MEDICAL PROFESSIONALS' LIABILITY IN INDIA: INTERSECTIONS OF TORT LAW, CONTRACT LAW AND CONSUMER PROTECTION LAW

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ABSTRACT

Medical liability in India operates within an increasingly complex framework shaped by tort law, contract law and the Consumer Protection Act, 2019, each contributing distinct but overlapping principles governing the responsibilities of medical professionals. As healthcare transitions from traditional individual practice to corporatised, technology-driven institutions, courts have been required to refine the standards of reasonable care, informed consent and institutional responsibility. This article examines the doctrinal evolution of these liability regimes through landmark decisions such as Indian Medical Association v. V.P. Shantha, Jacob Mathew v. State of Punjab, Kusum Sharma v. Batra Hospital and Arun Kumar Manglik v. Chirayu Health and Medicare, which collectively shape the contemporary understanding of medical negligence. Tort law remains the foundational basis for determining duty, breach and causation, while contract law reinforces patient autonomy through implied assurances of skill, diligence and meaningful consent. The Consumer Protection Act has become the most utilised mechanism for redress, offering accessible procedures and broad remedial powers to address deficiencies in medical service. The article further analyses the expanding scope of institutional and vicarious liability in corporate hospitals, the implications of product liability provisions under CPA 2019, and emerging medico-legal challenges posed by telemedicine, artificial intelligence, data protection norms, National Medical Commission regulations and evolving criminal negligence standards under the Bharatiya Nyaya Sanhita, 2023. By synthesising these frameworks, the study highlights the convergence around a common standard of reasonable care while identifying procedural divergences that generate both opportunities and uncertainties for litigants and healthcare providers. It concludes by proposing reforms to harmonise medico-legal standards, strengthen expert review mechanisms, and foster an accountability system that balances patient rights with professional autonomy in a rapidly evolving healthcare landscape.

Keywords: Medical negligence; Tort liability; Contractual duty; Consumer Protection Act 2019; Informed consent; Institutional liability; Healthcare regulation.

I. INTRODUCTION

The legal regulation of medical practice in India is shaped by professional ethics, societal expectations and judicial supervision. For decades, medical negligence claims were confined primarily to tort actions in civil courts, which were often inaccessible due to procedural complexity and high litigation costs. The Consumer Protection Act, 1986 changed this trajectory by granting patients a cost-effective and swift forum for redress. The Supreme Court's landmark judgment in *Indian Medical Association v. V.P. Shantha* expanded the reach of the Act by including medical services within the definition of "service," thereby ushering in a new era of medico-legal accountability[1].

Subsequent jurisprudence refined the standard of care and clarified the interplay between civil, consumer and criminal liability. The decision in *Jacob Mathew* adopted the Bolam standard of professional competence while simultaneously limiting the scope of criminal prosecution for medical acts undertaken in good faith[2]. *Kusum Sharma v. Batra Hospital* further urged caution against hindsight bias and emphasised that adverse outcomes do not automatically imply negligence[3]. Most recently, *Arun Kumar Manglik* indicated that courts may look beyond rigid application of Bolam where contemporary medical knowledge or patient safety demands heightened scrutiny[4].

Healthcare's corporatisation has compounded legal complexities, making hospitals not just individual doctor's central actors in negligence litigation. The intersection of tortious, contractual and consumer law principles now determine liability, and emerging technologies such as telemedicine and AI pose new questions about standards of care and evidentiary burdens. This article uses doctrinal analysis to clarify each liability framework and to evaluate their collective impact on medical practice in India.

II. TORTIOUS LIABILITY OF MEDICAL PROFESSIONALS

A. Foundations of the Duty of Care

Tortious liability for medical negligence rests on the existence of a duty of care, breach of that duty and resulting harm. Indian courts recognise that once a doctor undertakes to diagnose or

[1] *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 S.C.C. 651.
[2] *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1.
[3] *Kusum Sharma v. Batra Hosp.*, (2010) 3 S.C.C. 480.
[4] *Arun Kumar Manglik v. Chirayu Health & Medicare (P) Ltd.*, (2019) 7 S.C.C. 401.

treat a patient, a legal duty arises to exercise reasonable skill and care[5]. This standard does not demand perfection but requires that the doctor act with the competence expected of an ordinarily skilled professional in similar circumstances[6].

The judicial adoption of the **Bolam test**, from *Bolam v. Friern Hospital Management Committee*[7], has been central to defining this standard. Bolam holds that a doctor is not negligent if their conduct aligns with a practice accepted as proper by a responsible body of medical professionals. India formally adopted Bolam in *Jacob Mathew*, grounding medical liability in professional norms while cautioning against criminalising ordinary clinical judgment.

However, courts increasingly acknowledge that Bolam alone is insufficient, particularly when blind deference to professional opinion may undermine patient safety. The modification introduced by the English *Bolitho* decision supports judicial scrutiny of whether professional opinion is logical and defensible[8]. Indian jurisprudence reflects similar reasoning: *Arun Kumar Manglik* indicates that courts may depart from Bolam when the medical explanation lacks rational basis or conflicts with established scientific knowledge.

Thus, the Indian standard of care in tort is shaped by a triad of principles professional custom, logical defensibility and contemporary medical science.

B. Breach of Duty and Judicial Assessment

To establish a breach, the claimant must demonstrate that the doctor failed to meet the expected standard of care. Courts assess breach by evaluating medical records, expert testimony, procedural adherence, hospital protocols and the clinical demands of the situation.

The Supreme Court has repeatedly emphasised that adverse outcomes do not automatically indicate negligence. In *Kusum Sharma*, the Court outlined guiding principles cautioning against equating mishaps with malpractice and noted that medicine is an inexact science where success cannot be guaranteed.

Nevertheless, negligence may arise from errors of commission such as inappropriate treatment, incorrect medication, or procedural mistakes and errors of omission, including delayed diagnosis, inadequate monitoring or failure to refer. The seminal decision in *Spring Meadows*

[5] *Laxman Balkrishna Joshi v. Trimbak Bapu Godbole*, A.I.R. 1969 S.C. 128.
[6] *Achutrao Haribhau Khodwa v. State of Maharashtra*, (1996) 2 S.C.C. 634.
[7] *Bolam v. Friern Hosp. Mgmt. Comm.*, [1957] 1 W.L.R. 582 (Q.B.).
[8] *Bolitho v. City & Hackney Health Auth.*, [1998] A.C. 232 (H.L.).

Hospital v. Harjol Ahluwalia found a hospital liable where the administration of a wrong injection and poor supervision resulted in severe brain damage to a child patient. The Court also recognised the parents as consumers entitled to independent compensation, expanding the scope of recoverable damages[9].

Indian courts often deal with conflicting expert evidence by evaluating which opinion better aligns with established medical literature and logical reasoning. They may refer to international guidelines where domestic standards are absent, though such references remain supportive rather than determinative.

C. Causation and Evidentiary Complexity

Proving causation in medical negligence is challenging due to the multifactorial nature of medical harm. Courts apply the "but for" test cautiously, recognising that complications may arise even with reasonable care. Expert testimony plays a crucial role in establishing whether the doctor's conduct materially contributed to the injury.

Where negligence is apparent on the face of the record, courts may invoke **res ipsa loquitur**, shifting the burden onto the hospital or doctor to disprove negligence. In *V. Kishan Rao v. Nikhil Super Speciality Hospital*, the Supreme Court held that expert evidence is not mandatory in every case and that obvious negligence such as failure to diagnose malaria despite clear symptoms may justify drawing adverse inference against the healthcare provider[10].

This doctrine is particularly important because hospitals often control access to medical records, placing patients at an evidentiary disadvantage. Burden-shifting ensures fairness while still requiring credible demonstration of negligent conduct.

D. Vicarious Liability and Institutional Responsibility

The rise of corporate and multispecialty hospitals has made institutional liability a central feature of medical negligence litigation. Hospitals may be held vicariously liable for negligent acts of doctors, nurses and technicians acting within the scope of their employment.

In *Spring Meadows*, the Supreme Court emphasised that hospitals owe a **non-delegable duty of care** and are liable not only for individual error but for systemic failures such as inadequate supervision, lack of equipment or poor staffing. This aligns with trends in foreign jurisdictions,

[9] *Spring Meadows Hosp. v. Harjol Ahluwalia*, (1998) 4 S.C.C. 39.
[10] *V. Kishan Rao v. Nikhil Super Speciality Hosp.*, (2010) 5 S.C.C. 513.

where courts recognise that modern healthcare is delivered through institutional structures rather than isolated individual practice.

The landmark *Kunal Saha* litigation further demonstrated the courts' willingness to impose substantial compensation for systemic and institutional negligence[11].The case involved prolonged errors, mismanagement at multiple levels and lack of adherence to established treatment protocols. The Court's unprecedented damages award underscored the seriousness with which institutional failures are treated.

Institutional liability not only compensates victims but also incentivises hospitals to adopt stringent internal controls, maintain training standards and enforce clinical protocols.

E. Civil vs. Criminal Negligence: The Jacob Mathew Doctrine

The distinction between civil and criminal negligence is crucial. Civil negligence requires breach of a duty of care resulting in injury, while criminal negligence requires a significantly higher degree of culpability conduct so grossly negligent or reckless that it demonstrates disregard for human life or safety.

In *Jacob Mathew*, the Supreme Court ruled that criminal prosecution under Section 304A IPC should be reserved for gross negligence and should not be initiated without independent medical expert opinion. The Court also emphasised that doctors should not be arrested routinely and that courts must consider the inherent risks and uncertainties of medical treatment.

Comparative jurisprudence reinforces this approach. UK courts follow the *Adomako* standard for gross negligence manslaughter, while US courts reserve criminal sanctions for egregious conduct such as intoxicated surgery or intentional disregard of life-saving protocols.

India's approach thus balances accountability with protection for medical professionals acting in good faith.

III. CONTRACTUAL LIABILITY OF MEDICAL PROFESSIONALS

A. Nature and Formation of the Doctor–Patient Contract

The doctor–patient relationship is historically grounded in fiduciary trust, but in legal terms it also possesses contractual attributes. Under the Indian Contract Act, 1872, a contract may be

[11] *Anuradha Saha v. AMRI Hosp.*, (2014) 1 S.C.C. 384.

express or implied. In medical practice, contracts are predominantly implied from conduct: when a patient consults a doctor, pays consultation fees, undergoes diagnosis or treatment, and when the doctor accepts the patient, an enforceable contractual relationship is formed[12]. The courts treat these interactions as involving mutual promises patients agree to pay for services while doctors implicitly promise to render treatment with reasonable skill and care[13].Though the promise is not a guarantee of cure, it constitutes an assurance of a standard of competence expected of a professional.

The contract is also coloured by fiduciary obligations because doctors possess specialised knowledge, while patients are vulnerable and dependent on that expertise. The Supreme Court has recognised that the unique nature of this relationship requires heightened standards of disclosure, honesty and diligence[14]. The rise of corporate hospitals has further intensified this contractual dimension: hospitals enter into service agreements with patients, specify treatment packages, and create contractual duties regarding admission, discharge, billing, and access to medical records[15]. In such settings, a breach of these obligations can constitute not only negligence but also breach of contract.

B. Implied Terms: Reasonable Skill, Care, and Diligence

Indian courts consistently hold that every medical contract includes implied terms requiring the doctor to exercise reasonable skill, due care, appropriate diligence and adherence to established clinical protocols[16]. These implied conditions mirror tort principles but also operate independently within contractual jurisprudence. In *Laxman Balkrishna Joshi v. Trimbak Bapu Godbole*, the Court emphasised that the doctor's duty includes not only undertaking treatment with due care but continuing such care throughout the course of treatment[17]. The ongoing nature of these obligations indicates that a patient's consent to treatment is dynamic, and the doctor's duties evolve as the treatment progresses.

Hospital contracts frequently include additional implied promises such as obligations to maintain hygienic environments, provide trained staff, ensure availability of emergency support, maintain accurate records and implement safe protocols for medication and surgery[18].

[12] Indian Contract Act, 1872, No. 9 of 1872,
[13] *A.S. Mittal v. State of U.P.*, (1989) 2 S.C.C. 232.
[14] *Dr. Mukhtiar Chand v. State of Punjab*, (1998) 7 S.C.C. 579.
[15] *Bombay Hosp. Trust v. Asha Jaiswal*, (2019) 9 S.C.C. 745.
[16] *Achutrao Haribhau Khodwa v. State of Maharashtra*, (1996) 2 S.C.C. 634.
[17] *Laxman Balkrishna Joshi v. Trimbak Bapu Godbole*, A.I.R. 1969 S.C. 128
[18] *State of Haryana v. Smt. Santra*, (2000) 5 S.C.C. 182

A breach of any of these implied terms may constitute actionable contractual liability regardless of whether tort elements of negligence can be separately proved.

C. Informed Consent as a Contractual Obligation

Informed consent is a crucial doctrinal bridge linking contract, tort and constitutional law. Consent is not merely a procedural formality but an essential component of patient autonomy protected under Article 21 of the Constitution[19]. The Supreme Court has drawn parallels to contract principles: just as consent is required to validate agreements, informed consent validates medical treatment. A patient must be informed of the nature of the procedure, risks, alternatives and potential complications in order for consent to be meaningful.

Although Indian law traditionally adopted the "doctor-centric" Bolam approach to disclosure, courts increasingly recognise the "patient-centric" duty to disclose material risks particularly those that would influence a reasonable patient's decision[20]. In *Samira Kohli v. Dr. Prabha Manchanda*, the Supreme Court held that consent obtained for a diagnostic procedure does not automatically authorise a therapeutic procedure unless exigent circumstances exist[21].This decision placed informed consent firmly within a contractual framework: the scope of the doctor's authority is defined by the boundaries of the consent granted. Deviating from these boundaries constitutes breach of contract, breach of duty and violation of bodily autonomy.

Failures in informed consent such as concealing risks, failing to disclose alternatives, not providing information in understandable language or pressuring the patient may lead to liability even when the procedure itself was performed with skill. Contract law thus imposes obligations beyond technical competence, ensuring patient participation and decision-making.

D. Breach of Contract and Remedies

Remedies for breach of medical contract include damages for financial loss, physical harm, mental distress and violation of autonomy. Indian courts do not strictly separate contract and tort damages; rather, they frequently award a blended compensation package addressing all forms of injury[22].Courts consider loss of earning capacity, medical expenses, lifelong care, pain and suffering, emotional anguish and loss of consortium.

[19] *Common Cause v. Union of India*, (2018) 5 S.C.C. 1
[20] *Montgomery v. Lanarkshire Health Bd.*, [2015] U.K.S.C. 11
[21] *Samira Kohli v. Dr. Prabha Manchanda*, (2008) 2 S.C.C. 1
[22] *Nizam's Inst. of Med. Scis. v. Prasanth S. Dhananka*, (2009) 6 S.C.C. 1

In hospital settings, breach may also arise from billing irregularities, overcharging, denial of records, improper discharge, refusal of emergency treatment or failure to provide promised facilities[23]. The right to medical records has contractual implications: the Supreme Court in *Kishan Rao* and subsequent decisions emphasised transparency as an essential component of both professional ethics and contractual fairness[24].

Contractual liability thus complements tortious doctrines by focusing on patient expectations, autonomy, and enforceable promises rather than solely on professional fault.

IV. LIABILITY UNDER THE CONSUMER PROTECTION ACT, 2019

A. Evolution from CPA 1986 to CPA 2019

The Consumer Protection Act has become the most influential framework governing medical liability in India. Its journey began with *Indian Medical Association v. V.P. Shantha*, where the Supreme Court held that medical services provided for consideration constitute "service" under the Act unless rendered wholly free of charge. The ruling drastically expanded patient access to legal remedy by allowing them to approach District, State and National Consumer Commissions, bypassing the procedural rigours of civil courts.

The Consumer Protection Act, 2019 replaced the earlier statute but retained its essential character, broadening the definition of "consumer" and "service"[25]. Although "healthcare" was deleted from the examples in the draft Bill, parliamentary debates and subsequent judicial reaffirmation indicate that **medical services remain squarely within the Act**[26]. The definitional structure of Section 2(42) is intentionally broad, covering any paid service that is not rendered gratuitously or under a contract of personal service thus encompassing medical treatment[27].

The 2019 Act introduces additional mechanisms such as mediation cells, e-filing of complaints, stricter penalties for unfair trade practices, and enhanced pecuniary jurisdiction making consumer fora more accessible for medical disputes.

B. Defining "Service" and "Deficiency" in the Medical Context

Section 2(42) defines "service" broadly as any service made available for consideration,

[23] *Bihar State Electricity Bd. v. Parmeshwar Kumar*, (2013) 8 S.C.C. 246
[24] *V. Kishan Rao v. Nikhil Super Speciality Hosp.*, (2010) 5 S.C.C. 513
[25] Consumer Protection Act, 2019, No. 35 of 2019, (S.2(7))
[26] Lok Sabha Debates, Consumer Protection Bill, 2019
[27] Consumer Protection Act, 2019, (S.2(42))

excluding free services. In medical settings, hospitals may offer a mix of paid and free services. The Supreme Court has clarified that where a hospital charges paying patients and simultaneously provides free services to others, **all patients including free patients are considered consumers**, because the institution's functioning is cross-subsidised[28].

"Deficiency" under Section 2(11) refers to any fault, imperfection, inadequacy or shortcoming in the quality, nature or manner of performance of service required by law or contract[29].In medical cases, deficiency corresponds to negligence failure to provide the standard of reasonable care. Notably, consumer fora are not bound by technical rules of procedure and may adopt flexible approaches, allowing patients to present grievances without stringent evidentiary burdens.

C. Standard of Care under Consumer Law

Consumer fora consistently apply the negligence principles laid down in *Jacob Mathew*, *Kusum Sharma* and *Arun Kumar Manglik*[30]. The Bolam test continues to guide assessment, but it is not absolute; consumer fora may reject expert testimony if inconsistent with logic, contemporary standards or medical literature. The summary nature of consumer proceedings demands caution: although designed for simplicity, medical disputes often involve complex scientific evidence. Courts have repeatedly urged consumer fora not to treat every medical complication as negligence nor to assume causation without adequate inquiry[31].

However, consumer fora are also empowered to scrutinise hospital systems, staff behaviour, documentation practices and emergency response mechanisms more aggressively than civil courts. This allows for broader assessment of institutional negligence.

D. Vicarious, Composite and Institutional Liability under CPA

Under the Consumer Protection Act, hospitals can be held liable not only for their employees but also for independent consultants acting under hospital authority[32].This is significant because many private hospitals engage doctors on consultancy arrangements to avoid employee liabilities. Consumer fora reject such evasions, emphasising that patients rely on the hospital as an integrated medical establishment[33].

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[28] *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 S.C.C. 651
[29] Consumer Protection Act, 2019, (S.2(11))
[30] *Arun Kumar Manglik v. Chirayu Health & Medicare*, (2019) 7 S.C.C. 401
[31] *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1
[32] *Savita Garg v. Dir., Nat'l Heart Inst.*, (2004) 8 S.C.C. 56
[33] *Dr. Balram Prasad v. Dr. Kunal Saha*, (2014) 1 S.C.C. 384

Composite liability arises where manufacturers, hospitals, pharmacies and doctors contribute to harm through intertwined conduct. For example, negligent administration of a defective medical device may trigger claims against physicians (for improper oversight), hospitals (for procurement lapses) and manufacturers (for product defects). The CPA allows simultaneous adjudication of all parties.

Institutional liability is particularly prominent in consumer jurisprudence. In *Spring Meadows*, the Court found the hospital directly liable for poor supervision and negligent staffing. In *Kunal Saha*, the Court imposed massive compensation for institutional neglect, inadequate facilities and procedural failures. These cases underscore that modern liability assessments must consider systemic and organisational shortcomings, not only individual acts.

E. Product Liability under CPA 2019 and Its Impact on Healthcare

A major innovation of CPA 2019 is the statutory introduction of **product liability** (Sections 82–87)[34]. Although primarily aimed at consumer goods, these provisions significantly affect medical practice. Medical devices, implants, prosthetics, diagnostic kits, and pharmaceuticals fall squarely within the definition of "products." Hospitals and doctors may face liability claims when unsafe or defective products contribute to harm.

Manufacturers may be held liable for design defects, inadequate warnings or manufacturing errors. Sellers and distributors, including hospitals operating pharmacies, may be liable for failing to inspect or verify product quality. Healthcare professionals may be implicated if they used a defective device negligently or failed to monitor adverse reactions. The CPA framework thus intertwines professional negligence with product safety obligations.

F. Procedural Advantages and Concerns for Medical Professionals

The consumer protection framework offers substantial advantages to patients: minimal filing fees, simplified procedures, no requirement for legal representation, and relatively quick adjudication. However, these advantages also generate concerns among medical professionals. The Indian Medical Association has repeatedly argued that consumer fora sometimes adopt a claimant-friendly posture, leading to defensive medical practices, avoidance of high-risk patients, increased insurance costs and financial burdens on healthcare infrastructure[35].

[34] Consumer Protection Act, 2019, (S.82–87)
[35] Indian Medical Association Press Statements (2019–2024).

Courts have attempted to strike a balance by affirming respect for medical expertise while safeguarding patient rights. The *Kusum Sharma* guidelines cautioning courts against readily finding negligence reflect an effort to maintain equilibrium. Yet, the increasing corporatisation of medicine and rising public expectations continue to sustain high volumes of litigation.

V. COMPARATIVE ANALYSIS OF TORT, CONTRACT, AND CONSUMER PROTECTION ACT LIABILITY

The frameworks of tort, contract and consumer protection law overlap substantially in medical negligence jurisprudence but retain distinct conceptual and procedural features. A comparative synthesis helps clarify the interplay between these regimes and the degrees of liability they impose.

A. Conceptual Overlaps and Divergent Foundations

At the conceptual level, tort law focuses on **breach of duty**, contract law concerns **breach of express or implied promises**, and the Consumer Protection Act centres on **deficiency in service**. Despite these differences, all three frameworks pivot around a common normative core: the expectation that medical professionals will exercise reasonable skill and care[36]. The Supreme Court has repeatedly affirmed that negligence under tort and deficiency under the CPA involve identical standards, drawing heavily on *Jacob Mathew* and *Kusum Sharma* to prevent dilution of the standard in consumer fora[37].

Contract law, by contrast, emphasises expectation interests, consent and fiduciary responsibilities. Its focus is not merely on professional fault but on the fulfilment of legitimate expectations arising from the doctor–patient relationship[38]. Nevertheless, the breach analysis typically converges with tort principles because the implied contractual duties mirror the obligations recognised at common law.

Thus, although the three doctrines originate from different legal traditions, they converge in substance and diverge mainly in procedural and remedial consequences.

B. Procedural Differences and Their Impact on Litigation Strategy

Procedural distinctions significantly affect how patients and lawyers choose forums. Tort actions filed in civil courts involve detailed pleadings, formal evidence procedures, expert

[36] *Achutrao Haribhau Khodwa v. State of Maharashtra*, (1996) 2 S.C.C. 634
[37] *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1
[38] *Samira Kohli v. Dr. Prabha Manchanda*, (2008) 2 S.C.C. 1

testimony and extended timelines[39]. Remedies may include general, special and future damages, but the cost and duration of litigation discourage many claimants.

Contractual claims are seldom pursued independently because breach of contract and negligence are usually intertwined. Courts rarely treat medical breach purely as contractual unless the dispute relates to billing, denial of promised facilities or improper consent[40].

Consumer fora offer distinct advantages: low fees, flexible procedures, summary adjudication, limited reliance on technical rules and faster disposition.[41] For this reason, most medical negligence cases in India are now adjudicated under the CPA. The drawback, however, is the risk that summary procedures may inadequately handle complex medical evidence, prompting occasional judicial caution against overreaching findings[42].

These procedural differences mean that patients tend to approach consumer fora for compensation, while tort and contract principles operate largely as substantive doctrines within those proceedings rather than independent litigation routes.

C. Remedial Structures and Quantum of Damages

Tort law traditionally aims to restore the injured party to the position they would have been in had the negligence not occurred. Contractual damages restore the expectations created by the agreement, though in medical settings the distinction is largely academic because courts award blended damages[43].

Consumer fora possess broad remedial powers: they may award compensation, direct refunds, mandate corrective treatment, impose penalties for unfair trade practices, and order disclosure of medical records[44]. The expanded pecuniary jurisdiction under CPA 2019 allows the National Commission to entertain disputes involving extremely high compensation claims, making it attractive for catastrophic injury cases such as wrongful death, neonatal negligence or surgical errors.

However, CPA damages sometimes exceed traditional tort awards due to the consumer welfare orientation of the statute. Medical professionals express concern that such compensation trends

[39] Code Civ. Proc., 1908
[40] *Bombay Hosp. Trust v. Asha Jaiswal*, (2019) 9 S.C.C. 745
[41] Consumer Protection Act, 2019, (S.38)
[42] *Kusum Sharma v. Batra Hosp.*, (2010) 3 S.C.C. 480
[43] *Nizam's Inst. of Med. Scis. v. Prasanth S. Dhananka*, (2009) 6 S.C.C. 1
[44] Consumer Protection Act, 2019, (S.39–40)

increase defensive medicine and raise the cost of healthcare[45].

The Supreme Court's decision in *Kunal Saha* one of the highest medical negligence awards in Indian history demonstrates the convergence of tort and consumer principles to ensure substantial compensation for victims while reinforcing institutional accountability[46].

D. Forum Choice, Medical Autonomy and Public Perception

The coexistence of these liability regimes shapes public expectations of medical accountability. Consumer fora are perceived as patient-friendly, while criminal prosecutions under *Jacob Mathew* remain rare due to the high threshold of "gross negligence." Tort law operates as the doctrinal backbone but less as a practical litigation route.

This dynamic produces a dual pressure on medical professionals: high exposure to civil/consumer liability and low exposure to criminal liability[47]. Courts attempt to maintain medical autonomy by applying the Bolam test carefully, yet growing public distrust, media scrutiny and corporate dominance in healthcare intensify demands for stringent accountability.

The challenge for the legal system is to balance these conflicting forces by ensuring rigor without provoking defensive medical practices.

VI. EMERGING CHALLENGES IN MEDICAL LIABILITY

India's medico-legal landscape is undergoing rapid transformation driven by technological innovation, regulatory reforms and the corporatisation of healthcare. These developments raise new doctrinal questions that courts and legislatures must confront.

A. Telemedicine and Cross-Border Digital Healthcare

Telemedicine grew significantly following the Telemedicine Practice Guidelines, 2020 issued by the Medical Council (now National Medical Commission)[48].While teleconsultations enhance access, they complicate liability because the standard of care must account for limitations in remote diagnosis. Issues such as identity verification, adequacy of information, cross-border jurisdiction, electronic consent, data privacy and emergency protocols create new vectors of risk.

[45] Indian Medical Association Press Briefings (2019–2024).
[46] *Dr. Balram Prasad v. Dr. Kunal Saha*, (2014) 1 S.C.C. 384
[47] *Jacob Mathew*, supra note 32.
[48] Telemedicine Practice Guidelines, Ministry of Health & Family Welfare (2020).

Courts have yet to fully articulate standards for telemedicine negligence, but the principles of reasonable care require doctors to recognise the limitations of remote assessment. Failure to refer patients for in-person examinations, improper reliance on telephonic diagnosis or inadequate documentation could constitute negligence. Consumer fora may also evaluate whether teleconsultation platforms maintain proper verification, data storage and privacy safeguards.

B. AI-Assisted Diagnosis and Algorithmic Errors

Artificial intelligence (AI) tools increasingly support medical diagnosis and treatment planning. While AI promises consistency and efficiency, it introduces complex questions about fault attribution. If a doctor relies on an AI-generated recommendation that later proves erroneous, liability may attach to the doctor (for blind reliance), the hospital (for procurement and oversight failures) and the manufacturer (for defective algorithms)[49].

Courts may analogise AI to medical devices, applying product liability provisions under CPA 2019[50]. But AI's adaptive and opaque nature complicates such analogies because algorithms evolve over time, making defect identification difficult. This necessitates new regulatory frameworks establishing minimum standards for algorithmic explainability, validation, clinical oversight and audit mechanisms.

C. Data Protection, Confidentiality and Digital Health Records

Electronic health records and digital platforms streamline healthcare delivery but create risks of privacy breaches, unauthorised sharing and cybersecurity failures. The Digital Personal Data Protection Act, 2023 (DPDP Act) imposes obligations on data fiduciaries including hospitals and telemedicine platforms to ensure informed consent, data minimisation, secure storage and breach notifications[51].

Failure to comply could produce liability under both statutory law and consumer law. Patients may claim that inadequate data safeguards constitute deficiency in service or breach of implied contractual duties of confidentiality. Courts historically recognise breach of medical confidentiality as actionable harm[52]. Digital vulnerabilities amplify this duty.

[49] S. K. Verma, Artificial Intelligence and Medical Liability in India, 62 J. Indian L. Inst. 55 (2022).
[50] Consumer Protection Act, 2019, (S.82–87)
[51] Digital Personal Data Protection Act, 2023
[52] *Mr. X v. Hosp. Z*, (1998) 8 S.C.C. 296

D. Corporate Hospitals, Commercialisation and Systemic Negligence

Large private hospitals increasingly dominate India's healthcare sector. Corporatisation introduces concerns about profit-driven treatment decisions, aggressive marketing, unnecessary diagnostic procedures, and cost overruns[53].Courts have responded by expanding institutional liability to include systemic failures such as staff shortages, inadequate supervision, flawed protocols and misleading advertisements.

The Supreme Court has repeatedly held that hospitals owe an independent, non-delegable duty of care to all patients[54]. Consumer fora now scrutinise organisational structures, emergency preparedness, and governance failures more aggressively than individual negligence.

E. National Medical Commission Regulations and Professional Accountability

The establishment of the National Medical Commission (NMC) in 2020 restructured medical regulation. The NMC's ethics code, standard treatment guidelines and disciplinary mechanisms influence civil and consumer liability by defining the professional standards expected of doctors. Courts often rely on regulatory norms to determine whether conduct was negligent or deficient[55].

Moreover, increased emphasis on record-keeping, continuing medical education and informed consent practices under the NMC framework enhances accountability and clarifies the evidentiary boundaries in medical negligence disputes.

F. Criminal Liability under the Bharatiya Nyaya Sanhita, 2023 (BNS 2023)

The Bharatiya Nyaya Sanhita replaces the Indian Penal Code with updated language on causing death or harm by negligence. While the fundamental distinction between civil and criminal negligence remains, courts must reinterpret *Jacob Mathew* in light of the BNS[56].Criminal liability for medical professionals will continue to require "gross" negligence, though emerging technologies and systemic risks may challenge traditional boundaries.

G. Medical Insurance and Defensive Medicine

Rising litigation has triggered higher medical indemnity insurance premiums, increased

[53] R. Srinivasan, Corporatisation of Healthcare and Liability Challenges in India, 14 Nat'l Med. J. India 211 (2021).
[54] *Spring Meadows Hosp. v. Harjol Ahluwalia*, (1998) 4 S.C.C. 39
[55] National Medical Commission Act, 2019
[56] Bharatiya Nyaya Sanhita, 2023, (S.75–79)

documentation, excessive testing, avoidance of high-risk patients and general practice of "defensive medicine"[57]. While defensive medicine may reduce legal exposure, it raises treatment costs and undermines patient trust.

The legal system must therefore calibrate liability to avoid incentivising inefficient or overly cautious practices while still safeguarding patient rights.

VII. POLICY RECOMMENDATIONS

A. Harmonising Tort, Contract and CPA Principles

A unified medico-legal code or statutory framework could harmonise negligence standards across forums, reducing inconsistency and confusion. Such a framework should codify the standard of reasonable care, outline guidelines for expert evidence, and integrate informed consent obligations[58]. The law should clarify the relationship between implied contractual duties and tort obligations, eliminating doctrinal overlap that currently complicates judicial analysis.

B. Strengthening Expert Evidence and Medical Panels

An institutionalised mechanism for medical expert review would improve accuracy in negligence assessments. The *Jacob Mathew* requirement for expert opinion should be expanded into formalised medical boards attached to State and National Commissions[59]. Panels should include domain specialists, independent experts and representatives from patient advocacy groups to prevent institutional bias.

C. Developing Standards for Telemedicine and AI Liability

Comprehensive guidelines are needed to govern AI-assisted diagnosis, algorithmic transparency, telemedicine practices, and cross-border medical services. Liability rules should distinguish between algorithmic defects and negligent oversight[60]. A regulatory sandbox under the NMC could test emerging technologies while preserving patient safety.

D. Enhancing Hospital Governance and Institutional Accountability

Hospitals should be required to implement mandatory clinical governance structures, including

[57] Indian Medical Association Survey on Defensive Medicine (2023).
[58] Law Commission of India Report No. 226 (2009).
[59] *Jacob Mathew*, supra note 32.
[60] Ministry of Electronics & IT, AI Governance Framework (Draft 2023).

periodic audits, credentialing committees, standardised protocols, adverse event reporting systems and infection control mechanisms. Courts should continue to hold hospitals accountable for systemic failures under institutional negligence doctrines.[61]

E. Strengthening Patient Rights and Transparency

Patients should have statutory rights to access medical records promptly, receive clear disclosure of risks and options, and obtain itemised billing[62]. Hospitals should be mandated to maintain standardised consent forms and provide counselling before invasive procedures to reinforce autonomy and trust.

F. Reforming Compensation Structures

Compensation guidelines could help ensure proportionality and mitigate unpredictability in awards. Structured compensation including annuities for long-term care would better serve victims of catastrophic negligence[63]. At the same time, caps on non-economic damages may be considered in appropriate contexts to prevent excessive financial burden on healthcare institutions.

VIII. CONCLUSION

Medical liability in India stands at a critical juncture. Tort law, contract law and consumer protection jurisprudence collectively shape an accountability framework that is dynamic, multifaceted and increasingly responsive to the complexities of modern medicine. Courts have endeavoured to maintain a balance between patient welfare and medical autonomy, drawing from doctrines such as Bolam, informed consent, institutional negligence and product liability.

The Consumer Protection Act remains the most accessible avenue for patients seeking redress, while tort and contract principles continue to supply substantive content. The corporatisation of medicine, emergence of AI and telemedicine, evolving regulatory standards, and the introduction of the Bharatiya Nyaya Sanhita require continuous adaptation of medico-legal doctrine.

A coherent statutory framework integrating ethical norms, technological risks and patient rights would enhance clarity and fairness. Ultimately, the goal is to create a medico-legal ecosystem

[61] *Kunal Saha*, supra note 42.
[62] *Smt. Santra*, supra note 18.
[63] *Nizam's Inst.*, supra note 38.

where accountability strengthens not undermines trust between patients and professionals, promoting a safer and more equitable healthcare system.