RECALIBRATING CRIMINAL CULPABILITY IN MEDICAL NEGLIGENCE: INDIAN LAW IN TRANSITION

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ABSTRACT

The rapid expansion of medical services and enhanced access to healthcare in recent years have fundamentally altered the landscape of medical practice. This growth has been accompanied by a noticeable increase in allegations of medical negligence and malpractice, both in India and globally. The prevailing legal regime governing medical negligence reflects a dual inadequacy: procedural hurdles and the burdens of litigation deter many victims from pursuing legal remedies, allowing certain negligent acts to evade scrutiny, while the looming threat of criminal prosecution fosters excessive caution among medical professionals. Such over-deterrence often results in defensive medical practices, inflating healthcare costs and constraining professional judgment. Against this backdrop, the present paper undertakes a critical analysis of the concept of medical negligence, with particular emphasis on its criminal law implications. It examines the evolving standards of criminal culpability applicable to medical professionals in India, tracing judicial interpretations, statutory developments, and comparative legal approaches. The paper highlights the shifting contours of criminal liability and interrogates whether existing thresholds adequately balance patient protection with medical autonomy. By situating Indian jurisprudence within a transitional legal framework, the study advocates a recalibrated approach to criminal liability that is principled, proportionate, and responsive to the realities of contemporary healthcare delivery.

Keywords: Medical, Negligence, Litigation, Malpractice, Health Care, Consumers, Liability, criminal liability.

I. Concept of Medical Negligence and Grounds of Liability

The position of the medical professional in contemporary society has undergone a profound transformation. While the doctor continues to serve a vital public function, the relationship between the physician and the patient is no longer governed by unquestioned paternalism. Modern society, increasingly informed though not uniformly about medical science and healthcare rights, exhibits a marked scepticism towards unilateral decision-making by medical practitioners. The traditional paternalistic model has gradually given way to a framework grounded in autonomy, accountability, and informed choice. The language of "provider and consumer" has become firmly entrenched, reflecting the acceptance of the principle that the recipient of medical services possesses a legitimate voice in determining the course of treatment. Correspondingly, the competent patient's inalienable right to be adequately informed, and to consent to or refuse medical intervention, now stands as a settled principle of medical jurisprudence.

The medical profession has rendered immeasurable service to humanity through the prevention of disease and the restoration of health. Medical service, in its true sense, encompasses professional assistance or benefits relating to the science and practice of medicine, directed towards the preservation of health and the treatment of illness. It necessarily implies the delivery of competent and quality healthcare to the community at large. Thus, medical service is not merely a contractual or commercial activity but a service rendered in furtherance of human welfare, aimed at alleviating suffering and restoring bodily integrity. Beyond the curative role, the physician also functions as an educator, guiding patients on matters of health maintenance and disease prevention. In legal parlance, a doctor is understood to be a duly qualified practitioner of medicine or surgery in any of its recognised branches, while a patient refers to an individual receiving treatment for illness or injury. Flowing from this professional relationship is a legal duty cast upon the doctor to exercise reasonable skill, care, diligence, and judgment in the diagnosis and treatment of patients. Any failure to adhere to this standard of care gives rise to liability for medical negligence or malpractice.

The doctrines of negligence and medical malpractice, as recognised in common law, formally emerged during the nineteenth century, although their conceptual origins can be traced to earlier legal actions founded in trespass and assumpsit. A historical analysis of medical malpractice reveals that the distinction often drawn between negligence and malpractice evolved largely as

a matter of legal happenstance rather than principled reasoning. This artificial differentiation lacks a coherent doctrinal foundation and has, over time, contributed more to conceptual ambiguity than to legal clarity. The notion of medical accountability is not a modern development. References to medical responsibility can be traced as far back as 2030 BCE, when the Code of Hammurabi prescribed severe penalties for physicians whose interventions resulted in grave harm. Under Roman law, medical malpractice was expressly recognised as a civil wrong. By the thirteenth century, Roman legal principles were received and expanded across continental Europe. In England, following the Norman Conquest of 1066, the development of common law laid the foundation for a consistent body of medical negligence jurisprudence. During the reign of Richard I in the late twelfth century, systematic records maintained in the Court of Common Pleas and the Plea Rolls reveal an unbroken chain of medical malpractice adjudication extending to the modern era. Early English cases demonstrate that both servants and their masters could maintain actions for damages against physicians whose negligent treatment aggravated illness through the administration of harmful remedies.

A significant institutional development occurred in 1532 during the reign of Charles V, when legislation mandated the formal consultation of medical experts in cases involving violent death. This requirement marked an important precursor to the modern principle that expert medical testimony is essential in determining the standard of care in medical negligence litigation. At the international level, the recognition of health as a fundamental human right reinforces the ethical and legal obligations of medical professionals. Article 25 of the UNDHR[1] affirms the right of every individual to an adequate standard of living conducive to health and well-being, including access to medical care and essential social services. It further accords special protection to motherhood and childhood, emphasising equal social safeguards for all children irrespective of birth status. These principles, later reflected in binding international covenants, underscore the universal commitment to healthcare as an integral component of human dignity and social justice.

II. International Recognition of the Right to Health and Conceptual Foundations of Negligence and Medical Malpractice

Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 affirms the recognition by States Parties of the right of every individual to the enjoyment of the

[1] Universal Declaration of Human Rights, 1948

highest attainable standard of physical and mental health. To ensure the progressive realisation of this right, the Covenant obligates States to undertake concrete measures, including the reduction of stillbirth and infant mortality rates, the promotion of healthy child development, improvement of environmental and industrial hygiene, prevention and control of epidemic, endemic, occupational and other diseases, and the creation of conditions that guarantee access to medical services and medical attention in cases of illness.[2]These international commitments are further reinforced by subsequent human rights instruments, including the United Nations Declaration on the Elimination of All Forms of Discrimination against Women, 1967, the Convention on the Elimination of All Forms of Discrimination against Women, 1979, and the Convention on the Rights of the Child, 1989. Collectively, these instruments recognise and seek to protect the healthcare rights of individuals, with particular emphasis on women, children, and other vulnerable or disadvantaged sections of society.[3] The World Health Organization has, for more than five decades, played a central role in shaping global and national health policies, offering technical guidance and normative frameworks aimed at achieving the highest possible standards of healthcare for all populations worldwide.[4] This international emphasis on health as a human right underscores the importance of accountability mechanisms within healthcare systems, particularly in addressing instances of professional negligence.

At a conceptual level, negligence and medical malpractice are often mistakenly treated as synonymous; however, a closer legal examination reveals important distinctions. Medical malpractice is properly understood as a specific subcategory within the broader doctrine of negligence. While the terms are frequently used interchangeably in common discourse, they represent distinct legal concepts differentiated primarily by the element of intent. Negligence occupies an intermediary position, encompassing conduct that may occur with or without intent, whereas medical negligence refers specifically to unintentional lapses or omissions within the medical context. Medical malpractice, by contrast, involves conduct that deviates from accepted medical standards with a degree of recklessness or intentional disregard that results in serious harm. Negligence, in its general sense, arises when an individual fails to discharge a basic duty of care owed to others, and such failure results in injury or loss. The

[2] International Covenant on Economic, Social and Cultural Rights,1966, art. 12.
[3] United Nations Declaration on the Elimination of All Forms of Discrimination against Women, 1967; Convention on the Elimination of All Forms of Discrimination against Women, 1979; Convention on the Rights of the Child, 1989.
[4] Constitution of the World Health Organization, 1946; WHO, *Health Systems Governance for Universal Health Coverage* (WHO 2014).

harm caused by negligent conduct may be physical, financial, or emotional in nature. Although all human actions carry consequences, liability in negligence arises when those consequences are the foreseeable result of inaction, carelessness, or ignorance rather than a deliberate intention to cause harm. Any individual may act negligently, and the avoidance of negligence requires adherence to ordinary standards of reasonable conduct and civic responsibility.

The doctrine of negligence entered the common law during the seventeenth century, a period marked by increasing social interaction and mobility, particularly reflected in disputes arising from horse-drawn carriage accidents on public highways. This era witnessed a gradual yet significant doctrinal shift from actions grounded in *trespass on the case* to a distinct cause of action based on negligence. In its modern articulation, the law of negligence is not indigenous to Indian jurisprudence but is substantially derived from English common law, where negligence has evolved as an independent tort. An understanding of the English legal position is therefore essential to appreciate the foundations of medical negligence in India.

Initially, negligence was perceived primarily as inadvertence or carelessness, distinguished from deliberate or intentional breaches of legal duty. Mere carelessness, however, does not attract legal liability unless it is accompanied by the existence of a duty of care and demonstrable damage resulting from its breach. When carelessness satisfies these conditions, it assumes juridical significance and gives rise to the legal consequences associated with negligence. Given that every profession demands a particular degree of specialized knowledge, skill, and learning, individuals professing such expertise may incur liability if they fail to exercise the level of care commensurate with their professional undertaking. English law encapsulates this principle in the maxim *imperitia culpa annumeratur*, signifying that lack of requisite skill itself constitutes a fault.[5]

In legal terms, a claim of negligence is established through four essential elements: the existence of a duty of care, breach of that duty, a causal connection between the breach and the harm suffered, and the resulting damage. These elements must be proved cumulatively for liability to arise. Negligence thus functions as an umbrella concept, encompassing various forms such as ordinary negligence, criminal negligence, medical negligence, and medical malpractice, each assessed according to the specific factual and professional context involved. The evidentiary sequence requires, first, identification of the precise duty owed, followed by

[5] *Imperitia culpa annumeratur* — lack of skill is counted as negligence.

demonstration of how that duty was breached, proof of causation, and finally quantification of damages suffered by the claimant. The frequent conflation of negligence, medical negligence, and medical malpractice stems from their shared structural elements, notwithstanding the crucial distinction of intent. Illustratively, a motorist who causes an accident by texting while driving, or by failing to maintain vehicle brakes, may be held negligent due to a breach of the duty of care owed to other road users. In such cases, liability arises not from intent but from inattentiveness or omission that foreseeably endangers others.

Medical negligence similarly involves a failure to act in accordance with the standard of care expected of a reasonably competent medical professional, absent any intention to cause harm. Common instances include failure to revise an incorrect diagnosis, failure to warn patients of material risks, failure to provide timely treatment, or misdiagnosis. Medical malpractice, on the other hand, signifies conduct that goes beyond mere error or omission. The Latin prefix *mal* meaning "bad" captures the qualitative difference inherent in malpractice, denoting serious deviation from accepted medical standards, often accompanied by recklessness or conscious disregard for patient safety. Such conduct may result in grave outcomes, including wrongful death, errors during childbirth, anaesthetic mishaps, or surgical mistakes, thereby attracting heightened legal scrutiny and liability.

III. Medical Malpractice

Medical malpractice litigation in the United States began to emerge with some regularity during the nineteenth century. Nevertheless, until the mid-twentieth century particularly prior to the 1960s claims alleging professional negligence against physicians remained relatively infrequent and exerted minimal influence on everyday medical practice. This position altered markedly in the latter half of the twentieth century, when malpractice litigation expanded both in volume and visibility. Since that period, the incidence of claims has risen substantially, rendering malpractice lawsuits a routine feature of the contemporary healthcare system in the United States.

Empirical studies underscore the pervasiveness of this phenomenon. Surveys conducted among high-risk medical specialties, including orthopaedic and arthroplasty surgeons, indicate that a significant majority of practitioners often exceeding seventy per cent have faced at least

one malpractice claim during the course of their professional careers.[6]The implication is that exposure to medico-legal proceedings is no longer exceptional but constitutes a foreseeable professional risk for physicians, particularly those engaged in procedural or surgical practice. Once a malpractice action is initiated, the defendant physician is compelled to navigate a legal environment that differs fundamentally from clinical practice. The objectives of litigation, the standards governing professional conduct, and the procedural norms adopted by courts and legal counsel operate according to principles distinct from those guiding medical decision-making. Consequently, physicians often find themselves operating within an unfamiliar institutional framework, where legal accountability, rather than therapeutic judgment, becomes the central focus of scrutiny.

IV. Medical Negligence in Maternity Hospitals in India

Maternal healthcare is an essential component of the right to life under Article 21 of the Indian Constitution.[7] India has made considerable progress in reducing its Maternal Mortality Ratio (MMR); however, incidents of medical negligence in maternity hospitals—both public and private—remain frequent. These incidents highlight systemic deficiencies in infrastructure, staffing, training, and accountability mechanisms. Medical negligence in maternity care can occur at various stages, including antenatal care, labour and delivery, and postnatal management. Given the vulnerability of pregnant women and newborns, even minor lapses can result in irreversible harm.

a) Concept and Legal Meaning of Medical Negligence

Medical negligence refers to a failure by a medical professional to exercise reasonable skill and care, resulting in harm to the patient.[8] The Supreme Court of India has consistently held that negligence must be assessed based on the standard of care expected from an ordinarily competent medical practitioner.[9]

b) Essential Elements of Medical Negligence

[6] David M. Studdert et al., "Prevalence and Characteristics of Physicians Sued for Malpractice," *New England Journal of Medicine* 354, no. 6 (2006): 629–636.
[7] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37.
[8] Black's Law Dictionary, 11th ed.
[9] Jacob Mathew v. State of Punjab, (2005) 6 SCC 1.

Duty of care

Existence of a doctor–patient relationship

Breach of duty

Failure to follow accepted medical standards

Direct link between breach and injury

Actual harm suffered by patient

c) Medical Negligence in Maternity Hospitals: Nature and Scope

Medical negligence in maternity hospitals commonly manifests in the following forms:

Delay in attending labour cases

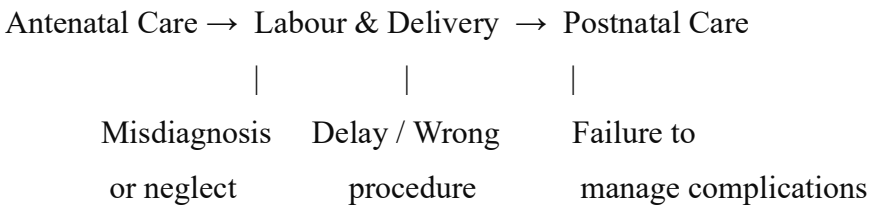
Improper monitoring of foetal distress

Wrong administration of drugs or anaesthesia

Unnecessary or delayed caesarean sections

Poor postnatal monitoring

Figure 1: Stages Where Maternity Negligence Commonly Occurs



Recent incidents reported across India—including unattended deliveries, failure to inform relatives of complications, and procedural mistakes—demonstrate that negligence is often systemic rather than incidental.[10]

[10] Times of India reports on maternity negligence incidents across Indian states.

d) Causes of Medical Negligence in Maternity Hospitals

i) Infrastructure and Staffing Deficiencies

Many public maternity hospitals operate under severe pressure due to overcrowding, inadequate labour rooms, and shortage of trained obstetricians and nurses.[11]

ii) Lack of Training and Protocol Compliance

Failure to follow Standard Treatment Guidelines (STGs) and lack of emergency obstetric care training contribute significantly to adverse outcomes.

e) Common Causes and Their Consequences

Staff shortage

Delay in delivery management

Poor training

Wrong clinical decisions

Communication failure

Lack of informed consent

Inadequate equipment

Maternal or neonatal death

f) Legal Framework Governing Medical Negligence in India

Medical negligence in maternity care can attract civil, criminal, and consumer liability.

a) Consumer Protection Act, 2019

Healthcare services fall within the definition of "service," allowing aggrieved patients or

[11] Ministry of Health and Family Welfare, National Health Profile.

families to seek compensation for deficiency in service.[12]

b) Criminal Liability

Under Section 304A of the Indian Penal Code, criminal liability may arise in cases of gross negligence causing death.[13] However, courts exercise caution to avoid criminalising medical judgment errors.[14]

c) Vicarious Liability of Hospitals

Hospitals are vicariously liable for negligent acts of doctors and staff employed by them.[15]This principle strengthens institutional accountability in maternity negligence cases.

g) Impact of Medical Negligence on Maternal and Neonatal Health

Medical negligence results in:

Maternal deaths and lifelong disability

Birth injuries and neonatal mortality

Psychological trauma to families

Erosion of trust in healthcare institutions

Consequences of Maternity Negligence

Medical Negligence

↓

Physical Harm → Psychological Trauma → Social & Economic Loss

h) Challenges in Proving Maternity Negligence

Despite legal remedies, victims face hurdles such as:

[12] Consumer Protection Act, 2019, s. 2(42).
[13] Indian Penal Code, 1860, s. 304A.
[14] Dr. Suresh Gupta v. Govt. of NCT of Delhi, (2004) 6 SCC 422.
[15] Spring Meadows Hospital v. Harjol Ahluwalia, (1998) 4 SCC 39.

Difficulty in accessing medical records

High burden of proof

Medical expert bias

Lengthy litigation process

Consumer forums often dismiss claims when negligence is not conclusively proven, even where adverse outcomes exist.[16]

i) Recommendations

Mandatory training in emergency obstetric care

Clinical audits and maternal death review committees

Clear informed consent protocols

Strengthening grievance redressal mechanisms

Awareness programmes for pregnant women regarding patient rights

Medical negligence in maternity hospitals undermines the constitutional promise of safe and dignified healthcare for women. While legal frameworks provide remedies, prevention through systemic reform, accountability, and professional ethics is imperative. Ensuring safe motherhood requires not only legal intervention but also sustained investment in healthcare quality and human resources.

Authoritative jurists have provided enduring definitions of negligence that continue to shape its legal contours. Winfield characterizes negligence as the breach of a legal duty to take care, resulting in damage to another, which is undesired by the defendant.[17]Baron Alderson, in a classic formulation, defined negligence as the omission to do something which a reasonable person, guided by considerations that ordinarily regulate human conduct, would do, or the commission of an act which such a person would refrain from doing.[18]Charlesworth refined

[16] National Consumer Disputes Redressal Commission decisions on medical negligence.
[17] P. H. Winfield, *The Law of Tort* (Sweet & Maxwell, London).
[18] *Blyth v. Birmingham Waterworks Co.* (1856) 11 Ex 781.

this definition by emphasizing that negligence consists in the breach of a duty imposed by law to take care, leading to damage to the complainant, whether through an act or an omission inconsistent with the conduct of a reasonably prudent person in comparable circumstances.[19]

In the context of healthcare, the law relating to medical negligence has developed predominantly through civil liability rather than criminal prosecution. Although the offence of gross negligence manslaughter continues to exist in theory, it is infrequently invoked in medical settings. In practice, instances involving allegations of gross negligence are often resolved internally or through civil proceedings, partly to mitigate reputational harm to the profession. Over time, the conception of negligence has evolved to reflect changing professional standards and societal expectations. Winfield notes that even medieval law recognized forms of negligence, understood broadly as conduct deviating from what a responsible individual would or would not have done under similar circumstances[20]

The seminal English decision in *R v. Bateman* significantly clarified the duties and liabilities of medical practitioners.[6][21] The court held that a medical professional who represents himself as possessing particular skills is legally bound to exercise reasonable care, diligence, knowledge, and competence in the treatment of patients. The law does not demand an exceptionally high or unattainable standard of care, nor does it tolerate a substandard or negligent one; rather, it insists upon a fair and reasonable level of professional competence. Importantly, liability does not depend upon whether the practitioner is highly qualified or minimally trained, nor upon whether the services are rendered gratuitously or for remuneration. A practitioner is, however, entitled to decline treatment if the case lies beyond his professional competence. In determining whether the requisite standard of care has been met, courts must take into account a range of contextual factors, including the practitioner's professional standing and specialization, the prevailing state of medical knowledge, the availability of infrastructure and facilities, and the conditions of practice in the relevant locality. This balanced and pragmatic approach, firmly established within the English judicial system, has profoundly influenced the development of medical negligence jurisprudence in common law jurisdictions, including India.

[19] R. M. Jackson & J. L. Powell, *Charlesworth & Percy on Negligence* (Sweet & Maxwell).
[20] P. H. Winfield, *The Province of the Law of Tort*.
[21] *R v. Bateman* (1925) 19 Cr App R 8.

V. Changing Dimensions of Criminal Liability

While medical negligence has traditionally been addressed within the domain of civil liability, the contours of criminal liability in the healthcare context have undergone significant transformation over time. Historically, criminal law intervened only in exceptional cases involving gross negligence or recklessness, reflecting judicial reluctance to criminalize professional errors committed in the course of medical practice. However, with the increasing recognition of patient rights, heightened public awareness, and growing expectations of accountability within healthcare systems, the threshold for invoking criminal liability has been subjected to closer scrutiny. Contemporary jurisprudence acknowledges that while mere errors of judgment or ordinary negligence should not attract criminal sanctions, conduct displaying gross negligence, a blatant disregard for patient safety, or a conscious departure from accepted medical standards may warrant criminal prosecution.

This evolving approach seeks to strike a delicate balance between protecting patients from egregious professional misconduct and safeguarding medical practitioners from the chilling effect of excessive criminalization. Courts have emphasized that criminal liability must be confined to cases where negligence transcends civil wrongfulness and assumes the character of moral blameworthiness, typically evidenced by recklessness or a degree of negligence so gross as to endanger life. The shift reflects a nuanced understanding that medicine, by its very nature, involves uncertainty and risk, yet demands accountability where professional conduct falls far below acceptable norms. Consequently, the changing dimensions of criminal liability in medical negligence signify a move away from blanket immunity towards a calibrated legal framework one that integrates patient protection, professional autonomy, and the overarching objectives of criminal justice.

VI. The New Criminal Law Perspective

The changing dimensions of criminal liability in cases of medical negligence acquire renewed significance under India's restructured criminal law framework introduced through the Bharatiya Nyaya Sanhita, 2023 (BNS) and the Bharatiya Nagarik Suraksha Sanhita, 2023 (BNSS). While the classical position confined criminal liability of medical professionals to instances of gross negligence amounting to recklessness, the new legislative regime reinforces a more calibrated and rights-sensitive approach. The emphasis continues to remain on distinguishing civil negligence from criminal culpability, thereby preserving the long-standing

judicial principle that criminal sanctions should be invoked only when professional conduct exhibits a high degree of moral blameworthiness or a callous disregard for human life.

Under the BNS, offences corresponding to causing death or grievous harm by negligence retain the foundational requirement of *gross* or *culpable* negligence, thereby aligning statutory language with established judicial precedents such as *Jacob Mathew v. State of Punjab*.[22] Importantly, the rearticulation of negligence-based offences under the new code reflects legislative intent to prevent the routine criminalization of medical errors arising from bona fide judgment, diagnostic complexity, or systemic constraints. The BNSS further strengthens procedural safeguards by reinforcing fair investigation standards, thereby reducing the scope for arbitrary prosecution of healthcare professionals at the pre-trial stage.

The new criminal law framework thus represents a doctrinal continuity rather than a rupture. It integrates patient safety concerns with constitutional values of fairness, proportionality, and professional autonomy. Criminal liability in medical negligence cases, even under the reformed codes, remains an exception rather than the rule triggered only when negligence transcends civil liability and enters the realm of recklessness or gross disregard for life. This legislative recalibration underscores a broader jurisprudential shift: from punitive reflexes toward a balanced accountability model that recognizes both the inherent risks of medical practice and the imperative of protecting patients from egregious professional misconduct.

VII. Conclusion

The foregoing analysis has outlined the principal theoretical foundations governing tortious liability, with particular reference to negligence in the medical context. Negligence, in its classical legal formulation, consists in the breach of a duty of care arising either from the failure to do something that a reasonable person, guided by ordinary considerations of human conduct, would have done, or from doing an act that such a person would have avoided. The tort of negligence is thus structured around three essential elements: the existence of a duty of care, a breach of that duty, and consequential damage suffered by the claimant. Within the framework of tort law, the burden of establishing medical negligence rests upon the claimant and must be discharged on the standard of the preponderance of probabilities. In practice, however, this burden often proves onerous. Victims of medical negligence frequently encounter substantial

[22] *Jacob Mathew v. State of Punjab* (2005) 6 SCC 1.

evidentiary obstacles, chief among them being limited or delayed access to medical records and expert evidence necessary to substantiate claims of professional breach. The inherent complexity of medical procedures, coupled with the technical nature of negligence doctrine, further compounds the difficulty faced by claimants in pursuing civil remedies against medical practitioners or hospital authorities. Given these practical constraints, the traditional tort-based mechanism has often been found inadequate in providing timely and effective redress to victims of medical negligence. In this context, recourse to remedies available under consumer protection legislation assumes particular significance. Judicial interpretation has consistently recognized medical services as falling within the ambit of consumer law, thereby enabling patients to seek relief through a more accessible, cost-effective, and expeditious adjudicatory framework. Consequently, while tort law continues to provide the conceptual foundation for medical negligence claims, consumer protection fora offer a more efficacious remedial avenue, better aligned with the needs of aggrieved patients and the realities of contemporary healthcare litigation.