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Medical Negligence in India: The Rise of Standards of Duty of Care and the Evolution of Tortious Liability

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Abstract
Medical negligence is one of the most dynamic areas of contemporary Indian tort law because it lies at the intersection of professional standards, patient autonomy, consumer protection, constitutional remedies and criminal responsibility. Medical liability ordinarily arises when a medical practitioner or healthcare institution owes a duty of care to a patient, breaches the applicable standard of care, and that breach causes legally cognisable harm. This paper undertakes a doctrinal, statutory and jurisprudential study of the evolving standards of duty of care, professional skill and tortious liability in India. It traces the historical development of the English Bolam test and its qualification through Bolitho, and examines the manner in which Indian courts have adapted these principles in cases such as Dr. Laxman Balkrishna Joshi, Jacob Mathew, Kusum Sharma, V. Kishan Rao, Nizam's Institute of Medical Sciences, Samira Kohli, Savita Garg and Balram Prasad. The paper further examines the principal avenues of liability—civil tort, consumer protection, constitutional remedies in appropriate cases, and criminal liability for gross or statutorily punishable negligence. It also analyses informed consent, res ipsa loquitur, vicarious liability of hospitals, telemedicine, artificial intelligence in healthcare and defensive medicine. The paper concludes that Indian medical-negligence law should move towards clearer statutory and clinical standards, specialised adjudication, effective pre-litigation dispute resolution and a predictable compensation framework, while preserving patient autonomy and protecting competent medical practice from unwarranted criminalisation.

Keywords: Medical Negligence, Duty of Care, Standard of Care, Bolam Test, Bolitho, Jacob Mathew, Informed Consent, Samira Kohli, Res Ipsa Loquitur, Consumer Protection Act 2019, Vicarious Liability, Telemedicine, Artificial Intelligence

1. Introduction

Medicine is a profession involving a high degree of trust, skill and responsibility. The traditional ethical ideal of non-maleficence remains important, but the modern doctor–patient relationship is no longer purely paternalistic. The growth of specialised medicine, private hospitals, insurance, consumer litigation, digital health and artificial intelligence has transformed healthcare into a complex legal and socio-economic relationship.

In tort law, negligence broadly consists of a legal duty to take reasonable care, a breach of that duty, and damage caused by the breach. In medical-negligence litigation, the standard is not one of perfection or guaranteed success. A medical practitioner is required to exercise the degree of care, skill and knowledge reasonably expected from a competent practitioner in the relevant circumstances.

The traditional tripartite structure of actionable negligence therefore requires consideration of: (i) duty of care; (ii) breach of the applicable standard of care; and (iii) causation and legally compensable damage. The claimant must establish a sufficiently direct causal connection between the alleged breach and the injury, subject to recognised evidentiary doctrines and statutory or procedural rules applicable to the forum.

Indian medical-negligence jurisprudence has developed by drawing upon English common law while adapting those principles to Indian constitutional values, consumer legislation and the realities of healthcare delivery. The result is not a single uniform cause of action but a network of overlapping legal regimes.

2. Duty of Care and Standard of Skill: Doctrinal Development

2.1. The Classical Bolam Test

The English decision in Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582 became the classical reference point for determining professional negligence. McNair J. explained that a doctor would not ordinarily be negligent if acting in accordance with a practice accepted as proper by a responsible body of medical professionals skilled in the relevant field.

The significance of Bolam lies in its recognition that medical treatment involves genuine differences of professional opinion. Courts are not ordinarily expected to substitute their own clinical preferences for a responsible medical judgment. The test therefore protects practitioners from liability merely because another medically respectable course of treatment might also have been adopted.

Two central propositions follow:

The law requires reasonable competence, not the highest conceivable degree of skill or infallibility.

A responsible body of professional opinion may support a particular course of diagnosis or treatment, even where another responsible body would have adopted a different approach.

2.2. The Bolitho Qualification

The apparent deference of Bolam was qualified in Bolitho v. City and Hackney Health Authority [1998] AC 232. The House of Lords recognised that professional opinion is not immune from judicial scrutiny. A court may examine whether the opinion relied upon has a logical and defensible basis, including consideration of competing risks and benefits.

Bolitho therefore does not abolish professional judgment; rather, it prevents professional custom from becoming conclusive merely because it is professionally asserted. The court retains the ultimate legal responsibility for determining whether the standard of care has been satisfied.

3. Indian Jurisprudential Synthesis

3.1. Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole

In Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole, AIR 1969 SC 128, the Supreme Court articulated three important duties of a medical practitioner: a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give; and a duty of care in the administration of that treatment. The decision remains foundational because it recognises that medical responsibility may arise at different stages of the doctor–patient relationship, not merely from the technical performance of a procedure.

3.2. Jacob Mathew v. State of Punjab (2005)

Jacob Mathew v. State of Punjab, (2005) [16] 6 SCC 1, is a leading authority on the distinction between civil medical negligence and criminal negligence. The Supreme Court emphasised that criminal liability requires a substantially higher degree of negligence than that ordinarily sufficient for civil liability.

The Court recognised that an error of judgment, an accident, or a mere departure from an ideal course of treatment does not automatically amount to criminal negligence. For criminal prosecution, the negligence must be sufficiently gross or culpable to satisfy the criminal-law threshold.

The Court also issued safeguards concerning prosecution of medical professionals, including the importance of obtaining credible medical opinion in appropriate cases and caution against routine arrest of doctors. These safeguards were intended to prevent criminal process from becoming a means of harassment while preserving accountability for genuinely culpable conduct.

For present-day analysis, Jacob Mathew must be read alongside the Bharatiya Nyaya Sanhita, 2023 (BNS), which replaced the Indian Penal Code from 1 July 2024. Section 106(1) BNS specifically deals with causing death by negligence and provides a distinct punishment where the negligent act is committed by a registered medical practitioner while performing a medical procedure.

3.3. Kusum Sharma v. Batra Hospital & Medical Research Centre

In Kusum Sharma v. Batra Hospital & Medical Research Centre, (2010) 3 SCC 480 [17], the Supreme Court reiterated that a doctor should not be held negligent merely because treatment did not produce the desired result. The relevant inquiry is whether the practitioner exercised reasonable competence and followed an accepted course of professional practice in the circumstances.

3.4. Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka

Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka, (2009) 6 SCC 1 [21], demonstrates the compensatory dimension of medical negligence. The claimant suffered catastrophic disability following medical treatment. The Supreme Court considered future medical care, nursing, physiotherapy, loss of earning capacity, pain and suffering and other consequences in assessing compensation. The amount computed by the Court was Rs. 1,00,05,000, rounded to Rs. 1 crore, with applicable interest.

The decision illustrates that compensation in serious medical-negligence cases is not confined to immediate medical expenditure. The objective is restorative and should, as far as money can achieve it, address the continuing financial and human consequences of the injury.

3.5. Malay Kumar Ganguly and Balram Prasad

Malay Kumar Ganguly v. Dr. Sukumar Mukherjee, (2009) 9 SCC 221 [18], is a major decision concerning medical negligence, hospital responsibility and compensation in the death of Anuradha Saha. The subsequent decision in Dr. Balram Prasad v. Kunal Saha, (2014) 1 SCC 384 [11], dealt extensively with the computation and apportionment of compensation and affirmed the hospital's vicarious liability in the circumstances of that case.

These decisions are significant not because they establish a fixed compensation scale, but because they demonstrate the Court's willingness to award substantial, evidence-based compensation where negligence causes grave and lasting consequences.

4. The Doctrine of Informed Consent

4.1. Samira Kohli v. Dr. Prabha Manchanda

Consent is a central element of lawful medical treatment. In Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 SCC 1 [24], the Supreme Court examined the consequences of performing a more extensive procedure than that for which the patient had consented.

The Court emphasised that consent should be real, voluntary and informed. Ordinarily, a patient should be informed of the nature and purpose of the proposed treatment, its broad consequences, material risks and available alternatives in circumstances where those matters are relevant to the patient's decision. Consent to a diagnostic procedure cannot ordinarily be treated as unlimited consent to a substantially different operative procedure, except where immediate intervention is genuinely necessary to save life or prevent serious harm.

The Indian position in Samira Kohli is historically closer to a professional-disclosure model than the fully patient-centred material-risk test subsequently articulated in Montgomery. The two cases should therefore not be presented as identical. Montgomery v. Lanarkshire Health Board [2015] UKSC 11 [20] is best used as a comparative development in common-law informed-consent doctrine, particularly its emphasis on patient autonomy and material risks.

4.2. Montgomery and the Autonomy Model

In Montgomery, the UK Supreme Court held that an adult patient of sound mind is entitled to decide which available treatment to undergo. The doctor must take reasonable care to ensure that the patient is aware of material risks and reasonable alternatives. A risk is material when a reasonable person in the patient's position would likely attach significance to it, or when the doctor knows or ought reasonably to know that the particular patient would attach significance to it.

The comparative importance of Montgomery for Indian scholarship lies in the broader movement from medical paternalism towards patient autonomy. However, any claim that Montgomery has completely replaced Samira Kohli as the binding Indian rule would be overstated. Indian courts continue to work within their own constitutional, statutory and professional framework.

5. Evidentiary Dimensions: Res Ipsa Loquitur

Medical-negligence claims frequently present evidentiary difficulties because the patient may have been unconscious, anaesthetised or otherwise unable to observe the relevant events. The doctrine of res ipsa loquitur ('the thing speaks for itself') may assist where the circumstances themselves strongly indicate negligence.

Its application generally depends upon considerations such as:

The relevant instrumentality or process was within the defendant's control or responsibility in the circumstances.

The occurrence is of a kind that ordinarily does not happen without negligence, subject to the nature of the medical procedure and known complications.

The defendant does not provide a satisfactory non-negligent explanation.

In Achutrao Haribhau Khodwa v. State of Maharashtra, (1996) 2 SCC 634 [8], the circumstances surrounding a foreign object left in the patient's body provided a classic factual setting for drawing an inference of negligence.

V. Kishan Rao v. Nikhil Super Speciality Hospital, (2010) 5 SCC 513 [26], clarified that expert evidence is not an inflexible prerequisite in every consumer medical-negligence case. Where negligence is obvious, res ipsa loquitur may apply; in more technically complex matters, expert evidence may be necessary. The decision therefore supports a fact-sensitive approach rather than an absolute rule dispensing with expert evidence.

6. Multiple Legal Regimes of Medical Liability in India

Regime	Principal Law / Forum	Core Standard	Typical Remedy
Civil tort	Civil courts; law of torts	Duty, breach, causation and damage; reasonable professional standard	Compensatory damages
Consumer law	Consumer Protection Act, 2019; District/State/National Consumer Commissions	Deficiency in service; medical service within the applicable statutory framework	Compensation, refund, costs and other consumer remedies
Constitutional remedy	High Courts under Art. 226; Supreme Court under Art. 32 in appropriate cases	Violation of public-law/constitutional obligations, especially in State healthcare contexts	Public-law compensation and directions in appropriate cases
Criminal law	BNS, 2023; criminal courts	Criminal negligence meeting the statutory and jurisprudential threshold	Punishment and fine, subject to law

6.1. Consumer Protection and IMA v. V.P. Shantha

Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651 [15], brought medical services within the consumer-protection framework under the Consumer Protection Act, 1986, subject to the distinctions recognised by the Court. The judgment treated medical services rendered for consideration as 'service' and addressed the position of wholly free services and institutions providing both paying and free services.

The Consumer Protection Act, 2019 continues the consumer-remedy framework. Section 2(11) defines 'deficiency' in service. Consumer Commissions provide a comparatively accessible forum, although medical-negligence disputes may still involve substantial technical and evidentiary complexity.

6.2. Constitutional Tort and the Right to Health

Constitutional remedies should be distinguished from ordinary private medical-negligence claims. Article 21 has been interpreted to include important dimensions of health and medical care, particularly in relation to State obligations. Decisions such as Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37 [22], demonstrate the constitutional importance of access to emergency medical treatment.

It would, however, be legally imprecise to describe every medical-negligence dispute as a constitutional tort. Public-law compensation depends upon the nature of State action, violation of constitutional rights and the circumstances recognised by constitutional courts.

6.3. Criminal Liability under the BNS, 2023

The Indian Penal Code has been repealed and replaced by the Bharatiya Nyaya Sanhita, 2023. Section 106(1) BNS addresses causing death by negligence. It provides a general punishment of up to five years and also creates a specific provision for a registered medical practitioner who causes death by a negligent act while performing a medical procedure, for which imprisonment may extend to two years, along with fine.

The transition from Section 304A IPC to Section 106 BNS should be expressly acknowledged in contemporary research. At the same time, the distinction drawn in Jacob Mathew between ordinary civil negligence and criminally culpable negligence remains important when courts assess whether medical conduct crosses the criminal threshold.

7. Contemporary Problems in Medical-Negligence Law

7.1. Corporate Accountability and Vicarious Liability of Hospitals

Modern healthcare is usually institutional rather than individual. Patients commonly rely upon hospitals, nursing homes and diagnostic institutions as integrated providers of healthcare. The Supreme Court has repeatedly recognised hospital responsibility for negligent acts of doctors and other personnel in appropriate cases.

Savita Garg v. National Heart Institute, (2004) 8 SCC 56 [25], is a leading authority on hospital responsibility. Later decisions, including Balram Prasad and Maharaja Agrasen Hospital v. Master Rishabh Sharma, have reinforced the principle that a hospital may be vicariously liable for negligence committed by doctors engaged or empanelled to provide medical care, depending on the facts.

The modern debate should therefore move beyond a simple employee-versus-independent-contractor distinction and examine the hospital's institutional duties concerning staffing, equipment, protocols, supervision, emergency preparedness, record keeping and coordination of care.

7.2. Telemedicine and Digital Healthcare

Telemedicine has altered the spatial structure of the doctor–patient relationship. The Telemedicine Practice Guidelines, 2020 provide a regulatory framework for remote consultations. The central negligence questions include whether telemedicine was clinically appropriate, whether the practitioner recognised the limitations of remote examination, whether referral or physical examination was required, whether adequate records were maintained and whether consent and confidentiality requirements were observed.

Digital health also raises questions concerning the protection of electronic health information. The Digital Personal Data Protection Act, 2023 is relevant to the broader data-protection framework, although its precise application depends upon the facts, the applicable rules and the status of the entity processing personal data.

7.3. Artificial Intelligence and Algorithmic Clinical Decision-Making

Artificial intelligence and machine-learning systems create novel questions of attribution and causation. If an AI-supported diagnostic tool produces an erroneous result, possible defendants may include the treating professional, hospital or healthcare institution, software developer or manufacturer, depending on the nature of the defect, contractual relationships and applicable statutory regimes.

At present, Indian medical-negligence law does not establish a comprehensive autonomous liability regime for clinical AI. A cautious approach is therefore to retain human clinical responsibility where a practitioner makes the final decision, while separately examining product liability, software defects, inadequate warnings, negligent procurement, validation and institutional governance.

7.4. Defensive Medicine and Patient Safety

Fear of litigation may encourage defensive medicine, including unnecessary investigations, excessive referrals or avoidance of high-risk patients. Such conduct can increase healthcare costs and may itself create patient-safety risks. The appropriate legal response is not to dilute accountability but to provide predictable standards that distinguish unavoidable adverse outcomes and reasonable clinical judgment from genuine negligence.

8. Recommendations and Policy Reforms

Specialised Medical Negligence Adjudication: Consider establishing specialised benches or tribunals with judicial members assisted by independent medical assessors, while preserving judicial review and procedural safeguards.

Pre-Litigation Mediation: Encourage structured pre-litigation mediation and expert-assisted settlement in appropriate medical-negligence disputes to reduce delay and litigation costs.

Uniform Informed-Consent Standards: Develop clear, multilingual and specialty-sensitive consent protocols that explain material risks, reasonable alternatives and patient-specific concerns without reducing consent to a mere signature.

Clinical Guidelines and Safe-Harbour Principles: Encourage transparent, evidence-based clinical guidelines and clarify the legal relevance of substantial compliance, justified deviation and documented clinical reasoning.

Emergency-Care Protection: Strengthen statutory and regulatory protections for doctors providing bona fide emergency care, particularly in resource-constrained settings, while preserving accountability for gross misconduct.

Hospital Governance: Require stronger systems for incident reporting, credentialing, staffing, infection control, equipment maintenance, clinical documentation and internal quality assurance.

AI Governance: Establish standards for validation, auditability, explainability, human oversight and documentation of AI-assisted clinical decisions.

Compensation Methodology: Develop more consistent principles for assessing future medical care, attendant costs, loss of earning capacity and non-pecuniary loss, without imposing a rigid statutory cap that could under-compensate catastrophic injuries.

9. Conclusion

Indian medical-negligence jurisprudence reflects a continuing attempt to balance two legitimate interests: the patient's right to competent, safe and accountable medical care, and the medical professional's right to practise without the constant threat of liability for every unsuccessful outcome or reasonable difference of clinical opinion.

The jurisprudential journey from Dr. Laxman Joshi through Bolam-informed reasoning, Jacob Mathew, Kusum Sharma, Samira Kohli, Nizam's Institute, V. Kishan Rao, Savita Garg

and Balram Prasad demonstrates that Indian law has gradually moved towards a more structured and context-sensitive approach. The law protects professional judgment, but it does not permit professional custom to become a complete defence to irrational or clearly negligent conduct.

The next stage of development will be shaped by informed consent, institutional responsibility, telemedicine, algorithmic healthcare and the increasing demand for timely compensation. The objective should not be either excessive judicial intervention or excessive professional immunity. A scientifically informed, patient-centred and predictable framework—supported by specialised adjudication, effective mediation and clear clinical standards—can strengthen both patient safety and confidence in medical practice.

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