or some other factors.

Vignette 2: Error of Judgment vs Negligence

A 30-year-old male patient presented with fever, cough, and weakness for 3 days. The physician assessed it and believed it was a viral fever. He prescribed symptomatic treatment and told him that some investigations would be done after 3 days, if required. After 3 days, since the relief was not satisfactory, he conducted the investigations and found some abnormality in the right upper zone on chest X-ray. Further investigations were done, and when the NCCT chest suggested a possible malignancy, he referred the case to an oncologist. Further investigations and assessments were done to confirm the diagnosis & its stage before the adjuvant chemotherapy could be started. The patient, disappointed with the diagnosis and the prolonged plan of treatment with uncertain prognosis, blamed his physician for the delay in diagnosis and the resultant spread. His initial diagnosis of viral fever was projected in his complaint as an irresponsible & negligent conduct.

The court dismissed the complaint as being devoid of any valid evidence of negligence or deficiency of service. The court accepted

the doctor's version that he had provided the standard of care as required under the circumstances, and when the diagnosis of malignancy was suspected, he had referred the case to an oncologist after due counselling. The court invoked the Bolam test and held the complaint unsustainable. Moreover, the limited information available to him at the initial stage necessitated the doctor to start with a working diagnosis and proceed as any average doctor does under the circumstances. The error of judgment by itself does not amount to negligence. A physician prescribes a standard line of treatment for a patient presenting with non-specific symptoms. Despite adherence to accepted medical practice, the patient's condition deteriorates due to an atypical presentation of the disease. Allegations of negligence are unwarranted.

This vignette underscores the distinction between medical negligence and error of judgment; a principle clarified in several Supreme Court judgments[3]. The Supreme Court has consistently held that a mere error of judgment or an accident is not proof of negligence. It highlights the inherent uncertainty in medical science and contrasts it with the law's retrospective evaluation of professional conduct.

Accountability and Liability

Accountability is a defining feature of both professions, though its manifestations differ. In medicine, liability may arise in civil or consumer courts, criminal courts, the medical council, or other forums. Civil liability typically involves compensation for harm caused by negligence, while criminal liability is reserved for cases of gross negligence or recklessness.

The landmark judgment in Indian Medical Association v. V.P. Shantha (1995) brought medical services within the ambit of consumer protection law, significantly expanding the scope of accountability[4]. Similarly, Samira Kohli v. Dr. Prabha Manchanda (2008) reinforced the doctrine of informed consent, emphasizing patient autonomy[5]. The Supreme Court judgment in Jacob Mathews differentiated between civil medical negligence and criminal medical negligence and directed that its guidelines be followed strictly in proceedings of criminal medical negligence till the Parliament enacted the legislative guidelines in the matter[6].

In the legal profession, accountability primarily takes the form of disciplinary action by bar councils, though civil liability for professional negligence is also recognized. However, the adversarial nature of legal practice and the complexity of causation often make such claims difficult to establish. For some reason, the courts have not included the law professionals under the ambit of the Consumer Protection Act.

Consent and Autonomy

The doctrine of consent occupies a central place in medical practice. A patient's informed consent is a prerequisite for any medical intervention, reflecting respect for bodily autonomy. Failure to obtain consent may constitute negligence or even assault. Informed consent is also required for issues related to privacy, confidentiality, and examination of sensitive parts of the body. Consent is also required for the use of Artificial Intelligence (AI) in healthcare, as well as for participation in clinical research. Violations may amount to medical negligence, deficiency of care, or professional misconduct.

In *Samira Kohli*, the Supreme Court held that consent must be real and valid, not merely a formality. It has elaborated on what information needs to be given to the patient and what risks of the procedure need to be disclosed before the signatures are taken on the consent document. It has also been stated that the doctor is not entitled to do anything more than what has been consented to, except in life-threatening situations, and only to the extent of the life-saving procedure, nothing more. This judgment underscores the ethical and legal importance of patient autonomy in medical decision-making.

In the legal domain, consent operates differently. Clients engage lawyers voluntarily and may influence material decisions, but ultimate control over legal strategy & tactics often rests with the advocate, with broad concurrence of the client. Thus, while consent is important, it does not carry the same existential significance as in medicine.

Vignette 3: The Emergency Dilemma (Medical Duty vs Legal Risk)

A middle-aged male patient is brought

unconscious to a private hospital by the bystanders following a road traffic accident, when his bike collided with a truck, which had sped away. The attending physician suspects internal haemorrhage and, after basic first-aid & supportive measures, immediately proceeds with life-saving intervention without waiting for formal consent from relatives, as none was available nor were they known as the patient's mobile phone & other belongings were not available. The patient survived but later developed complications. The family members had arrived after some days. They were initially thankful to the doctor, but their stance changed when the patient developed complications related to sepsis. The aggressive efforts of the doctor succeeded in achieving full recovery, but the family was disappointed with the 11 Lakh expenditure they had to incur. The family filed a consumer court complaint alleging negligence, with the main allegation that proper consent was not obtained before surgery, also stating that the surgery was not conducted properly, resulting in complications. Ultimately, the complaint was dismissed because of frivolous allegations without any substantiation. It is interesting to state that the advocate representing the complainant, though empowered to counsel the client at the beginning itself about the futility of litigation in his case because there was no merit in the allegations, agreed to go only by the instructions of the client, for obvious reasons.

This scenario reflects the tension between clinical urgency and legal formalism. Indian jurisprudence, particularly in Parmanand Katara v. Union of India (1989), has unequivocally held that preservation of life is paramount and that procedural requirements must not impede emergency care[7]. The vignette illustrates how medical professionals often operate in time-sensitive environments where strict compliance with legal protocols may not be feasible, yet their actions remain subject to retrospective legal scrutiny.

Vignette 4: The Informed Consent Conflict

A 42-year-old female patient presented with chronic abdominal pain, nausea, and vomiting on and off for 6-7 months. Blood tests, Urine r/m, USG, UGIE, and CECT Abdomen were all normal. The doctor advised a diagnostic laparoscopy to have a direct look at the abdominal structures. The patient consented, and the procedure was done. During surgery, the surgeon found that everything was normal, but the appendix was unusually long and adherent to the terminal ileum. In his wisdom, he removed the appendix, believing this to be the source of his patient's chronic suffering. The patient & his family members were duly informed of the operative findings and what was done. After about 2 weeks of discharge, the patient again developed abdominal pain, nausea, and vomiting, like before. The doctor managed with symptomatic treatment, but the symptoms persisted. The doctor, in his wisdom, thought that the problem was more functional than physical. He sent the patient to a clinical psychologist. The patient felt offended and rather approached a lawyer and sent a legal notice for doing a procedure that had not been consented to. The legal notice threatened criminal action for assault and a consumer court complaint for medical negligence and deficiency of service for first removing the appendix unnecessarily and then sending her to a psychologist as if she was making up her complaints and sought compensation of 10 Lakh within 15 days. The doctor chose to negotiate with the patient through some common friends and settled the matter by paying Rs. 2.0 Lakh for an out-of-court settlement.

This scenario reflects the doctrine of informed consent, as elaborated in Samira Kohli v. Dr. Prabha Manchanda (2008), where the Court emphasized that consent must be specific and informed. The importance of properly taken informed consent in litigation has been emphasised. The vignette illustrates the delicate balance between patient autonomy and medical necessity, a recurring theme in medico-legal disputes. It also demonstrates the ease with which the doctor preferred to succumb to an out-of-court settlement to avoid the 'agony' of prolonged litigation

Professional Regulation

Both professions are subject to self-regulation through statutory bodies. The medical profession is governed by regulatory authorities such as the National Medical Commission, which oversees medical education, ethics, and disciplinary action. The legal profession is regulated by the Bar Council of India and

state bar councils for disciplinary action where required.

These bodies play a crucial role in maintaining professional standards and addressing misconduct. However, judicial oversight remains a common feature, ensuring that professional autonomy does not lead to abuse.

The Medico-Legal Interface

The intersection of medicine and law is most evident in cases of medical negligence and forensic practice. In medical negligence cases, the doctors & hospitals are the defendants against the allegations of the complainant. In Forensic medicine cases, the doctors are in the role of medical experts to assist the courts in the adjudication of criminal cases. Courts are often required to evaluate complex medical evidence and balance competing interests. Judicial pronouncements have consistently recognized the need to protect doctors from frivolous litigation while ensuring accountability.

In **Parmanand Katara** *v. Union of India* (1989), the Supreme Court emphasized the duty of doctors to provide immediate medical aid, highlighting the primacy of human life over procedural formalities. Similarly, Malay Kumar Ganguly v. Sukumar Mukherjee (2009) demonstrated the judiciary's willingness to hold medical professionals accountable in cases of proven negligence[8].

Advocates and the Consumer Protection Act: Current status of the Supreme Court Position

A significant development in the medico-legal landscape emerged from the Supreme Court's decision in Bar of Indian Lawyers v. D.K. Gandhi PS National Institute of Communicable Diseases (2024), which has rekindled the hope of the medical professionals on their inclusion/ exclusion under CPA[9].

Background

The appellant, an advocate, was hired by the respondent (D.K.Gandhi) for a complaint under Section 138 of the Negotiable Instruments Act against one Kamal Sharma for a bounced cheque of Rs. 20,000/- issued by Kamal Sharma in favour of D.K.Gandhi. During this case, the accused agreed to pay the required amounts to settle the matter. The advocate received a DD of 20K and a Ch of 5K on behalf of DK Gandhi, but did not deliver the same to him and instead demanded 5K in cash as his fee.

The Advocate filed a recovery suit for the recovery of 5K. Later, the advocate gave the DD & the Cheque to DK Gandhi, but simultaneously made Kamal Sharma block the payment of the cheque.

DK Gandhi filed a complaint against the Advocate in the District Consumer court seeking compensation of 15K in addition to 5K of cheque amount and 10K for mental agony. The Advocate contested the complaint, stating that the Consumer court had no jurisdiction to adjudicate the complaint, as advocates were not covered under the provisions of the CPA. The District Consumer Forum rejected his objection and decided the case in favour of DK Gandhi.

The Advocate preferred an appeal before the SCDRC, which allowed the appeal in his favour, agreeing that the advocates did not fall within the ambit of 'service' under S.2(1)(o) of the CPA 1986. DK Gandhi filed a Revision Petition in NCDRC, which set aside the SCDRC order and held that advocates were covered under the CPA 1986.

The Bar of India Lawyers, Delhi Bar Association, Bar Council of India, and another Appellant, M. Mathias, approached the Supreme Court through sets of appeals challenging the NCDRC decision.

In Bar of Indian Lawyers v D.K. Gandhi[9], a Supreme Court bench of Justices Bela M. Trivedi and Pankaj Mithal held that advocates and legal services are not included under the Consumer Protection Act (2019). The Court ruled that legal services are unique (sui generis) and constitute a "contract of personal service" rather than a commercial service or "contract for personal service", making it exempt from the Act.

Key Aspects of the Judgment:

- **Exclusion from "Service":** The Court clarified that advocates providing services to clients are not rendering a "service" as defined under Section 2(42) of the CPA 2019.
- **Legal Profession is *Sui Generis*:** The judgment deemed the legal profession unique, distinguishing it from commercial businesses or trades covered by consumer law, as it requires special knowledge, training, and carries a fiduciary duty.

- **Contract of Personal Service:** The relationship between a client and an advocate involves direct control by the client, making it a "contract of service" (excluded) rather than a "contract for service" (included).
- **Overruled Previous Rulings:** The Supreme Court overruled the 2007 National Consumer Disputes Redressal Commission (NCDRC) decision that had brought lawyers under the CPA.
- The bench remarked that the 1995 Supreme Court ruling that brought medical professionals under the CPA (Indian Medical Association v. V.P. Shantha) should be re-examined.

The Supreme Court has recently addressed the issue of doctors' liability under the CPA through two significant procedural routes following the Bar of Indian Lawyers v. D.K. Gandhi (2024) judgment.

1. The Reference for Reconsideration

While Justice Bela M. Trivedi's bench initially suggested that the 1995 Indian Medical Association v. VP Shantha judgment (which brought doctors under the CPA) should be revisited, a three-judge bench of the Supreme Court later refused to reconsider it on November 7, 2024. The bench observed that the reference for a larger bench was "unnecessary" because the primary issue in the *D.K. Gandhi* case was specifically about the legal profession, which they had already unequivocally excluded[10].

2. The Medico-Legal Society Review Petition

Following this refusal, a review petition was filed by the Medico-Legal Society of India seeking a formal reconsideration of the *V.P. Shantha* ruling[11]. The review plea was dismissed in February 2025. The Court reaffirmed that medical professionals and doctors remain accountable under the CPA for paid services, concluding there was no justifiable reason to revisit the 1995 precedent. As of now, the legal position remains that while lawyers are excluded from the CPA, doctors continue to be liable for medical negligence under it. This reflects a paradox in professional accountability. While both professions are considered "noble" and non-commercial, only one (medicine) remains subject to consumer jurisdiction.

In a significant development, the Association of Healthcare Providers (India) (AHPI)[12] has filed a Public Interest Litigation (PIL) in the Supreme Court, which was recently admitted for hearing. The petition marks a pivotal moment in the legal debate following the Bar of Indian Lawyers v. D.K. Gandhi (2024) judgment that exempted advocates from the Consumer Protection Act (CPA). The AHPI's petition seeks a formal declaration that healthcare services provided by doctors and hospitals do not fall under the definition of "service" as per Section 2(42) of the CPA 2019. On February 10, 2026, a three-judge bench led by Chief Justice Surya Kant (along with Justices Joymalya Bagchi and N.V. Anjaria) issued notice to the Union Government and the National Medical Commission (NMC) seeking their responses. The matter is reportedly scheduled for further deliberation on July 28, 2026. The core argument of the AHPI is that medical professionals deserve parity with lawyers because the medical profession is also a "noble profession" based on fiduciary trust and skilled judgment, rather than a commercial transaction. Other Contentions of the AHPI are

- **Defensive Medicine:** The petition claims that the fear of consumer litigation has forced doctors into "defensive medicine" - prescribing excessive tests to avoid lawsuits - which unnecessarily increases healthcare costs for patients.
- **Complexity of Science:** It argues that medical science is not an "exact science" with guaranteed outcomes; therefore, treating a poor medical result as a "deficiency in service" is philosophically flawed.
- **Specialized Regulation:** AHPI asserts that the NMC is already a specialized body equipped to handle professional misconduct, making the CPA's oversight redundant and burdensome.

The AHPI reached the Supreme Court after following a specific legal hierarchy:

1. **Representation to Ministry:** In May 2024, they first petitioned the Health Ministry immediately after the *D.K. Gandhi* judgment.
2. **Delhi High Court:** They initially filed a writ in the Delhi High Court, which was dismissed on July 30, 2025, because the High Court noted that the 1995

V.P. Shantha ruling remains a "binding precedent" that only a larger bench of the Supreme Court can revisit.

Vignette 5: Advocate's Strategic Choice vs Client Expectation

A patient suddenly collapsed & soon died following a Spinal Anesthesia for a caesarean section, before the surgery could be started. The family created a ruckus in the hospital but refused a post-mortem examination, which was requested by the doctor/hospital to understand the cause of death. The police were called by the hospital in view of the unnatural cause of death and also to handle the ruckus created by the attendants. The police officer talked to the family members, but they used their influence to take away the body without a PME and gave their refusal consent in writing to the police.

The family engaged a lawyer for 'teaching a lesson' to the doctor/hospital. Police referred the matter to a Medical Board, which, by following the due procedure, found no evidence of any medical negligence on the part of the doctor/hospital. There was also no way to establish the cause of death in the absence of a PME. The police refused to register an FIR, in compliance with the Supreme Court guidelines. The complainant's lawyer filed a criminal complaint in the court under appropriate sections and misled his client about the high chances of success. He could convince the court to order an assessment by another Medical Board from a Medical College. This Board also absolved the doctor & hospital of any medical Negligence. The court dismissed the complaint. The client alleged a deficiency of service and filed a complaint against the lawyer in the Consumer Court seeking compensation for wilful deficiency and unfair business practice. The complaint was dismissed on the ground that advocates were not covered under the CPA 2019.

This vignette demonstrates the autonomy of legal strategy. Unlike medical practice, where patient welfare is paramount, legal representation allows for professional discretion that may not always align with client expectations. The recent Supreme Court ruling clarifying that advocates are not amenable to consumer jurisdiction further reinforces this distinction.

Vignette 6: Non-Appearance of Counsel

A patient filed a complaint of medical negligence against his doctor & hospital in the District Court. The complaint was admitted, and the proceedings started. However, the complainant's advocate failed to appear on three consecutive dates, although the complainant was keeping track of the case. The court asked the complainant to appear in person, or get his advocate to appear, or change his advocate. The complainant could not do any of these, and after 2 more hearings, the court dismissed the complaint. The complainant then quarrelled with his advocate & requested him to refund the fee that had been paid to him in advance. When he failed, the patient now filed a consumer court complaint against the advocate. This complaint was not admitted on the ground that advocates were not covered under the CPA 2019. An advocate repeatedly fails to appear in court, leading to the dismissal of the client's case. The aggrieved client seeks a remedy under consumer law for a deficiency of service, but fails on account of the technical glitch that advocates did not fall under the CPA.

While such conduct may amount to professional misconduct, the Supreme Court has clarified that consumer forums are not the appropriate remedy against the advocates. Instead, recourse lies before the Bar Council through disciplinary proceedings. This vignette highlights the difference in accountability mechanisms between the legal and medical professions, as the medical professionals also have the State Medical Councils & the NMC for their regulation.

Societal Expectations and Emerging Challenges

Both professions face increasing scrutiny in contemporary society. The medical profession grapples with rising patient awareness, commercialization, and litigation. The misconceptions acquired by the patients from the internet have been causing some difficulties for the doctors. The patients often come armed with internet-based information on their symptoms, diagnosis, or treatment options. When they consult a doctor, they tend to cross-check all that he says with his Human Intelligence (HI) in comparison with the internet-based information they have acquired. Any difference is taken as a motivated opinion of the doctor for commercial reasons. Not

realizing that the internet information is generic in nature, unlike the patient-specific assessment by the doctor, they tend to take back a negative opinion about the doctor. Now, the Artificial Intelligence (AI) has added another problem where the patients tend to resort to shortcuts for their ailments on diagnosis & treatment through Chat GPT without realizing the limitations & risk of inaccurate and inconsistent information on AI without proper validity & explainability. The trust between doctors and patients has eroded because of inclusion under the CPA, as well as because of other social factors. The legal profession, meanwhile, contends with delays in justice delivery and ethical dilemmas inherent in adversarial advocacy. The AI has affected the legal professionals, too, where the client, depending on the AI information, disregards the sane opinion & HI skills of the advocate, and regrets getting an adverse judgment. People use AI to draft their contracts & MOUs to save money, but in the process may repent later for inadequacies because they had ignored the HI of the advocate for some clauses incorrectly drafted with respect to their specific needs.

Vignette 7: Internet-based faux pas

A 66-year-old patient presented with chronic constipation and painless bleeding per rectum, off & on for 1 month. His son, an IT engineer, fed his symptoms to Chat-GPT, and from the information gathered, he concluded that the commonest cause of this symptom is piles, and several methods of surgical treatment were available. All had some pros & cons, and there was a risk of recurrence. Dietary modification with a high fibre diet, without chilies & spices in food, and avoidance of constipation was also an acceptable method of treatment. Since his father's diet was indeed poor in fibre and rich in chillies & spices, he ensured a diet modification for the next few months. When things did not improve, and his general condition continued to deteriorate, he consulted a surgeon. On examination, the surgeon found an anorectal growth which, on biopsy, revealed a well-differentiated carcinoma. On further investigations, there was some para-aortic lymphadenopathy and a doubtful metastasis in the liver. Depending too much on AI independent of the doctor's HI resulted in a situation where the treatment became more difficult and the prognosis poorer.

CONCLUSION

The black coat and the white coat symbolize two professions that, while distinct in purpose and practice, share a common commitment to human welfare. Their convergence lies in their ethical foundations and societal responsibilities, while their divergence is rooted in their objectives and methodologies.

In an era of increasing medico-legal complexity, both professions must develop a nuanced understanding of each other's domains. Such interdisciplinary awareness will not only enhance professional practice but also contribute to the broader goal of justice and human well-being. No wonder the speciality of Medicolegal service is growing faster than it was imagined.

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5. Samira Kohli v. Dr. Prabha Manchanda. (2008) 2 SCC 1.
6. Jacob Mathew v. State of Punjab. (2005) 6 SCC 1.
7. Parmanand Katara v. Union of India. (1989) 4 SCC 286.
8. Malay Kumar Ganguly v. Sukumar Mukherjee. (2009) 9 SCC 221.
9. Bar of Indian Lawyers v D.K. Gandhi (May 14, 2024)
10. Bar of Indian Lawyers v D.K. Gandhi (November 7, 2024)
11. Medico-Legal Society of India, Review petition in SC (Dismissed in February 2025; reference dismissal by 3-judge bench)
12. Association of Healthcare Providers and Anr. v. Union of India & Ors.