ROLE OF NEGLIGENCE IN MEDICAL MALPRACTICE CASES IN INDIA

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ABSTRACT

This paper examines how important negligence is in shaping medical malpractice cases in India. It surveys statutory frameworks (including Consumer Protection Act, 2019 and the Indian Penal Code), landmark Supreme Court authorities (notably Indian Medical Association vs. V.P. Shantha, Jacob Mathew vs. State of Punjab, Samira Kohli vs. Dr. Prabha Manchanda, Kusum Sharma vs. Batra Hospital), evidentiary rules (expert evidence, medical records, and res ipsa loquitur), and emerging problems. The paper argues that while negligence remains the doctrinal fulcrum of liability, recurring gaps in data, guidelines and specialised dispute – resolution mechanisms produce uncertainty and defensive medicine. It offers reform suggestions: clearer clinical standards, mandated documentation practices, statutory mediation for medical disputes, and sector – specific rules to allocate responsibility in telemedicine and AI – Supported care.

INTRODUCTION

Negligence is the central element on which malpractice litigation turns. In India, courts often ask whether a healthcare provider did not show the skill, knowledge, and care that a reasonably skilled professional would have in the same situation and whether that failure caused harm to the patient. The Indian Legal system overlays common-law standards (for e.g., the Bolam principle and the Bolitho gloss) on top of local statues and constitutional expectations, producing a distinctive jurisprudence, balancing patient protection and clinical discretion. This paper maps the jurisprudence, analyses evidentiary and doctrinal issues, and highlights policy gaps requiring reform.

STATUTORY FRAMEWORK

A. Consumer Protection Act, 2019

Medical treatment provided for consideration is treated as a "service" under the **CPA** architecture, which allows patients to seek compensation in consumer fora for "deficiency in service". Although the early versions of the CPA, 2019 raised doubts about whether health services were clearly included, experts and courts generally treat medical services as covered by the Act-unless they are completely free or only for personal use. The consumer route remains the dominant civil mechanism for compensation claims

B. Bharatiya Nyaya Sanhita - Section 106(1) – Criminal Negligence

Section 106(1) of the **BNS** corresponds to **Section 304A** of the Indian Penal Code. It criminalises causing death by a rash or negligent act not amounting to culpable homicide. However, criminal liability under this provision requires proof of a higher degree of negligence, often termed as gross or reckless negligence. The Supreme Court, in **Jacob Mathew vs. State of Punjab (2005),** directed that prosecution of medical professionals should proceed only after obtaining an independent expert medical opinion, so as to prevent harassment for ordinary complications or human error.

C. Bharatiya Nyaya Sanhita – Sections 125, 125(a) & 125(b): Acts Endangering Life and Negligent Conduct

Sections 125, 125(a), and 125(b) of the **BNS**, deals with situations where a person's act or

carelessness puts another person's life or safety in danger, even if no death occurs. In medical practice, these provisions apply to doctors or hospitals when they act recklessly or fail to take proper precautions that could put a patient at risk. These sections cover both wrongful actions and careless omissions, such as:

- Doing a surgery or treatment without proper sterilisation or care.
- Ignoring medical guidelines or warning signs during treatment.
- Giving the wrong medicine, wrong dosage, or mishandling anaesthetics or injections.
- Not taking steps to prevent harm or ensure patient safety.

Together, these provisions expand the doctor's legal duty of care beyond cases of death (as covered under **Section 106**) to include any conduct that endangers a patient's life or health. They highlight that doctors and hospitals must always act with reasonable skill, caution, and responsibility while treating patients

D. Bharatiya Nyaya Sanhita – Section 131: Causing Miscarriage or Injury to Unborn Child

Section 131 applies to cases where medical negligence during pregnancy or childbirth causes a **miscarriage, premature birth, or harm to the unborn child.** This can happen due to **unsafe medicines, careless surgery,** or **failure to properly monitor the mother's condition** during treatment. This section shows that doctors have a **legal duty of care toward both the mother and the unborn child.** It also relates to the case of ***State of Haryana vs. Santra (2000)***, where the court held a doctor responsible for negligence during sterilisation that led to an unwanted pregnancy.

E. Bharatiya Nyaya Sanhita – Sections 271: Forgery of Medical Certificates

Sections 271 of the **BNS** penalizes medical practitioners or staff who **dishonestly prepare, alter, or falsify medical certificates.** The provision ensures the **authenticity and integrity of medical records,** which serve as crucial evidence in medical negligence cases. It upholds ethical conduct within the medical profession by discouraging any form of documentary manipulation.

F. Bharatiya Nyaya Sanhita – Sections 272: Use of False Medical Certificates

Section 272 of the **BNS** punishes individuals who **knowingly use forged or falsified medical certificates** as genuine. This section aims to prevent the **misuse of fraudulent medical documents** in legal, administrative, or professional contexts and to maintain the **credibility of medical evidence** in matters concerning medical negligence or malpractice.

This combined framework shows how the ***Bharatiya Nyaya Sanhita, 2023*** and the ***Consumer Protection Act, 2019*** work together to form a **comprehensive legal system.** It covers **civil compensation, criminal negligence, proper legal procedures, and honest record-keeping**, ensuring **fairness and accountability** in medical malpractice cases.

➢ KEY ELEMENTS TO PROVE MEDICAL NEGLIGENCE

Indian courts consistently hold that four essential elements must be proved for a successful claim of medical negligence. These elements talk about general tort principles of negligence but are applied with sensitivity to the medical context:

A. Existence of a Duty of Care:-

- The first requirement is that a legal duty of care was owned by the doctor or hospital to the patient.
- A doctor–patient relationship builds either contractually or fiduciary.
- Once established, the professional is legally bound to exercise reasonable care, skill and diligence.
- **Case Law:** In Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole (1969), the Supreme Court held that a doctor owes duties of care in deciding what treatment to administer and in administering that treatment.

B. Breach of Duty of Care:-

- The claimant must prove that the doctor/hospital failed to exercise the degree of care expected of a reasonably competent professional in that situation.

- Courts apply the Bolam test - whether the conduct was in accordance with a practice accepted by a responsible body of medical professionals.

- **Case Law:** Kusum Sharma vs. Batra Hospital (2010) clearly stated that a mere difference in opinion or an error of judgement is not negligence unless the practice followed was noticeably unreasonable.

C. Causation (Link Between Breach and Injury):-

- There must be a close-casual connection between the breach of duty and the harm suffered by the patient.

- The claimant must show that the injury would not have occurred but for the defendant's negligence.

- Courts are cautious here: complications or poor outcomes are not automatically attributable to negligence.

- **Case Law:** Spring Meadows Hospital vs. Harjol Ahluwalia (1998) illustrates liability where a nurse's negligent administration of a wrong injection directly caused injury.

D. Resultant Damage (Injury, Loss or Death):-

- Actual harm must have resulted from the breach. This can be physical injury, prolonged illness, additional medical expenses, loss of income or even death.

- Without proof of damage, negligence claims do not succeed even if duty and breach are shown.

- **Case Law:** In State of Haryana vs. Smt. Santra (2000), the Supreme Court awarded compensation where negligent sterilisation surgery resulted in the woman giving birth, causing physical and mental suffering.

DOCTRINAL TESTS: BOLAM, BOLITHO AND INDIAN ADAPTATIONS

Historically, Indian courts have relied on the Bolam test (a legal rule that says a doctor is not considered careless if their actions are backed by other reasonable doctors). Over time, courts

introduced the Bolitho gloss, that is, the professional opinion relied on must be reasonable and defensible in logic. Indian courts apply these rules carefully. If there are different valid expert opinions, the court won't judge the action wrong if one of those opinions supports them. Landmark Supreme Court decisions iteratively shaped this balance.

EVIDENCE AND PROOF: EXPERTS, RECORDS AND RES IPSA LOQUITUR

A. Expert Evidence

Expert testimony is the key to showing breach of duty and if it caused harm. Courts check how trustworthy the medical experts are and how logical their views are. Courts often trust agreement between independent experts and may get neutral expert opinions in difficult cases.

B. Medical Records and Documentation

Strong medical records often decide the case. Courts see records made at the time of treatment as the main proof about what happened, including consent and any problems. Weak or missing records usually count against the doctor. Experts often suggest using standard record-keeping to avoid legal trouble and make the facts clearer.

C. Res ipsa loquitur – Limited Application

The Doctrine of 'Res Ipsa Loquitur', which means, 'the thing speaks for itself', only applies in rare cases where something happens that normally wouldn't occur without negligence, and the doctor had full control. Indian courts warn against using this rule too freely in medical cases. A bad result alone in not enough to prove negligence without other evidence. Today, courts still use this rule only as a last option.

CASES AND STATUTES

A. Indian Medical Association vs. V.P. Sharma (1995) – Consumer Jurisdiction

Shantha was seminal in bringing fee – charging medical services within the consumer redressal system, enabling patients to litigate deficiency in service before consumer fora. This decision reoriented medical negligence litigation by broadening access to remedies and altering procedural dynamics. Because the consumer courts were cheaper and faster, more people

started filing malpractice cases, which shifted the balance of power between patients and doctors.

B. Jacob Mathew vs. State of Punjab (2005) – Criminal Liability Threshold

In Jacob Mathew, the Supreme Court emphasised that criminal prosecution of medical professionals should be used occasionally to and only where negligence is gross or reckless. The Court suggested procedural safeguards (including obtaining preliminary expert opinion) to present harassment of doctors and to ensure only culpable behaviour attracts criminal penalties. The decision thus protected professionals from being treated like criminals for bad outcomes in routine cases, but still allowed the government to punish serious misconduct.

C. Samira Kohli vs. Dr. Prabha Manchanda (2008) – Informed Consent

Samira Kohli set out the modern law of 'Informed Consent in India', that is, Consent must be voluntary, informed and specific to the procedure. Consent to one procedure does not automatically authorise routine additional procedures. Doctors must disclose material risks and alternatives in a comprehensible manner. Lack of informed consent can independently constitute negligence or even actionable assault. The case fixed an important gap in the law: patients have the legal right to make their own decisions, not just an ethical one.

D. Kusum Sharma vs. Batra Hospital & Medical Research Centre (2010) - Evaluating Clinical Judgement

Kusum Sharma re-affirmed judicial restraint: courts should not substitute their views for a reasonable clinical judgement. If a group of medical experts agrees with the treatment given, the doctor is not careless just because things didn't turn out well. The judgement made it clear that courts should respect doctor's decision in surgery and complex care, as long as they follow reasonable standards.

CIVIL REMEDIES AND COMPENSATION

Under **CPA** and **Tort Law**, victims may recover medical expenses and compensation for pain and suffering. The Supreme Court, in several cases, described the heads of damages and directed compensation for loss of expectation of life and rehabilitation needs. The law is known for being fair, but people still criticize it for giving inconsistent compensation and not having

clear rules on how much should be awarded.

CRIMINAL PROCEEDINGS: UNITS AND SAFEGUARDS

Criminal prosecution under **section 304A** {**BNS Section 106(1)**} requires proof of negligence conduct causing death. In the case of Jacob Mathew vs. State of Punjab, the honorable Supreme Court emphasized that not every medical error shall be subjected to criminal penalty but only gross negligence does. Courts have recommended that police may consult medical boards or shall obtain expert opinion prior to the arrest and prosecution to prevent unnecessary harassment of medical professionals and to respect the clinical independence. So, most cases are handled in civil courts, and criminal punishment is saved for serious or clearly wrongful actions.

SPECIAL ISSUES AND EMERGING CHALLENGES

A. Telemedicine and Digital Health

As telemedicine grows, it raises questions about doctors, responsibilities, how much information they must share, rules across different regions and what counts as proper evidence in online consultation. The Samira Kohli case rules about giving clear information and getting voluntary consent still apply, but telemedicine also needs special rules for checking who the patient is, keeping records of online consent, and setting the duties of the platforms used. Recent studies suggest making clear laws and rules for each group, that is, doctors, platforms and device or AI companies, so that everyone knows their responsibilities.

B. Institutional Liability and Hospital Systems

Liability of hospitals vs. Individual practitioners raises questions on vicarious liability, institutional policies, staffing and equipment maintenance. Consumer fora often find hospitals liable for lack in management, sterilisation and staffing. Stronger compliance and audit standards at institutional level are frequently recommended to reduce systemic failures that give rise to negligence claims.

COMPARATIVE ANALYSIS

Comparing with legal systems in countries like the United Kingdom, Australia, and New

Zealand may provide useful examples for balancing medical accountability with efficiency.

- The UK has gradually included medical guidelines from NICE (National institute for health and care excellence) in medico-legal assessments. This lets courts evaluate the standards of health care more objectively. Additionally, Alternate Dispute Resolution methods like mediation and early settlement offers have significantly helped in reducing lawsuits and speed up compensation.

- Australia's state-level "no-fault" compensation discussions and New Zealand's long standing accident compensation corporation model offers alternatives to fault based litigations.

While India's legal system is not ready to completely shift on a no-fault based litigation system but it may adopt some reforms from these models. India's system is primarily based on case laws, which evolves through gradual judicial decisions rather than proactive legislative changes. Though this provides some flexibility but it also creates unpredictable and inconsistent legal outcomes. Therefore, a mixed approach which combines statutory medical protocols, expert-led boards and structured guidelines could reduce unnecessary lawsuits.

RECOMMENDATIONS FOR LAW AND POLICY REFORM

i. **National Clinical Guidelines:** Official, specialty-based medical guidelines that courts can use to judge what's considered proper care.

ii. **Mandatory Documentation Standards:** Basic rules for keeping records like digital files and online consent that all doctors must follow.

iii. **Pre – Litigation Mediation Cell:** A system at state medical councils or the national consumer forum to help settle disputes early and keep trust between doctors and patients.

iv. **Clear Telemedicine Rules:** Laws that clearly divide responsibility between doctors and online platforms, including rules for getting online consent and keeping records.

v. **Criminal Prosecution Safeguards:** Rules to protect doctors from unfair criminal charges by requiring expert review before filing cases in patient death situations.

vi. **Transparent Compensation Registry:** A public database showing how much compensation is given in different cases to make pay-outs more fair and predictable.

CONCLUSION

Negligence remains the doctrinal core of medical malpractice in India. Key court cases like Shantha, Jacob Mathew, Samira Kohli and Kusum Sharma have tried to balance patient rights with clinical autonomy, but the rapid digitisation of healthcare, new AI tools, and ongoing gaps in legal procedures, there's a need for clear laws and better systems. These should set clear standards, improve record-keeping and offer affordable ways to settle disputes. Such changes will help protect patients, support good medical practice and build more public trust in healthcare.

SECONDARY LITERATURE & POLICY PIECES

- "Legal mechanisms and procedures in alleged medical negligence: a review of Indian laws and judgements," National Medical Journal of India (review).
- "The Consumer Protection Act, 2019: A Critical Analysis from a Medical Practitioner's Perspective," IJME / PMC Commentary
- "The role of clinical guidelines in medical negligence litigation" IJME Article
- Empirical and practice notes on negligence and defensive medicine; practitioner – oriented summaries (legal blogs and law reviews cited in the body).