
MEDICAL NEGLIGENCE AND DOCTORS' LIABILITY IN INDIA: A DOCTRINAL AND JURISPRUDENTIAL ANALYSIS OF HEALTH LAW

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ABSTRACT

Medical negligence occupies one of the most intellectually demanding and socially sensitive domains within contemporary health law. It is not merely a question of professional error but a sight of deep legal negotiation between patient vulnerability, institutional responsibility, professional autonomy, and public trust.¹ The law governing medical negligence must simultaneously protect individuals from preventable harm while ensuring that health care Professionals are not punished for outcomes that arise from the inherent uncertainty of medical science.² This tension makes medical negligence jurisprudence fundamentally different from ordinary negligence law.³

In India, the legal framework governing medical negligence has developed through judicial interpretation rather than comprehensive statutory codification.⁴ Liability arises through tort principles, consumer protection law, criminal law, professional regulation, and constitutional guarantees relating to the right to life and health.⁵ Courts have gradually refined the standards governing professional responsibility, evidentiary thresholds, and the distinction between civil and criminal negligence.⁶ Landmark decisions of the Supreme Court have played a central role in defining when medical error becomes legal fault, when professional judgement deserves protection, and when institutional accountability must be enforced.⁷

This paper provides a detailed doctrinal and jurisprudential examination of the liability of doctors under Indian health law. It analyses the conceptual foundations of professional duty, the evolution of standards of care, the

¹ R.K. Bangia, *Law of Torts* (24th ed., Allahabad Law Agency 2022).

² *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

³ *Dr. Suresh Gupta v. Gov't of NCT Delhi*, (2004) 6 S.C.C. 422 (India).

⁴ *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 S.C.C. 651 (India).

⁵ *Consumer Protection Act, 2019*, No. 35 of 2019, India Code; *Parmanand Katara v. Union of India*, (1989) 4 S.C.C. 286 (India).

⁶ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India).

⁷ *Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Babu Godbole*, A.I.R. 1969 S.C. 128 (India); *Savita Garg v. Nat'l Heart Inst.*, (2004) 8 S.C.C. 56 (India).

evidentiary structure of negligence litigation, and the interface between civil, criminal, consumer, and constitutional remedies.⁸ The discussion integrates leading judicial precedents by examining the factual context of each case and the principles articulated by the courts.⁹ Contemporary developments, including litigation trends, statistical data, and public policy debate surrounding criminal prosecution of doctors, are also examined.¹⁰ The paper argues that Indian medical negligence law reflects a dynamic attempt to reconcile competing normative commitments to patient safety, professional independence, and institutional accountability within a rapidly transforming healthcare system.¹¹

Introduction

The regulation of medical practise has undergone a profound transformation over the past century. Historically, physicians were governed primarily by ethical obligations embedded in professional codes and community trust. Legal intervention was limited, and litigation against doctors was relatively rare.¹² Modern health care, however, is no longer a purely interpersonal professional relationship. It is an institutionalised Technologically sophisticated, and economically significant sector involving corporate hospitals, insurance systems, regulatory bodies, and mass patient engagement.¹³ This structural transformation has inevitably increased legal scrutiny over medical decision making.¹⁴

Medical negligence arises when the conduct of a health care provider falls below the standard reasonably expected of a competent professional and results in injury or death.¹⁵ Yet the determination of negligence in medicine is uniquely complex. Clinical outcomes are influenced by biological variability, pre-existing conditions, treatment risks, an unpredictable physiological responses.¹⁶ A patient may suffer complications despite flawless treatment.

⁸ Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 S.C.C. 1 (India).

⁹ V. Kishan Rao v. Nikhil Super Speciality Hosp., (2010) 5 S.C.C. 513 (India).

¹⁰ Nat'l Consumer Disputes Redressal Comm'n, Annual Report 2023 (Gov't of India 2023); Nat'l Crime Recs. Bureau, Crime in India 2022 (Ministry of Home Affairs 2023).

¹¹ World Health Org., Patient Safety: Global Action on Patient Safety (2020); Ins. Regulatory & Dev. Auth. of India, Annual Report 2022–23 (2023); Ins. Regulatory & Dev. Auth. of India, Annual Report 2022–23 (2023); Ministry of Health & Family Welfare, National Health Accounts Estimates for India 2019–20 (Gov't of India).

¹² Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Gazette of India, Apr. 6, 2002; Law Comm'n of India, 201st Report on Emergency Medical Care to Victims of Accidents and During Emergency Medical Condition (2006).

¹³ Ministry of Health & Family Welfare, National Health Accounts Estimates for India 2019–20 (Gov't of India); Ins. Regulatory & Dev. Auth. of India, Annual Report 2022–23 (2023).

¹⁴ Indian Med. Ass'n v. V.P. Shantha, (1995) 6 S.C.C. 651 (India).

¹⁵ Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole, A.I.R. 1969 S.C. 128 (India).

¹⁶ Nat'l Crime Recs. Bureau, Crime in India 2022 (Ministry of Home Affairs 2023).

Conversely, negligent conduct may exist even when treatment appears successful if the process involved unacceptable risk or deviation from accepted standards.¹⁷

Indian courts have consistently recognised that medicine is not an exact science. Judicial reasoning repeatedly emphasises that the law cannot equate medical failure with legal fault.¹⁸ In *Kusum Sharma V. Batra Hospital*, the Supreme Court observed “*a medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care... neither the very highest nor a very low degree of care and competence Is required*”.¹⁹

Doctrinal Foundations of Medical Negligence

A doctrinal architecture of medical negligence in India rests upon three interrelated foundations and they are:

- a. the existence of a legally enforceable duty of care governed by professional standards,
- b. the structured elements necessary to establish civil liability, and
- c. the conceptual distinction between medical error and legally actionable negligence.²⁰

These foundations collectively ensure that medical professionals are held accountable for unreasonable conduct without converting health care into a regime of strict liability.²¹

Once a doctor undertakes diagnosis or treatment, Indian jurisprudence recognises that a duty of care arises. This duty is neither symbolic nor abstract; it is operational and continuous. It includes accurate diagnosis, appropriate treatment selection, monitoring of patient response, communication of risks, obtaining informed consent, and adherence to established clinical protocols.²² The Supreme Court in *Dr. Laxman Balkrishna Joshi V. Dr. Trimbak Babu Godbole* clarified the scope of this duty when a patient died after improper administration of anaesthesia. The court held “*a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he possesses the requisite skill and knowledge... and that he will*

¹⁷ R.K. Bangia, *Law of Torts* (24th ed., Allahabad Law Agency 2022).

¹⁸ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

¹⁹ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480, ¶ 94 (India).

²⁰ R.K. Bangia, *Law of Torts* (24th ed., Allahabad Law Agency 2022).

²¹ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

²² Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

exercise a reasonable degree of care.”²³ This articulation continues to form the foundational Statement of professional duty in Indian medical negligence law.

A legal standard by which this duty is evaluated derives from the Bolam principle, adopted by Indian courts to assess professional negligence.²⁴ Under this doctrine, a medical practitioner is not negligent if the conduct conforms to a practise except it is proper by a responsible body of medical professionals skilled in that field.²⁵ The Supreme Court reaffirmed this standard in *Jacob Mathew v. State of Punjab*, arising from the death of a patient due to alleged oxygen supply failure. The court stated “*the standard to be applied for judging negligence is that of an ordinary competent practitioner exercising ordinary skill*”.²⁶ This principle recognises professional autonomy by acknowledging that medical science often permits multiple acceptable treatment methods.

However, the Bolam test has been subject to sustained academic criticism. Scholars such as Brasier and Cave argue that excessive judicial deference to professional opinion risks insulating negligent practises from accountability.²⁷ Comparative jurisprudence and *Bolitho v. City and Hackney Health Authority* refined Bolam by allowing courts to reject professional opinion lacking logical defensibility.²⁸ Although Indian courts have not formally adopted Bolitho, they have emphasised that professional opinion must be reasonable and responsible rather than merely existent.²⁹ For example, a surgeon selects a treatment method recognised in medical literature. However, the procedure is performed without proper sterilisation or post-operative monitoring. Even though the treatment method is accepted, the manner of execution violates basic professional standards. The Bolam defence therefore fails because professional acceptance applies to method, not negligent implementation.

The establishment of civil medical negligence requires proof of four elements:

- a. existence of duty,

²³ Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole, A.I.R. 1969 S.C. 128 (India).

²⁴ Jacob Mathew v. State of Punjab, (2005) 6 S.C.C. 1 (India).

²⁵ Bolam v. Friern Hosp. Mgmt. Comm., [1957] 1 W.L.R. 582 (Q.B.).

²⁶ Jacob Mathew v. State of Punjab, (2005) 6 S.C.C. 1, ¶ 48 (India).

²⁷ Law Comm’n of India, 196th Report on Medical Treatment After Accidents and During Emergency Conditions (2006).

²⁸ Bolitho v. City & Hackney Health Auth., [1998] A.C. 232 (H.L.).

²⁹ Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr., (2010) 3 S.C.C. 480 (India).

- b. Breach of duty,
- c. Causal connexion between breach and injury, and
- d. actual damage.³⁰

The burden of proof lies on the claimant. Courts require credible expert testimony demonstrating deviation from accepted medical practise. Section 45 of the Indian Evidence Act explicitly recognises expert opinion as relevant in matters involving specialised knowledge.³¹ Consumer forums and civil courts routinely rely on independent medical boards to evaluate professional conduct.³²

The evidentiary importance of expert testimony is reflected in litigation statistics. According to the National Consumer Disputes Redressal Commission annual report 2023, substantial proportion of medical negligence complaints are dismissed due to failure to establish breach through expert evidence.³³ NCRB data further indicates that allegations of professional negligence are frequently reported but rarely result in conviction due to stringent Evidentiary thresholds.³⁴ For example, a patient alleges that a surgeon cause nerve damage during spinal surgery. If expert medical opinion confirms that the complication is a recognised risk inherent in the procedure despite proper care, negligence is not established. Conversely, if expert testimony demonstrates improper surgical technique inconsistent with accepted standards, breach is proven.

A further doctrinal principle distinguishes medical error from negligence. Judicial decisions emphasise that medical professionals are not insurers of patient outcomes. In *Kusum Sharma*, the Supreme Court warned “*simply because a patient has not responded favourably to treatment does not lead to the conclusion that the doctor was negligent*”.³⁵ Similarly, in *Dr. Suresh Gupta v. Government of NCT Delhi*, Court held “*an error of judgement or accident is not proof of negligence... negligence must be of such a high degree as to be gross*”.³⁶

This distinction prevents retrospective evaluation based solely on outcomes and protects

³⁰ R.K. Bangia, *Law of Torts* (24th ed., Allahabad Law Agency 2022).

³¹ Indian Evidence Act, 1872, § 45).

³² *V. Kishan Rao v. Nikhil Super Speciality Hosp.*, (2010) 5 S.C.C. 513 (India).

³³ Nat'l Consumer Disputes Redressal Comm'n, Annual Report 2023.

³⁴ Nat'l Crime Recs. Bureau, Crime in India 2022.

³⁵ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India).

³⁶ *Dr. Suresh Gupta v. Gov't of NCT Delhi*, (2004) 6 S.C.C. 422 (India).

legitimate professional judgement. Medicine involves uncertainty, risk, and biological variability. The law therefore imposes liability only when conduct demonstrates lack of reasonable competence or care.³⁷ For example, a patient undergoing chemotherapy develops fatal complications due to immune suppression. If treatment followed recognised oncological protocols and risks were disclosed, the outcome is tragic but not negligent. However, if incorrect drug dosage was administered contrary to established guidelines, liability arises.

Academic research supports this doctrinal approach. Studies in health law scholarship emphasise that strict liability would discourage high risk but necessary treatment and promote defensive medicine.³⁸ Empirical data from the World Health Organisation indicates that fear of litigation significantly influences clinical decision making in high risk specialties.³⁹ Insurance industry reports from IRDAI demonstrate rising professional indemnity premiums correlated with increased malpractice claims.⁴⁰

Thus, the doctrinal foundations of medical negligence reflect a carefully structured equilibrium where professional autonomy is preserved, but accountability arises when conduct deviates from accepted standards in a manner that causes harm.⁴¹

Evolution of Judicial Standards and the Civil-Criminal Distinction

All the doctrinal foundations establish the conceptual basis of liability, the true evolution of Indian medical negligence law has occurred through judicial refinement of standards, particularly in distinguishing civil negligence from criminal culpability.⁴² The necessity of this distinction arises from the fundamentally different consequences attached to each form of liability. Civil negligence results in compensatory damages, whereas criminal negligence may deprive a medical practitioner of personal liberty and professional reputation.⁴³

The Supreme court's decision in *Jacob Mathew v. State of Punjab* remains the definitive authority in this regard.⁴⁴ The case arose from the death of a patient suffering from respiratory distress who allegedly died because the oxygen cylinder attached to him was empty. Criminal

³⁷ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

³⁸ Law Comm'n of India, 201st Report on Emergency Medical Care (2006).

³⁹ World Health Org., Global Patient Safety Report 2020.

⁴⁰ Ins. Regulatory & Dev. Auth. of India, Annual Report 2022–23.

⁴¹ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India).

⁴² *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

⁴³ K.D. Gaur, Textbook on Indian Penal Code (6th ed., Universal Law Publishing 2016).

⁴⁴ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

proceedings were initiated under section 304A of the Indian Penal Code. After reviewing the evidence, the court observed that negligence in the context of criminal law cannot be Acquainted with ordinary civil negligence. It held “*for negligence to amount to an offence, the element of men’s Ria must be shown to exist... the negligence must be gross or of a very high degree*”.⁴⁵

A court further emphasised that before prosecuting a doctor for criminal negligence, an independent and competent medical opinion must support the allegation.⁴⁶ This safeguard was introduced to prevent frivolous or retaliatory prosecutions that could paralyse medical decision making. The judgement recognised that doctors frequently operate in emergency environments or immediate decisions are required, and fear of criminal prosecution could discourage life saving Intervention.⁴⁷

This reasoning was reaffirmed in *Dr. Suresh Gupta v. Government of NCT Delhi*, where a patient died during nasal surgery allegedly due to improper anaesthesia administration. The Supreme Court quashed criminal proceedings, holding that “*a simple lack of care, an error of judgement or an accident is not proof of negligence... the negligence must be of such a high degree as to be described as gross*”.⁴⁸

Judicial insistence on “gross negligence” for criminal liability reflects recognition of the chilling effect criminal prosecution may have on medical practise.⁴⁹ And CRB statistical data demonstrates that although complaints alleging medical negligence are registered, conviction rates remain extremely low due to stringent evidentiary requirements.⁵⁰ This evidentiary threshold ensures that criminal sanction remains reserved for cases involving Reckless disregard for patient safety rather than mere professional misjudgment.⁵¹ Illustratively, if a surgeon deliberately ignores sterilisation protocols and proceeds with surgery despite known infection risks, resulting in patient death, such conduct may amount to gross negligence. Conversely, if a complication arises despite adherence to protocol and reasonable clinical

⁴⁵ Id. ¶¶ 48–52.

⁴⁶ Id. ¶ 52.

⁴⁷ Law Comm’n of India, 201st Report on Emergency Medical Care to Victims of Accidents and During Emergency Medical Condition (2006).

⁴⁸ *Dr. Suresh Gupta v. Gov’t of NCT Delhi*, (2004) 6 S.C.C. 422 (India).

⁴⁹ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India).

⁵⁰ Nat’l Crime Recs. Bureau, *Crime in India 2022* (Ministry of Home Affairs 2023).

⁵¹ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

judgement, criminal liability cannot be imposed.

The enactment of the Bharatiya Nyaya Sanhita 2023, replacing the Indian Penal Code, has renewed debate regarding criminal liability of medical practitioners. Section 106 of the new statute addresses causing death by negligence.⁵² All the statutory language remains broad, judicial interpretation continues to require proof of gross negligence in medical cases, thereby preserving the Jacob Mathew safeguard.⁵³

Consumer Protection and The Transformation of Medical Accountability

A major transformation in medical negligence jurisprudence occurred when medical services were brought within the ambit of consumer protection law.⁵⁴ In *Indian Medical Association v. P. Shantha*, the Supreme Court considered whether medical services fall within the definition of “service” under the Consumer Protection Act.⁵⁵ The court concluded that “*medical practitioners render service for consideration and Are therefore amenable to the jurisdiction of consumer fora*”.⁵⁶

This decision significantly expanded access to justice for patients period prior to this ruling, victims of medical negligence were required to pursue lengthy civil litigation. Consumer forums provided a relatively expeditious and cost effective alternative.⁵⁷

The decision also recognised the growing commercialization of healthcare. When hospitals operate as profit generating institutions charging substantial fees, accountability mechanisms must correspondingly expand.⁵⁸ The court clarified that even private hospitals and diagnostic centres are subject to consumer jurisdiction, provided services are rendered for consideration.⁵⁹

However, the consumerization of healthcare has generated criticism. Medical associations argue that exposure to consumer complaints encourages defensive medicine, leading to excessive diagnostic testing and avoidance of high risk procedures.⁶⁰ Empirical research cited

⁵² Bharatiya Nyaya Sanhita, 2023, § 106.

⁵³ Jacob Mathew v. State of Punjab, (2005) 6 S.C.C. 1 (India).

⁵⁴ Consumer Protection Act, 1986, No. 68 of 1986, India Code (repealed 2019); Consumer Protection Act, 2019, No. 35 of 2019, India Code.

⁵⁵ Indian Med. Ass’n v. V.P. Shantha, (1995) 6 S.C.C. 651 (India).

⁵⁶ Id. ¶ 55.

⁵⁷ Nat’l Consumer Disputes Redressal Comm’n, Annual Report 2023 (Gov’t of India 2023).

⁵⁸ Indian Med. Ass’n v. V.P. Shantha, (1995) 6 S.C.C. 651 (India).

⁵⁹ Id.

⁶⁰ Med. Council of India, Professional Conduct, Etiquette and Ethics Regulations, 2002; Law Comm’n of India,

by the World Health Organisation suggests that fear of litigation influences clinical decision making patterns, particularly in surgical specialties.⁶¹

Nevertheless, consumer forums have played a crucial role in awarding compensation in cases of demonstrable negligence. Data from the National Consumer Disputes Redressal Commission indicates a steady increase in medical negligence complaints over the past decade, particularly in metropolitan regions.⁶² This trend reflects rising patient awareness and greater willingness to pursue legal remedies. Illustratively, where a hospital fails to maintain basic emergency equipment and a patient dies due to equipment malfunction, consumer forums have awarded substantial compensation.⁶³ Such cases reinforce institutional accountability in a corporatized healthcare environment.

Institutional Liability and Vicarious Responsibility

Modern healthcare delivery is institutional rather than purely individual. Patients typically contract with hospitals rather than specific physicians. Consequently, institutional liability has become central to medical negligence law.⁶⁴

In *Savita Garg v. National Heart Institute*, the Supreme Court rejected the hospitals attempt to evade liability by arguing that the treating doctor was an independent consultant.⁶⁵ The court held “*once a patient is admitted in a hospital, it becomes the duty of the hospital to provide proper care... the hospital cannot escape liability by pleading that the Doctor was not its employee*”.⁶⁶

This decision reinforced the principle of vicarious liability and acknowledged that hospitals benefit economically from services rendered by associated doctors. Institutional responsibility ensures that victims are not left remedy less due to contractual technicalities.⁶⁷

Similarly, in *V. Kishan Rao V. Nikhil Super Speciality Hospital*, the Supreme Court emphasised that hospitals must ensure proper diagnostic evaluation and cannot ignore pathological reports

201st Report on Emergency Medical Care (2006).

⁶¹ World Health Org., Global Patient Safety Report 2020.

⁶² Nat'l Consumer Disputes Redressal Comm'n, Annual Report 2023.

⁶³ V. Kishan Rao v. Nikhil Super Speciality Hosp., (2010) 5 S.C.C. 513 (India).

⁶⁴ Indian Med. Ass'n v. V.P. Shantha, (1995) 6 S.C.C. 651 (India).

⁶⁵ Savita Garg v. Nat'l Heart Inst., (2004) 8 S.C.C. 56 (India).

⁶⁶ Id. ¶ 14.

⁶⁷ Consumer Protection Act, 2019, No. 35 of 2019, India Code.

available in their possession.⁶⁸ The failure to interpret laboratory results constituted deficiency in service.⁶⁹

Institutional liability also extends to systemic failures, such as inadequate staffing, poor hygiene, lack of monitoring, or malfunctioning equipment. In such cases common negligence may arise not from individual incompetence but from structural inadequacies.⁷⁰ Illustratively, if a hospital's intensive care unit lacks trained personnel to monitor ventilated patients, and a patient suffers preventable harm, liability may arise from institutional negligence even if individual doctors acted reasonably within available constraints.

Informed Consent and the Expansion of Patient Autonomy

Medical negligence jurisprudence has increasingly incorporated principles of patient autonomy and informed consent.⁷¹ The Supreme Court's decision in *Samira Kohli v. Dr. Prabhu Manchanda* represents a watershed moment in this evolution.⁷²

A patient had consented to diagnostic laparoscopy but underwent hysterectomy during the procedure without explicit authorization.⁷³ The court held that “*consent for a diagnostic procedure cannot be construed as consent for therapeutic surgery unless specifically authorised*”.⁷⁴ It further emphasised that “*the patient has the right to decide what is to be done with her body*”.⁷⁵

This ruling aligned Indian law with global bioethical standards emphasising bodily integrity and self determination.⁷⁶ It recognised that medical negligence may arise not only from technical incompetence but also from violation of autonomy.⁷⁷

A doctrine of informed consent requires disclosure of material risks, alternative treatments, and

⁶⁸ V. Kishan Rao v. Nikhil Super Speciality Hosp., (2010) 5 S.C.C. 513 (India).

⁶⁹ Id.

⁷⁰ Law Comm'n of India, 201st Report on Emergency Medical Care to Victims of Accidents and During Emergency Medical Condition (2006).

⁷¹ Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

⁷² Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 S.C.C. 1 (India).

⁷³ Id.

⁷⁴ Id. ¶ 49.

⁷⁵ Id. ¶ 51.

⁷⁶ Suchita Srivastava v. Chandigarh Admin., (2009) 9 S.C.C. 1 (India) (recognising reproductive autonomy and bodily integrity under Article 21).

⁷⁷ Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 S.C.C. 1 (India).

potential consequences.⁷⁸ Failure to disclose significant risks may constitute negligence even if the procedure is performed competently.⁷⁹ Illustratively, if a surgeon fails to inform a patient of a significant risk of paralysis associated with spinal surgery, and the risk materialises, liability may arise for failure to obtain informed consent.⁸⁰

Constitutional Dimensions and the Right to Health

A constitutional framework under Article 21 significantly influences medical negligence jurisprudence.⁸¹ The Supreme Court has interpreted the right to life to include the right to health and access to emergency medical care.⁸²

In *Parmanand Katara v. Union of India*, the Court declared that “*preservation of human life is of paramount importance... every doctor whether in government or private practice has the professional obligation to extend services to protect life.*”⁸³ This judgement established that denial of emergency treatment violates constitutional guarantees.⁸⁴

The right to health has also been reinforced through reference to international instruments. Article 12 of the International Covenant on economic, social and cultural rights recognises the right to the highest attainable standard of Health.⁸⁵ In *People’s Union for Civil Liberties v. Union of India*, the Supreme Court acknowledged that International Covenants inform constitutional interpretation.⁸⁶

While constitutional remedies typically address systemic healthcare deficiencies rather than individual negligence, they provide a normative backdrop against which professional accountability operates.⁸⁷

Contemporary Trends and Statistical Context

The expansion of medical negligence jurisprudence in India cannot be fully understood without

⁷⁸ Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

⁷⁹ *Samira Kohli v. Dr. Prabha Manchanda*, (2008) 2 S.C.C. 1 (India).

⁸⁰ *Id.*

⁸¹ INDIA CONST. art. 21.

⁸² *Consumer Educ. & Rsch. Ctr. v. Union of India*, (1995) 3 S.C.C. 42 (India); *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, (1996) 4 S.C.C. 37 (India).

⁸³ *Parmanand Katara v. Union of India*, (1989) 4 S.C.C. 286, ¶ 8 (India).

⁸⁴ *Id.*

⁸⁵ International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.

⁸⁶ *People’s Union for Civil Liberties v. Union of India*, (2001) 5 S.C.C. 577 (India).

⁸⁷ *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, (1996) 4 S.C.C. 37 (India).

examining the statistical growth of litigation and institutional complaints over the past two decades.⁸⁸ Empirical data reflects not only rising patient awareness but also structural transformation in the healthcare sector.⁸⁹

According to the national consumer disputes Redressal Commission (and CDRC) annual report 2023, medical negligence constitutes one of the most significant categories of service related complaints before consumer fora.⁹⁰ In metropolitan jurisdictions such as Delhi, Mumbai, and Bengaluru, medical negligence claims represent a substantial proportion of high value compensation disputes.⁹¹ Report indicates that thousands of healthcare related complaints are filed annually across district, state, and national consumer commissions.⁹² While a significant percentage of complaints are dismissed for lack of expert evidence, the increasing filing rate demonstrates heightened legal consciousness among patients.⁹³

Further statistical insight is available from the National Crime Records Bureau (and CRB). The NCRB's crime in India 2022 report records registered cases under provisions relating to causing death by negligence and professional negligence.⁹⁴ Although not all cases involve medical professionals, the data shows that allegations of negligence resulting in death are frequently reported.⁹⁵ However, conviction rates remain comparatively low, reinforcing the judicial insistence on strict proof standards in criminal medical negligence cases.⁹⁶ This evidentiary stringency aligns with the Supreme Court's direction in *Jacob Mathew* that criminal prosecution must be preceded by credible medical opinion.⁹⁷

The Insurance Regulatory and Development Authority of India (IRDAI) has also documented a steady increase in professional indemnity insurance claims filed by healthcare providers.⁹⁸ Rising indemnity premiums reflect growing exposure to malpractice litigation.⁹⁹ In particular, high risk specialties such as obstetrics, anesthesiology, and surgery report significantly higher

⁸⁸ Nat'l Consumer Disputes Redressal Comm'n, Annual Report 2023 (Gov't of India 2023).

⁸⁹ Ministry of Health & Family Welfare, National Health Accounts Estimates for India 2019–20 (Gov't of India).

⁹⁰ Nat'l Consumer Disputes Redressal Comm'n, Annual Report 2023.

⁹¹ *Id.*

⁹² *Id.*

⁹³ *V. Kishan Rao v. Nikhil Super Speciality Hosp.*, (2010) 5 S.C.C. 513 (India).

⁹⁴ Nat'l Crime Recs. Bureau, Crime in India 2022 (Ministry of Home Affairs 2023).

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

⁹⁸ Ins. Regulatory & Dev. Auth. of India, Annual Report 2022–23 (2023).

⁹⁹ *Id.*

premium brackets due to litigation frequency.¹⁰⁰ This economic indicator indirectly confirms the increasing legal vulnerability of medical practitioners.

At a global level, the World Health Organisation has emphasised that unsafe medical practises contribute significantly to preventable harm.¹⁰¹ The WHO's patient safety report 2020 estimates that adverse events occur in approximately 10% of hospitalised patients worldwide.¹⁰² While Indian specific hospital harm data remains unreported, extrapolations suggest systemic risk areas such as medication errors, surgical Complications, and diagnostic delays.¹⁰³

Healthcare expenditure data also provides contextual relevance. India's national health accounts indicate rising out of pocket expenditure in private healthcare facilities.¹⁰⁴ As treatment costs increase, patient expectations regarding quality and accountability correspondingly intensify.¹⁰⁵ The commercialization of tertiary care has therefore contributed to greater scrutiny of clinical decision making.¹⁰⁶

Empirical scholarship and health law supports the correlation between corporatized healthcare and litigation growth.¹⁰⁷ Studies suggest that when medical services are perceived as commercial transactions rather than purely fiduciary relationships, patients are more inclined to pursue legal remedies.¹⁰⁸ This trend is particularly visible in urban private hospitals or treatment packages are marketed and build systematically.

However, statistical growth in complaints does not automatically equate to increased proven negligence.¹⁰⁹ Data from Consumer Commission's shows that a substantial proportion of complaints are dismissed for failure to establish breach of duty through expert testimony.¹¹⁰ This demonstrates that while awareness has increased, courts continue to adhere strictly to doctrinal requirements.¹¹¹ Illustratively, patient may file a complaint alleging surgical

¹⁰⁰ Id.

¹⁰¹ World Health Org., Global Patient Safety Report 2020.

¹⁰² Id.

¹⁰³ Id.

¹⁰⁴ Ministry of Health & Family Welfare, National Health Accounts Estimates for India 2019–20 (Gov't of India).

¹⁰⁵ Id.

¹⁰⁶ Indian Med. Ass'n v. V.P. Shantha, (1995) 6 S.C.C. 651 (India).

¹⁰⁷ Law Comm'n of India, 201st Report on Emergency Medical Care (2006).

¹⁰⁸ Id.

¹⁰⁹ Nat'l Consumer Disputes Redressal Comm'n, Annual Report 2023.

¹¹⁰ Id.

¹¹¹ Jacob Mathew v. State of Punjab, (2005) 6 S.C.C. 1 (India).

negligence after a post operative infection. Statistical data shows such complaints are common. Yet unless evidence demonstrates deviation from sterilisation protocol or improper monitoring common negligence cannot be established merely because infection occurred as a recognised medical risk.

A statistical landscape therefore reinforces the doctrinal equilibrium described earlier.¹¹² There is increased access to remedies and rising litigation awareness, yet courts maintain rigorous evidentiary thresholds to prevent outcome based liability.¹¹³

Defensive Medicine and Policy Concerns

A statistical rise in medical negligence complaints has generated significant policy debate regarding defensive medicine.¹¹⁴ Defensive medicine refers to the practise of recommending additional diagnostic tests, procedures, or referrals primarily to reduce exposure to liability rather than to advanced patient welfare.¹¹⁵

Empirical studies cited by the World Health Organisation indicate that litigation anxiety influences clinical behaviour, particularly in high risk surgical and obstetric fields.¹¹⁶ Indian professional associations have similarly argued that increasing consumer complaints encourage overt diagnostic testing and unnecessary specialist referrals.¹¹⁷

Insurance data supports this concern. IRDAI reports demonstrate higher indemnity premiums and specialties associated with childbirth complications and emergency surgery.¹¹⁸ As premiums rise, healthcare costs may correspondingly increase, indirectly affecting patient affordability.¹¹⁹

Nevertheless, policy discussions must avoid exaggeration. Judicial decisions consistently emphasise that medical professionals are protected from liability when acting in accordance

¹¹² *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India).

¹¹³ *Id.*

¹¹⁴ Nat'l Consumer Disputes Redressal Comm'n, Annual Report 2023 (Gov't of India 2023).

¹¹⁵ Law Comm'n of India, 201st Report on Emergency Medical Care to Victims of Accidents and During Emergency Medical Condition (2006).

¹¹⁶ World Health Org., Global Patient Safety Report 2020.

¹¹⁷ Indian Med. Ass'n, Position Statements on Medical Litigation and Professional Risk (various policy submissions to Government of India).

¹¹⁸ Ins. Regulatory & Dev. Auth. of India, Annual Report 2022–23 (2023).

¹¹⁹ Ministry of Health & Family Welfare, National Health Accounts Estimates for India 2019–20 (Gov't of India).

with accepted standards.¹²⁰ The doctrinal safeguards established in *Kusum Sharma, Jacob Mathew, and Dr. Suresh Gupta* ensure that honest errors or recognised risks do not attract penal sanction.¹²¹

Thus, while defensive medicine remains a legitimate policy concern, empirical evidence also demonstrates that courts are not imposing strict liability on health care providers.¹²² The statistical rise in complaints reflects awareness and access, not necessarily an erosion of professional protection.¹²³

Conclusion

Indian medical negligence jurisprudence reflects a carefully calibrated balance between professional autonomy and patient protection.¹²⁴ The doctrinal structure duty of care, standard, evidentiary requirements, civil-criminal distinction, informed consent doctrine, institutional liability, and constitutional safeguards collectively creates a multi layered accountability framework.¹²⁵

The Supreme Court's jurisprudence consistently rejects outcomebased liability and insists upon proof of unreasonable deviation from accepted professional standards.¹²⁶ Criminal prosecution is restricted to cases of gross negligence, preserving proportionality.¹²⁷ Consumer protection law enhances accessibility of remedies, while constitutional jurisprudence reinforces the centrality of health care to human dignity.¹²⁸

As healthcare continues to evolve technologically and institutionally, the legal framework must adapt by strengthening expert adjudication mechanisms, clarifying statutory standards, and promoting patient safety initiatives.¹²⁹ The legitimacy of medical practise ultimately depends

¹²⁰ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

¹²¹ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India); *Dr. Suresh Gupta v. Gov't of NCT Delhi*, (2004) 6 S.C.C. 422 (India).

¹²² Nat'l Crime Recs. Bureau, *Crime in India 2022* (Ministry of Home Affairs 2023).

¹²³ *Id.*

¹²⁴ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India).

¹²⁵ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India); *Samira Kohli v. Dr. Prabha Manchanda*, (2008) 2 S.C.C. 1 (India); *Savita Garg v. Nat'l Heart Inst.*, (2004) 8 S.C.C. 56 (India).

¹²⁶ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

¹²⁷ *Dr. Suresh Gupta v. Gov't of NCT Delhi*, (2004) 6 S.C.C. 422 (India).

¹²⁸ *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 S.C.C. 651 (India); *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, (1996) 4 S.C.C. 37 (India).

¹²⁹ Law Comm'n of India, *201st Report on Emergency Medical Care to Victims of Accidents and During Emergency Medical Condition* (2006); Ministry of Health & Family Welfare, *National Health Accounts Estimates for India 2019–20* (Gov't of India).

upon public trust space trust that professionals will act competently and ethically, and trust that the legal system will intervene where that expectation is betrayed.¹³⁰

The equilibrium achieved by Indian courts demonstrates a nuanced understanding of medicines inherent uncertainty. By distinguishing error from negligence and negligence from crime, the law safeguards both patient welfare and professional integrity.¹³¹ A delicate balance remains the defining feature of medical negligence liability under Indian health law.¹³²

¹³⁰ Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

¹³¹ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India); *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480 (India).

¹³² *Id.*