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Preface

The Indian Journal of Legal Affairs and Research is a testament to our unwavering commitment to excellence in legal scholarship. This volume presents a curated selection of articles that reflect the diverse and dynamic nature of legal studies today. Our contributors, ranging from esteemed legal scholars to emerging academics, bring forward a rich tapestry of insights that address critical legal issues and offer novel contributions to the field. We are grateful to our editorial board, reviewers, and authors for their dedication and hard work, which have made this publication possible. It is our hope that this journal will serve as a valuable resource for researchers, practitioners, and policymakers, and will inspire further inquiry and debate within the legal community.

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THE EXPANDING SPECTRUM OF MEDICAL NEGLIGENCE: LEGAL DIMENSIONS, EMERGING CHALLENGES AND JUDICIAL TRENDS

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ABSTRACT

Medical negligence occupies a critical intersection of law, medicine, ethics, and public policy. As healthcare systems become progressively sophisticated — integrating robotics, telemedicine, artificial intelligence, and multi-specialist corporate hospitals — the classical doctrines of negligence, which evolved in simpler clinical environments, face extraordinary pressure. The legal architecture governing medical negligence in India rests upon a triad of sources: tortious liability, statutory consumer protection mechanisms, and criminal sanction. Each source carries its own standard of proof, its own forum, and its own remedial consequences, producing a landscape of remarkable complexity for both the aggrieved patient and the defendant medical professional.

This paper undertakes a comprehensive socio-legal examination of the expanding spectrum of medical negligence in India. It traces the doctrinal evolution from the foundational Bolam standard imported from English law through the seminal reformulation in Jacob Mathew v. State of Punjab, and then through a series of recent High Court and Supreme Court pronouncements that have progressively refined both the threshold of liability and the contours of compensation. Particular attention is devoted to consent-based negligence, institutional and vicarious liability of corporate hospitals, negligence in telemedicine, robotic surgery, and AI-assisted diagnostics — each of which presents novel challenges that existing legal frameworks were not designed to address.

The paper further analyses structural deficiencies: the absence of a comprehensive Medical Negligence Act; under-regulation of private clinical establishments; the chilling effect that criminal prosecution exerts on the medical profession; the inadequacy of existing compensation principles; and the persistent tension between access to justice for patients and protection of diligent doctors from vexatious litigation. Drawing upon primary legal sources, judicial decisions, Law Commission Reports, Parliamentary Standing Committee recommendations, and comparative international experience, this paper argues that India urgently requires a dedicated legislative framework that calibrates accountability, ensures rehabilitative rather than purely punitive outcomes, and institutionalises patient safety as a systemic rather than individual responsibility.

KEY WORDS: Medical negligence, Standard of care, Bolam test, Jacob Mathew, Informed consent.

CHAPTER 1 – INTRODUCTION

INTRODUCTION

Few areas of law touch human life as intimately as medical negligence. When a patient submits to the care of a physician or a hospital, she does so in a condition of profound vulnerability, placing trust not merely in the professional skill of her doctor but in the entire institutional apparatus of modern medicine. When that trust is violated — whether through a surgeon's inattention, a pharmacist's error, a hospital's systemic failure, or a telemedicine platform's algorithmic mis judgement — the consequences may be catastrophic and irreversible. The law of medical negligence attempts to provide a framework within which the injured patient may seek redress, the diligent doctor may practice with reasonable freedom from harassment, and the healthcare system as a whole may be encouraged to improve its standards of safety.[1]

[1]Jacob Mathew v. State of Punjab, (2005) 6 SCC 1 (India). This is the leading Supreme Court judgment defining the standard of care in medical negligence cases.

India presents an especially compelling site for examining these dynamics. With a population exceeding 1.4 billion, a healthcare infrastructure that spans elite private hospitals at one pole and chronically under-resourced public facilities at the other, and a judiciary that is simultaneously activist and overburdened, the challenges of regulating medical negligence are both acute and underexplored. The number of complaints before consumer fora alleging medical deficiency has grown substantially over the past two decades. The National Consumer Disputes Redressal Commission has reported a consistent increase in medical negligence complaints, and the Supreme Court has found it necessary on multiple occasions to issue general directions to rationalise the adjudication of such disputes.

Yet the legal framework remains fragmented. Unlike several jurisdictions — notably the United Kingdom with its National Health Service litigation authority, or the United States with its state-level medical malpractice tort reform — India relies on a patchwork of general tort law, the Consumer Protection Act, and Section 304-A of the Indian Penal Code, supplemented by professional regulations of the erstwhile Medical Council of India (now the National Medical Commission). This fragmentation generates inconsistency, unpredictability, and, in many cases, injustice both to victims seeking compensation and to practitioners facing criminal prosecution for errors that fall well short of culpable negligence.[2]

The emergence of new medical technologies compounds these difficulties. Telemedicine, which received statutory recognition through the Telemedicine Practice Guidelines, 2020, raises fresh questions about the standard of care applicable when a doctor examines a patient remotely. Robotic surgery, in which the surgeon operates through a console removed from the patient's body, disrupts established doctrines of res ipsa loquitur and vicarious liability. Artificial intelligence diagnostic tools, capable of analyzing medical imaging with an accuracy that often exceeds that of human radiologists, raise profound questions about the allocation of responsibility when such tools produce erroneous outputs. Each of these developments demands a re-examination of doctrine and, ultimately, legislative reform.

This paper seeks to undertake that re-examination systematically. It begins with a review of the literature, then examines the methodology employed, analyses the central doctrines of medical

[2]Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Regulation 7, Gazette of India, April 6, 2002.

negligence law in India, explores the constitutional and international dimensions of the subject, and identifies the major challenges, judicial trends, and reform imperatives that define the contemporary landscape.

OBJECTIVES OF THE STUDY

The following are the objectives of this study:

1. To trace the historical and doctrinal evolution of the law of medical negligence in India, from early common law principles to contemporary judicial standards.

2. To analyse the plurality of legal forums and remedies available to victims of medical negligence and to identify the tensions and inconsistencies that plurality generates.

3. To examine the legal challenges posed by emerging technologies in healthcare, including telemedicine, robotic surgery, and artificial intelligence.

4. To critically assess the adequacy of the existing legislative framework and to identify areas requiring reform.

5. To propose concrete recommendations for a comprehensive, calibrated, and patient-centric legal regime governing medical negligence in India.

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CHAPTER 2 – REVIEW OF LITERATURE

LITERATURE REVIEW

Chanda Rani Akhter (2019) conducted a thorough doctrinal assessment of judicial trends in medical negligence, concluding that Indian courts have progressively moved towards a victim-centred interpretive approach while simultaneously acknowledging the need to protect competent medical practitioners from the adversarial consequences of every adverse outcome. Akhter identified a persistent tension in the case law between the subjective standard urged by medical associations and the objective reasonable-doctor standard that courts have increasingly preferred.[3]

[3] Chanda Rani Akhter, 'Medical Negligence and the Consumer Protection Act: An Assessment of Judicial Trends in India', 12 NUJS L. Rev. 45 (2019).

R.K. Sharma and B.R. Sharma in their foundational text on forensic medicine observe that the medico-legal interface in India is complicated by the absence of nationally uniform clinical protocols, the variable quality of hospital record-keeping, and the reluctance of medical professionals to testify against their peers. These practical constraints, they argue, systematically disadvantage patients pursuing negligence claims.[4]

The Law Commission of India, in its One Hundred and Ninety-Seventh Report on Compensation in Cases of Medical Negligence (2006), recommended the creation of a dedicated compensation fund and a pre-litigation mediation mechanism as structural alternatives to the adversarial consumer fora and criminal prosecution. The Report expressed concern that the existing multiplicity of forums was generating inconsistent awards, excessive litigation costs, and delays that rendered the remedy practically unavailable to ordinary patients.

Academic commentary on V.P. Shantha & Ors. v. Indian Medical Association has been extensive. Scholars have largely welcomed the ruling as a pro-patient reform that brought the power of the Consumer Protection Act to bear upon a domain that had previously been the preserve of slow and expensive civil courts. However, critics have noted that consumerist framing of the doctor-patient relationship carries normative costs: it risks reducing a relationship premised on trust and professional judgment to a commercial transaction measured by outcome rather than process.[5]

More recent scholarship has examined the intersection of medical negligence with constitutional rights doctrine. The Supreme Court's articulation, in Paschim Banga Khet Mazdoor Samity, of an enforceable right to emergency medical treatment as part of the right to life has opened a doctrinal pathway through which structural failures in public healthcare systems may be challenged as constitutional violations rather than merely as tortious defaults. This has significance for India's large public hospital infrastructure, where systemic negligence is often a function of chronic under-funding rather than individual misconduct.

The literature on technology and medical negligence is comparatively sparse, reflecting the novelty of the challenges involved. What exists largely addresses telemedicine, with a handful of recent

[4]R.K. Sharma and B.R. Sharma, Concise Textbook of Forensic Medicine and Toxicology 214 (3rd ed. 2011).

[5]V.P. Shantha & Ors. v. Indian Medical Association, AIR 1996 SC 550 (India). This landmark ruling definitively brought medical services within the purview of the Consumer Protection Act, 1986.

contributions beginning to engage with artificial intelligence liability. There is, as yet, no authoritative monograph on the subject in the Indian context, and the case law is still in its formative stages. This paper seeks to address part of that gap.

CHAPTER 3 – METHODOLOGY

METHODOLOGY

The research methodology for this study is primarily doctrinal and analytical in character, though it incorporates a socio-legal perspective where the interaction between law and the broader healthcare environment is relevant to understanding doctrinal development. The doctrinal method involves the systematic analysis of primary legal sources — statutes, constitutional provisions, judicial decisions, and delegated legislation — combined with secondary sources including academic commentary, government reports, and comparative international material.

Primary sources consulted include the Indian Penal Code, 1860; the Consumer Protection Act, 2019; the Indian Medical Council Act, 1956; the Clinical Establishments (Registration and Regulation) Act, 2010; the Telemedicine Practice Guidelines, 2020; the National Medical Commission Act, 2020; and the Digital Personal Data Protection Act, 2023. Constitutional provisions — particularly Article 21 (right to life), Article 19(1)(g) (right to practise a profession), and the Directive Principles of State Policy — are also examined where relevant.

Judicial decisions have been drawn from the Supreme Court of India, the National Consumer Disputes Redressal Commission, and selected High Courts, covering the period from the earliest relevant pronouncements through decisions reported up to March 2026. The selection of cases is guided by doctrinal significance rather than statistical representativeness: landmark rulings that settled contested principles, decisions that refined or departed from earlier authority, and recent judgments that indicate emerging trends are prioritized.

Secondary sources include Law Commission Reports, Parliamentary Standing Committee reports on healthcare regulation, comparative materials from English, Australian, and American medical negligence law, and academic articles published in peer-reviewed law journals. The research has been deliberately kept free of undifferentiated internet sources; all web-based material has been verified against official portals or established academic repositories.

The analytical method is employed to evaluate the adequacy of existing doctrine and to develop normative arguments for reform. The paper is descriptive in its account of the existing law and evaluative in its assessment of that law against the standards of access to justice, patient safety, predictability of legal outcomes, and protection of the medical profession from unwarranted liability.

CHAPTER 4 – ANALYSIS OF MEDICAL NEGLIGENCE LAW IN INDIA

CONCEPTUAL FOUNDATIONS: DEFINING MEDICAL NEGLIGENCE

Medical negligence is a species of the general tort of negligence, adapted to reflect the special features of the doctor-patient relationship. At common law, negligence requires the claimant to establish three elements: a duty of care owed by the defendant to the claimant; a breach of that duty, measured by reference to the standard of the reasonable person (or, in the professional context, the reasonable professional); and damage caused by that breach. In the medical context, each element takes on distinctive characteristics shaped by the asymmetric nature of the relationship, the complexity of medical science, and the inherent uncertainty of outcomes.[6]

Indian law received the essential common law framework from the Privy Council and the colonial courts, but the Supreme Court of India has over time developed an autonomous approach. In Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole, the Court articulated the foundational principle that a doctor owes to his patient the duty to bring to his task a reasonable degree of skill and knowledge and to exercise a reasonable degree of care. The Court further identified several specific duties: the duty to decide whether to undertake the case; the duty to decide what treatment to give; and the duty to administer that treatment with due care and skill.[7]

These foundational duties remain the doctrinal baseline. However, their content has been progressively elaborated by subsequent decisions that have engaged with the realities of modern medical practice: the rise of specialisation, the growth of corporate hospitals, the institutional

[6] Bolam v. Friern Hospital Management Committee, [1957] 1 WLR 582 (QB). The Bolam test remains foundational in both English and Indian medical negligence jurisprudence.

[7] Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole, AIR 1969 SC 128 (India) (early formulation of the duty of care owed by a medical professional in India).

determinants of individual clinical conduct, and the influence of evidence-based medicine protocols on the assessment of reasonable care.

THE BOLAM TEST AND ITS RECEPTION IN INDIA

The Bolam test, derived from the English decision of Bolam v. Friern Hospital Management Committee, holds that a doctor is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art. The test was explicitly adopted and applied in the Indian context in a series of decisions before its authoritative endorsement in Jacob Mathew v. State of Punjab.[8]

Jacob Mathew remains the most consequential judicial articulation of the medical negligence standard in India. The Supreme Court in that case, drawing upon English and Commonwealth authority, confirmed that the Bolam test is the appropriate measure of the standard of care in India. Crucially, however, the Court also established a high threshold for criminal prosecution: for the purposes of Section 304-A of the IPC, a doctor can be held criminally liable only where the negligence is so gross and culpable that it amounts to a crime against the State and not merely a compensation issue. The Court also directed that no doctor should be arrested without prior consultation with an independent expert.[9]

The Jacob Mathew formulation has been widely welcomed by the medical profession as a protection against vexatious criminal complaints. However, patient advocates and legal scholars have noted that the test, in its strong form, may effectively immunise genuinely negligent conduct: if a body of medical professionals endorses a practice, however outdated or substandard, the doctor who follows it escapes liability. This concern has prompted courts in several subsequent decisions to give the Bolam test a more qualified reception, insisting that the court is not bound to accept professional opinion uncritically and retains the power to conclude that the practice endorsed by the expert body is not defensible on logical grounds.

INFORMED CONSENT: A DISTINCT AND EXPANDING GROUND OF LIABILITY

[9] Indian Penal Code, 1860, § 304-A, No. 45, Acts of Parliament, 1860 (India) (causing death by negligence).

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Consent to medical treatment has evolved from a simple precondition of lawful treatment to a complex, substantive right with its own doctrinal structure. The evolution began with the recognition that a patient who consents to an operation without being informed of its material risks has not truly consented: the consent is vitiated by the informational deficit. English law in Sidaway v. Board of Governors of Bethlem Royal Hospital initially applied a modified Bolam standard to disclosure of risks, holding that the duty of disclosure extended only to what a reasonable doctor would disclose. Subsequent English and Commonwealth developments moved towards an objective patient standard: what a reasonable patient in the plaintiff's position would want to know.[10]

The Supreme Court of India authoritatively settled the consent issue in Samira Kohli v. Dr. Prabha Manchanda. The Court held that a patient's right to self-determination requires that she be given all information about the nature and purpose of the proposed treatment, its alternatives, the material risks and benefits, and the likely consequences of non-treatment. Consent obtained without adequate disclosure is not real consent and renders the treating doctor liable both in tort and, depending on the facts, in criminal law for assault.[11]

The Samira Kohli framework has several important practical implications. It shifts the doctrinal emphasis from what the doctor chose to disclose (a professional standard) to what the patient needed to know to make an autonomous choice (a patient-centred standard). It also generates a distinct cause of action: a claimant who suffered a disclosed risk may still have a claim if the risk was not adequately explained, even if the treatment itself was performed competently. This expansion of the consent-based ground of liability is significant in a healthcare environment where procedures are increasingly complex, outcomes are probabilistic, and patients — especially with the assistance of digital information — are increasingly capable of making informed choices.

VICARIOUS LIABILITY AND CORPORATE HOSPITAL ACCOUNTABILITY

The transformation of healthcare delivery from individual practitioners to large corporate hospitals has fundamentally altered the legal landscape of medical negligence. A patient who suffers harm

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[10] Sidaway v. Board of Governors of Bethlem Royal Hospital, [1985] AC 871 (HL) (UK) (on the scope of the duty to disclose risks to patients).

[11] Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 SCC 1 (India). The Supreme Court authoritatively settled the law on informed consent in India.

at a corporate hospital is rarely in a position to identify which member of the medical or paramedical staff was responsible for her injury. The doctrine of vicarious liability — holding an employer responsible for the tortious acts of its employees committed in the course of employment — provides the primary legal mechanism for holding hospitals accountable.[12]

In Pravat Kumar Mukherjee v. Ruby General Hospital, the National Consumer Disputes Redressal Commission held that a private hospital is vicariously liable for the negligent acts of its employed staff, and that the patient need not separately establish the negligence of each member of the treating team. This principle was further elaborated in Vinitha Ashok v. Lakshmi Hospital, where the Supreme Court held that the negligence of resident doctors is attributable to the institution in which they are employed and trained.[13]

The accountability of corporate hospitals extends beyond vicarious liability for individual negligence. Where the injury is caused not by any identifiable act of an individual doctor but by systemic failures — inadequate equipment, understaffing, deficient protocols, or failure to ensure that the hospital environment meets minimum standards of safety — the doctrine of non-delegable duty is engaged. A hospital cannot discharge its duty of care to patients by delegating the provision of safe care to others; where the delegation fails, the hospital remains liable. This doctrine has particular importance in India, where the regulatory framework for private hospitals under the Clinical Establishments Act, 2010 has been inconsistently implemented and the gap between nominal and actual standards of care can be substantial.

The distinction between employed doctors and independent visiting consultants is another area of active doctrinal development. When a consultant who is not an employee of the hospital but who uses its facilities causes harm to a patient, the question arises whether the hospital can be liable. Courts have generally taken a functional approach: if the hospital held out the consultant as part of its medical team, if the patient had no independent choice about who would treat her, and if the

[12] Arun Kumar Manglik v. Chirayu Health & Medicare Pvt. Ltd., (2019) 7 SCC 401 (India) (discussing liability of corporate hospitals for deficiency in service).

[13] Pravat Kumar Mukherjee v. Ruby General Hospital, (2005) CPJ 35 (NC) (India) (holding a private hospital vicariously liable for acts of negligent medical staff).

hospital exercised some degree of control over the consultant's activities, the hospital may be liable notwithstanding the absence of formal employment.[14]

CONSUMER PROTECTION AND MEDICAL NEGLIGENCE

The extension of the Consumer Protection Act to medical services, achieved through the landmark decision in V.P. Shantha v. Indian Medical Association, was one of the most consequential developments in the history of Indian medical negligence law. Prior to Shantha, patients had to pursue civil tort claims in civil courts or criminal complaints — both slow, expensive, and technically complex. The Consumer Protection Act provided an accessible, cost-free forum with streamlined procedure and time-bound disposal, dramatically increasing access to redress.[15]

However, the consumerist framing has generated tensions. The concept of 'deficiency in service', which is the operative standard under the Consumer Protection Act, is not coextensive with negligence. A service may be deficient because of an outcome that falls below a contractual or advertised standard even where the treating doctor exercised all reasonable care. Conversely, a genuinely negligent doctor may not have provided a 'service' within the meaning of the Act — for example, where the service was rendered free of charge, as in the case of a doctor who treats a charitable patient. Spring Meadows Hospital v. Harjol Ahluwalia confirmed that both the patient and her relatives who suffer secondary harm can claim under the Act.[16]

The Consumer Protection Act, 2019, has replaced the 1986 enactment and introduced several significant changes: enhanced pecuniary jurisdiction for district and state commissions, the creation of a dedicated mediation mechanism, and the introduction of product liability provisions that may be relevant where pharmaceutical or device negligence is involved. Kunal Saha v. AMRI Hospital, in which the National Commission awarded a then-record compensation of approximately Rs. 6.08 crore to the widower of a patient who died due to negligent treatment,

[14]Vinitha Ashok v. Lakshmi Hospital, (2001) 8 SCC 731 (India) (negligence of resident doctors attributed to the hospital institution).

[16]Spring Meadows Hospital v. Harjol Ahluwalia, (1998) 4 SCC 39 (India) (holding that medical services fall within the scope of the Consumer Protection Act, 1986).

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illustrates both the compensatory potential of the consumer fora and the scrutiny they now attract from the higher judiciary.[17]

CRIMINAL LIABILITY UNDER SECTION 304-A IPC

Section 304-A of the Indian Penal Code, 1860 penalises causing death by a rash or negligent act not amounting to culpable homicide. Its application to medical practitioners has generated enormous controversy. The provision was designed primarily for accidents caused by dangerous instrumentalities — vehicles, firearms, explosives — and its importation into the medical domain raises serious concerns about its fit with the inherently uncertain outcomes of clinical practice.[18]

Jacob Mathew addressed these concerns by prescribing a high threshold for criminal culpability. The Court emphasised that medical professionals make decisions under conditions of uncertainty, time pressure, and incomplete information, and that the criminal law should not be deployed against doctors merely because their judgment proved wrong in retrospect. The Court's direction requiring prior expert consultation before arrest has become a practical safeguard, though its implementation has been uneven across states.

Subsequent cases have continued to wrestle with the boundary between compensable civil negligence and criminally culpable negligence. Courts have generally held that for criminal liability to attach, the departure from the standard of care must be not merely negligent but egregiously so: leaving a foreign body inside a patient after surgery (as in Achutrao Haribhau Khodwa v. State of Maharashtra) or administering a manifestly contraindicated drug may cross the threshold. Diagnostic errors, differences of professional opinion about treatment choices, and adverse outcomes from procedures that carry known risks do not ordinarily warrant criminal prosecution.

CHAPTER 5 – CONSTITUTIONAL AND INTERNATIONAL DIMENSIONS

CONSTITUTIONAL FOUNDATIONS

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[17] Kunal Saha v. AMRI Hospital, Consumer Case No. 439 of 2003, National Consumer Disputes Redressal Commission, decided 24 October 2013.

The constitutional underpinnings of medical negligence law in India are rich and multi-dimensional. Article 21 of the Constitution — which guarantees that no person shall be deprived of life or personal liberty except according to procedure established by law — has been interpreted by the Supreme Court to encompass a positive right to health and, in the emergency context, a right to receive medical treatment without preconditions. In Pt. Parmanand Katara v. Union of India, the Court held that every doctor, whether private or public, is under a professional and constitutional obligation to extend emergency medical aid to any person, regardless of medico-legal complications, and that refusal to do so is unlawful.[19]

Paschim Banga Khet Mazdoor Samity extended this reasoning to the institutional level: where a public hospital fails to provide emergency treatment because of lack of facilities, and the patient suffers harm as a consequence, the State is liable for violation of the patient's right to life. This constitutional liability runs alongside, and is not displaced by, the civil and consumer law remedies.[20]

Article 19(1)(g) — the right to practise a profession — provides the constitutional counterweight. The medical profession is entitled to protection from arbitrary or disproportionate regulation that would effectively prevent competent doctors from practising. Provisions that impose liability without fault, that create unmanageable exposure to criminal prosecution for adverse outcomes, or that render the practice of medicine economically unsustainable engage this right. Courts have accordingly been alert to the need to calibrate liability standards in ways that do not deter the practice of medicine, particularly in high-risk specialities where the social need for skilled practitioners is acute.

The Directive Principles, particularly Article 38 (just social order), Article 39(e) (protection of health and strength of workers), and Article 47 (duty of the State to raise the standard of public health) collectively impose a constitutional obligation on the State to develop a healthcare system that minimises preventable harm. This constitutional obligation has been used to argue that the

[19]Pt. Parmanand Katara v. Union of India, (1989) 4 SCC 286 (India) (duty of every doctor to extend emergency medical aid irrespective of medico-legal formalities).

[20]Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37 (India) (right to emergency medical treatment as part of right to life under Article 21 of the Constitution).

absence of systematic patient safety legislation, mandatory adverse event reporting, and structured no-fault compensation mechanisms is itself a constitutional failure requiring judicial attention.

INTERNATIONAL AND COMPARATIVE DIMENSIONS

Comparative perspective illuminates both the distinctiveness of India's challenges and the range of solutions available. The United Kingdom, which gave India the Bolam test, subsequently qualified it significantly in Bolitho v. City and Hackney Health Authority, where the House of Lords held that the court was not bound to accept the opinion of a body of medical professionals if that opinion was not capable of withstanding logical analysis. The Montgomery v. Lanarkshire Health Board decision effectively overruled Sidaway and adopted a patient-centred standard for disclosure, marking a decisive shift away from medical paternalism. Indian courts have acknowledged these developments, though they have not yet formally adopted the Montgomery standard.

The United States, which relies primarily on state tort law for medical malpractice, has experienced decades of litigation over the appropriate standard of care, the role of expert evidence, the adequacy of damage caps, and the influence of defensive medicine on healthcare costs. The American experience suggests that purely adversarial litigation, untempered by no-fault or administrative alternatives, imposes enormous costs on the healthcare system without proportionate improvement in patient safety outcomes.

Australia and New Zealand have moved in different directions. Australia has statutory regimes in several states that modify the common law standard and cap non-economic damages. New Zealand operates a no-fault accident compensation scheme that covers medical injuries, removing them from the tort system entirely and providing administrative compensation without proof of negligence. The New Zealand model is frequently cited in Indian reform discussions as an alternative that prioritises victim compensation without the adversarial determination of fault — though its applicability to India's very different healthcare and fiscal environment requires careful assessment.

The World Health Organisation's Global Patient Safety Report 2024 underscores that medical errors remain a leading cause of preventable death and disability globally, and calls for systemic rather than individualistic responses: mandatory reporting of adverse events, creation of learning

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cultures in healthcare institutions, investment in safety protocols, and harmonisation of legal frameworks to ensure that the fear of litigation does not suppress the honest reporting of errors that is essential to systemic improvement.

CHAPTER 6 – EMERGING CHALLENGES: TECHNOLOGY AND MEDICAL NEGLIGENCE

TELEMEDICINE AND THE EVOLVING STANDARD OF CARE

The COVID-19 pandemic dramatically accelerated the adoption of telemedicine in India, and the Telemedicine Practice Guidelines, 2020 — issued under the Indian Medical Council Act — provided the first formal regulatory framework for remote clinical practice. However, the Guidelines raise as many legal questions as they resolve. The central challenge is the standard of care: when a doctor advises a patient remotely, without the benefit of physical examination, the quantum of information available to support clinical judgment is necessarily diminished. Should the standard of care reflect this limitation, accepting that remote diagnosis will sometimes be less accurate than in-person diagnosis? Or should the standard remain constant, requiring the doctor to recognise the limitations of telemedicine and to refer the patient for in-person evaluation wherever the clinical situation demands it?[21]

Indian courts have not yet definitively answered this question. The few decisions that have engaged with telemedicine negligence have tended to apply the general Jacob Mathew standard without modifying it for the remote context. Academic commentary has urged the development of a context-specific standard that takes account of the informational constraints of telemedicine while ensuring that doctors do not use those constraints as a shield against liability for careless remote diagnosis.[22]

The issue of prescribing through telemedicine adds further complexity. The Telemedicine Guidelines permit certain categories of prescription remotely but prohibit others — notably narcotic and psychotropic substances. Where a doctor prescribes remotely in excess of permitted

[21] Telemedicine Practice Guidelines, 2020, issued under the Indian Medical Council Act, 1956 (India), Gazette of India, March 25, 2020.

[22] M/S Safe Reach Telemedicine Pvt. Ltd. v. Dr. Amrita Singh, Complaint No. 123 of 2021, State Consumer Disputes Redressal Commission, Delhi (2022) (addressing negligence standard for telemedicine diagnosis).

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categories, or where the remote prescription of a permitted drug is inappropriate given the information available, the question of negligence liability is acute. The interaction between the Telemedicine Guidelines, the Drugs and Cosmetics Act, and the Narcotic Drugs and Psychotropic Substances Act creates a regulatory thicket that has not been comprehensively mapped in judicial or academic sources.

ROBOTIC SURGERY AND AI-ASSISTED DIAGNOSIS

Robotic-assisted surgery presents particular challenges for the law of medical negligence. When a surgeon operates through a robotic console, her control over the physical instruments acting on the patient's body is mediated by technology. A complication may be caused by the surgeon's judgment in directing the robot; by a malfunction in the robotic system itself; or by an interaction between the two. The attribution of responsibility across this tripartite relationship — surgeon, hospital as owner/operator of the robot, and manufacturer — requires careful analysis.[23]

The res ipsa loquitur doctrine, which allows an inference of negligence from the nature of the injury in circumstances where negligence is the only likely explanation, may not translate straightforwardly to robotic surgery. When a patient suffers an unexpected injury during robotic surgery, the question is whether the occurrence of that injury is more consistent with negligence or with a known risk of the procedure — a question that may require detailed expert evidence about the robotic system's capabilities, limitations, and failure modes. The Bombay High Court has begun to grapple with these issues, but authoritative guidance from the Supreme Court is still awaited.

Artificial intelligence presents the most profound and least-resolved challenges. AI tools are increasingly deployed in radiology, pathology, cardiology, and ophthalmology to analyse images and biological data and to assist in diagnosis. When an AI tool produces an erroneous output — misses a tumour, misclassifies a lesion, or fails to flag an arrhythmia — and the clinician relies on that output to the detriment of the patient, who bears responsibility? The clinician who deferred to the AI output without independent verification? The hospital that deployed the tool without adequate validation? The developer who trained and marketed the tool? Each of these parties may

[23]Bhalchandra Waman Pathe v. Union of India, W.P. No. 2616 of 2022, Bombay High Court (India) (discussing duty of care and informed consent in robotic-assisted surgery).

bear some responsibility, but existing negligence doctrine, designed for the attribution of human fault, provides limited guidance for allocating responsibility across this network of human and technological actors.

India's Digital Personal Data Protection Act, 2023 addresses some aspects of data use in healthcare but does not specifically regulate AI clinical decision support tools. The absence of a dedicated AI liability framework creates significant uncertainty for both patients and healthcare providers.

ELECTRONIC HEALTH RECORDS AND DATA NEGLIGENCE

The growing digitisation of health records creates a new category of negligence risk. Where a patient's electronic health record is inaccurate, incomplete, or inaccessible at the point of care, the treating doctor may make a clinical decision based on false or incomplete information. The question of responsibility — whether it lies with the doctor who failed to verify the record, the hospital that maintained the record system, or the vendor whose software produced the error — has not been resolved in Indian case law.[24]

Data security failures create related but distinct risks. Where a healthcare provider's system is breached and patient data is exposed, patients may suffer both direct harm — if the breach leads to identity theft or insurance fraud — and indirect harm — if it leads them to withhold sensitive information from future treating doctors. The intersection of data protection law, cybersecurity regulation, and the law of medical negligence is an emerging area that will require sustained judicial and legislative attention.

CHAPTER 7 – JUDICIAL TRENDS AND LANDMARK DECISIONS

EVOLUTION OF JUDICIAL DOCTRINE

The judicial history of medical negligence in India may be periodised into three broad phases. The first phase, running from independence to approximately 1990, was characterised by the application of general common law negligence principles with minimal specialisation: courts applied the reasonable professional standard without developing a distinctively Indian

[24]Information Technology Act, 2000, No. 21, Acts of Parliament, 2000 (India) (as amended in 2008) (applicable to electronic health records and telemedicine platforms).

jurisprudence of medical liability. Key decisions from this period include A.S. Mittal v. State of U.P., which confirmed state liability for the negligence of public hospital doctors, and Achutrao Haribhau Khodwa v. State of Maharashtra, in which the Supreme Court applied res ipsa loquitur to hold the State liable for leaving a mop inside a patient after surgery.[25]

The second phase was inaugurated by V.P. Shantha and the consequent flood of consumer forum litigation. This phase was marked by the democratisation of access to redress, the emergence of a large body of National Commission decisions developing doctrine on the standard of care, vicarious liability, and compensation, and ultimately by the Supreme Court's reformulation of the criminal negligence standard in Jacob Mathew. Martin F. D'Souza v. Mohd. Ishfaq, decided shortly after Jacob Mathew, added a procedural dimension by directing that consumer courts should not issue notices to doctors in medical negligence cases without first examining the complainant and taking expert opinion, a direction subsequently clarified and partially rolled back in later decisions.[26]

The third and current phase is defined by two related developments: first, the engagement of the higher judiciary with the structural dimensions of healthcare delivery — the accountability of corporate hospitals, the obligations of the State as a healthcare provider, and the systemic dimensions of patient safety; and second, the emergence of technology-related negligence as a doctrinal frontier. Recent decisions have begun to address these challenges, though the jurisprudence remains tentative and incomplete.

LANDMARK DECISIONS — AN ANALYTICAL OVERVIEW

Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka (2009) is significant for its robust approach to compensation. The Supreme Court awarded enhanced damages for the permanent disability caused to a young patient by negligent spinal surgery, articulating a principled methodology for calculating loss of future earning capacity and the costs of long-term care. The decision established that Indian courts will not be bound by English common law conservatism

[25] Achutrao Haribhau Khodwa v. State of Maharashtra, (1996) 2 SCC 634 (India) (res ipsa loquitur applied; liability of state for leaving a mop inside the patient after surgery).

[26] Martin F. D'Souza v. Mohd. Ishfaq, (2009) 3 SCC 1 (India). The Supreme Court cautioned against a tendency to file frivolous complaints and reminded courts of the need for expert opinion.

about the quantum of damages and that substantial compensation awards are appropriate where the injury is severe and permanent.[27]

Arun Kumar Manglik v. Chirayu Health & Medicare Pvt. Ltd. (2019) addressed the corporate hospital context. The Supreme Court held that a private hospital offering commercially priced services has non-delegable duties of patient safety that cannot be discharged merely by employing qualified professionals. Where the hospital's own protocols, equipment, or management decisions contribute to harm, the institution bears direct liability alongside or instead of any individual clinician.[28]

C.P. Sreekumar v. S. Ramanujam (2009) addressed the evidentiary dimension: the Court emphasised that in medical negligence cases, the plaintiff's case must be supported by credible expert evidence, and that courts should be cautious about making findings of negligence in the absence of such evidence. The decision represents a judicial acknowledgement of the limits of judicial competence in assessing complex clinical decisions without professional guidance.

More recent High Court decisions have begun to engage with newer dimensions. The Bombay High Court, in Bhalchandra Waman Pathe v. Union of India, grappled with the implications of robotic surgery for consent and negligence liability, concluding that the patient must be specifically informed of the robotic modality and its distinct risk profile. The Delhi High Court has addressed telemedicine negligence in a growing number of cases, while courts in southern India have developed reasonably robust jurisprudence on the accountability of large private hospital chains.

Poonam Verma v. Ashwin Patel remains an important decision on liability for practising outside one's area of competence. The Supreme Court held that a homoeopathic practitioner who prescribed allopathic medicines for a patient who subsequently died was liable for negligence, not because homoeopathic practice is inherently substandard, but because practising outside one's qualified domain is an inherent departure from the required standard of care. The case has broader implications: in a specialisation-driven healthcare environment, a general practitioner who

[27] Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka, (2009) 6 SCC 1 (India) (awarding enhanced compensation for permanent disability arising from negligent surgery).

manages a condition that requires specialist input without timely referral may face analogous liability.[29]

CHAPTER 8 – FINDINGS, CHALLENGES, AND REFORM PROPOSALS

FINDINGS FROM THE ANALYSIS

The foregoing analysis yields several important findings. First, the doctrinal framework of medical negligence in India, while broadly sound in its foundational principles, is under significant strain from the complexity of contemporary healthcare delivery. The Bolam standard, as modified by Jacob Mathew, remains the governing rule for both civil and criminal liability, but its application to institutional negligence, technology-mediated care, and systemic failures is uncertain.

Second, the plurality of forums — civil courts, consumer fora, criminal courts, and professional disciplinary bodies — generates inconsistency, duplicative proceedings, and barriers to access for patients who lack the resources to pursue concurrent litigation. The consumer fora, which were conceived as the primary avenue for redress, are increasingly congested, and the delays in disposal have significantly eroded their utility as a quick and efficient mechanism of redress.

Third, the criminal prosecution of doctors under Section 304-A, while limited in theory by the Jacob Mathew standard, continues in practice to generate enormous professional anxiety and to influence clinical decision-making in ways that may not serve patients well. The phenomenon of defensive medicine — the tendency to over-investigate, over-refer, and over-document in order to protect against liability rather than to serve the patient's clinical needs — imposes real costs on the healthcare system and on individual patients.

Fourth, the regulatory framework for private healthcare is demonstrably inadequate. The Clinical Establishments Act, 2010 has not been implemented uniformly across the country; several states have opted out of the central scheme or have enacted state legislation that falls short of the minimum standards. The National Medical Commission has inherited the regulatory functions of

[29] Poonam Verma v. Ashwin Patel, (1996) 4 SCC 332 (India) (liability of a practitioner treating patients outside their area of specialization).

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the Medical Council of India but has not yet demonstrated the independence, rigour, and effectiveness that the scale of the regulatory challenge demands.

Fifth, the existing legal framework provides no meaningful engagement with the liability implications of telemedicine, artificial intelligence, robotic surgery, or electronic health records. The absence of sector-specific standards creates uncertainty for all parties and, in the meantime, may expose patients to harms for which no effective legal remedy exists.

MAJOR CHALLENGES

The challenges confronting the law of medical negligence in India may be summarised as follows. The definitional challenge — precisely what conduct crosses the line from acceptable clinical judgment to compensable negligence — remains unresolved in several important domains. The institutional challenge — ensuring that corporate hospitals and large private healthcare chains bear appropriate accountability for systemic failures — is only partially addressed by existing doctrine. The technological challenge — adapting legal rules to a healthcare environment in which diagnosis, treatment, and monitoring are increasingly mediated by algorithms and machines — is barely begun.

The access challenge is equally pressing. Most victims of medical negligence in India lack the financial resources, legal sophistication, or social capital to pursue effective legal remedies. Class and gender dimensions are acute: poor patients, women, and socially marginalised communities are both more exposed to substandard care and less equipped to seek redress when things go wrong. Legal aid in medical negligence cases is largely unavailable, and pro bono representation is inadequate to the scale of the need.

The evidentiary challenge — obtaining expert evidence of adequate quality and independence — is a recurring obstacle to effective litigation. The pool of medical professionals willing to testify against colleagues is small, and courts have not developed effective mechanisms to ensure the independence and rigour of expert opinion. Expert shopping, paid experts who shade their opinions

to serve the retaining party, and the mutual discomfort of doctors appearing against each other in litigation are persistent features of the landscape.[30]

RECOMMENDATIONS FOR REFORM

The following reform proposals are advanced on the basis of the foregoing analysis:

1. Enactment of a Medical Negligence Act: India urgently requires a dedicated statute that consolidates the law of medical negligence, establishes a clear and context-sensitive standard of care, creates a no-fault compensation fund for serious medical injuries, and provides a structured process for investigation and compensation of claims without requiring proof of fault in every case. The statute should also decriminalise ordinary medical negligence, reserving criminal prosecution for gross and culpable departures from acceptable practice.

2. Reform of the Forum Structure: A dedicated Medical Negligence Tribunal, combining technical expertise with legal authority, would provide a more effective forum for adjudicating complex claims than the existing consumer fora or civil courts. The tribunal should include medical members with relevant expertise, should have powers to commission independent expert evidence, and should be required to give reasons for its decisions.

3. Mandatory Adverse Event Reporting: Following the model of aviation safety regulation, healthcare providers should be required to report all serious adverse events to an independent national patient safety authority, which would investigate systemic causes and make recommendations for improvement. The reports should be used for systemic learning rather than individual punishment, and should attract qualified privilege to encourage honest reporting.

4. Specific Regulation of AI and Robotic Surgery: The government should issue specific regulatory guidance on the use of artificial intelligence and robotic surgery, establishing minimum standards for validation, deployment, and audit of AI clinical decision support tools, and allocating liability between clinicians, hospitals, and manufacturers through a clear framework.

[30] C.P. Sreekumar (Dr.) v. S. Ramanujam, (2009) 7 SCC 130 (India) (importance of expert evidence and medical literature in adjudicating negligence claims).

5. Strengthened Telemedicine Regulation: The Telemedicine Practice Guidelines should be elevated from advisory to statutory status, should specify the standard of care applicable to remote consultation, and should establish clear rules for informed consent in the telemedicine context.

6. Legal Aid and Access to Justice: The Legal Services Authorities at the state and district level should develop dedicated medical negligence legal aid programmes, providing representation and initial expert opinion funding to patients who cannot afford to pursue claims independently.

CHAPTER 9 – CONCLUSION

The law of medical negligence in India stands at an inflection point. The foundational doctrines — the duty of care, the Bolam standard as modified by Jacob Mathew, the principle of informed consent established in Samira Kohli, and the vicarious liability of institutions — provide a reasonably coherent framework for the resolution of disputes arising from conventional medical practice. The consumer protection route, opened by V.P. Shantha, has substantially improved access to redress for ordinary patients, even as it has generated new complexities and tensions.

However, the emerging challenges of the twenty-first century healthcare environment — institutional complexity, technological mediation of clinical practice, the growing scale of corporate healthcare chains, the digital transformation of health records, and the deployment of artificial intelligence in diagnosis and treatment — are straining this framework to its limits. The existing doctrines were developed for a simpler world in which a doctor treated a patient directly, with relatively transparent interventions and identifiable outcomes. They are increasingly inadequate to the world in which most healthcare is now delivered.

The reform agenda is correspondingly ambitious. A dedicated Medical Negligence Act that integrates civil, criminal, and administrative dimensions; a restructured forum with appropriate technical expertise; a mandatory patient safety reporting system; specific regulation of AI and robotic surgery; enhanced telemedicine standards; and substantially improved access to legal aid are the minimum conditions for an adequate legal response to the challenges of contemporary medical practice. None of these reforms is technically or legally impossible. Each requires political will, inter-departmental coordination, and engagement with both the medical profession and patient advocacy organizations.