
INSTITUTIONAL MEDICAL NEGLIGENCE IN INDIA: MOVING BEYOND THE NEGLIGENT DOCTOR

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ABSTRACT

Medical negligence in India has traditionally been examined through the conduct of individual medical professionals, with courts principally asking whether a doctor exercised the degree of care and competence expected of a reasonably competent practitioner. While this approach remains essential to determining professional liability, the increasing complexity of modern healthcare raises a broader question: can patient harm always be attributed to the conduct of an individual doctor? Hospitals function through interconnected systems involving medical practitioners, nursing staff, technicians, administrators, protocols, infrastructure, record-keeping mechanisms and institutional policies. Failures within these systems may independently contribute to patient injury even where no single medical professional can be shown to have acted negligently.

The paper analyses the development of medical-negligence jurisprudence through decisions including *Achutrao Haribhau Khodwa v. State of Maharashtra*, *Spring Meadows Hospital v. Harjol Ahluwalia*, *Savita Garg v Director, National Heart Institute*, *Nizam Institute of Medical Sciences v. Prasanth S Dhananka* and *Jacob Mathew v. State of Punjab*. It distinguishes institutional negligence from conventional vicarious liability and examines circumstances in which hospitals may be directly responsible for inadequate supervision, deficient systems, poor staffing, failure to maintain records, defective protocols and other organisational failures. The paper further considers the implications of the Consumer Protection Act 2019 and the contemporary regulatory framework governing medical professionals and healthcare institutions.

It argues that Indian law should move beyond treating the hospital merely as an entity vicariously liable for the acts of its doctors and recognise an independent institutional duty of care. Such an approach would preserve the heightened protection afforded to medical professionals against unfounded claims while ensuring that patients are not left without an effective remedy where harm results from systemic failures rather than the isolated conduct of an individual doctor. The paper concludes by proposing a framework for identifying, attributing and remedying institutional medical negligence within Indian healthcare law.

I. Introduction

The modern healthcare system is no longer a relationship between a patient and an individual doctor alone. Medical treatment is delivered through complex institutional structures involving doctors, nurses, technicians, administrators, pharmacists, diagnostic laboratories, intensive-care units, emergency departments and hospital management. The quality of treatment received by a patient may therefore depend not merely upon the clinical judgment of the doctor attending to the patient, but upon the functioning of the institution as a whole. Failures in staffing, supervision, communication, maintenance of medical records, availability of equipment, infection control, referral mechanisms or adherence to institutional protocols may contribute to serious injury even where it is difficult to identify a single negligent medical professional. The law of medical negligence must consequently confront a question that is increasingly important in contemporary healthcare, when harm results from a failure of the healthcare institution itself, should liability continue to be framed principally through the negligence of an individual doctor.

Indian medical-negligence jurisprudence has historically developed around the standard of care owed by medical professionals. The Supreme Court has repeatedly emphasised that a medical practitioner is not liable merely because treatment has produced an adverse outcome or because another course of treatment might have produced a better result. The relevant inquiry is whether the practitioner exercised reasonable care, skill and competence in accordance with the standard expected of a reasonably competent medical professional.¹ This approach serves an important function by distinguishing genuine negligence from an error of judgment, an unsuccessful treatment or an unfortunate medical outcome. At the same time, an exclusive focus on the individual practitioner becomes increasingly difficult to sustain where healthcare is organised through institutions whose systems materially determine the manner in which medical treatment is provided.

The Supreme Court's jurisprudence already contains the foundations of a broader conception of institutional responsibility. In *Achutrao Haribhau Khodwa v. State of Maharashtra*, the Court rejected the proposition that the State could escape liability for negligence occurring in a government hospital merely because the hospital was operated by the State.² The Court

¹ *Achutrao Haribhau Khodwa v. State of Maharashtra* (1996) 2 SCC 634; *Jacob Mathew v. State of Punjab* (2005) 6 SCC 1.

² *Achutrao Haribhau Khodwa* (n 1).

characterised the running of a hospital as a welfare activity rather than an exercise of sovereign power and held the State capable of being liable for negligence occurring within the hospital.³ The decision is significant because it moves the inquiry beyond the private relationship between doctor and patient and towards the responsibility of the healthcare institution providing the treatment.

Similarly, in *Spring Meadows Hospital v. Harjol Ahluwalia*, the Supreme Court recognised the liability of a hospital in proceedings arising from negligent medical treatment provided to a child.⁴ The decision demonstrated that the legal responsibility of a hospital cannot necessarily be displaced by attributing the relevant conduct solely to the individual medical professional. Hospital liability consequently emerged as an important component of consumer-oriented medical-negligence jurisprudence.

The position was further developed in *Savita Garg v. Director, National Heart Institute*, where the Supreme Court considered the evidentiary difficulties faced by patients attempting to establish negligence within a hospital.⁵ The Court recognised that a patient and the patient's family may not possess knowledge of the internal events occurring during treatment, whereas the hospital controls the relevant medical records and information concerning the treatment provided.⁶ The judgment therefore has significance beyond the question of evidentiary burden: it acknowledges the structural imbalance between patients and healthcare institutions and the need for the law to account for that imbalance when determining institutional responsibility.

Yet, despite these developments, Indian law does not presently articulate a comprehensive and autonomous doctrine of institutional medical negligence. Hospital liability is frequently approached through established doctrines such as vicarious liability, deficiency in service or negligence attributable to employees and medical professionals. These doctrines are important but do not completely address situations in which the source of harm lies in the hospital's own organisational failure. A hospital may, for example, employ competent doctors while maintaining inadequate systems for emergency response, fail to ensure appropriate staffing, permit deficiencies in record maintenance, lack adequate supervision or fail to establish reasonable protocols for foreseeable clinical risks. In such circumstances, identifying one

³ Ibid.

⁴ *Spring Meadows Hospital v. Harjol Ahluwalia* (1998) 4 SCC 39.

⁵ *Savita Garg v. Director, National Heart Institute* (2004) 8 SCC 56.

⁶ Ibid.

negligent doctor may obscure the more fundamental question of whether the hospital itself failed in the duty of care owed to its patients.

This distinction is particularly important in India because healthcare is delivered through a diverse combination of government hospitals, private hospitals, charitable institutions, nursing homes and increasingly large corporate healthcare networks. The scale and complexity of these institutions mean that patient safety is often dependent upon organisational arrangements rather than individual clinical decisions alone. The legal framework must therefore be capable of addressing both clinical negligence, where the conduct of an individual professional falls below the applicable standard, and organisational negligence, where the institution's systems, policies or management contribute independently to patient harm.

The distinction also has important implications for access to justice. A patient who suffers injury because of a systemic failure may be unable to identify the particular employee responsible for the failure. Requiring the patient to establish the negligence of a specific doctor in every case risk placing an unrealistic evidentiary burden upon the person least capable of accessing information concerning the internal functioning of the hospital. Conversely, an excessively broad institutional liability rule could expose hospitals and medical professionals to liability for every adverse treatment outcome and encourage defensive medicine. The challenge is therefore to construct a standard that recognises institutional responsibility without converting hospitals into insurers against every medical complication.

This paper argues that Indian medical-negligence law should move beyond a predominantly doctor-centric model and recognise that hospitals may owe an independent institutional duty of care to patients. Such a duty should not replace existing standards governing individual medical negligence but should operate alongside them where patient harm results from organisational failures attributable to the institution itself. The paper examines the development of hospital liability under Indian law, distinguishes institutional negligence from vicarious liability, analyses the Supreme Court's approach to hospital responsibility and evidentiary burdens, and identifies gaps in the present framework. It ultimately proposes a more structured approach under which hospitals may be held directly responsible for foreseeable systemic failures while preserving appropriate safeguards against liability for genuine medical uncertainty or unavoidable adverse outcomes.

The central argument is therefore not that every hospital injury should be characterised as

institutional negligence. Rather, where the organisation of healthcare itself creates or materially increases a foreseeable risk of patient harm, the law should be capable of attributing responsibility to the institution independently of the fault of an individual doctor. Such an approach would better reflect the realities of contemporary healthcare and strengthen the ability of Indian medical-negligence law to protect patients without undermining legitimate professional autonomy.

II. Conceptualising Institutional Medical Negligence

The concept of institutional medical negligence requires a distinction between the negligence of an individual healthcare professional and negligence arising from the organisation or operation of a healthcare institution. Traditional medical negligence is ordinarily concerned with whether a particular doctor or other professional exercised the degree of reasonable care, skill and competence expected in the circumstances. Institutional negligence, by contrast, focuses on whether the hospital or healthcare provider, as an organisation, established and maintained systems reasonably capable of delivering safe medical care. The distinction is important because the source of patient harm may lie not in an isolated clinical decision but in a combination of organisational deficiencies that no individual doctor can reasonably be expected to correct.

At its simplest, institutional medical negligence may be understood as a failure by a healthcare institution to exercise reasonable care in the organisation, supervision, management or delivery of healthcare services, resulting in foreseeable patient harm. The relevant standard is therefore not limited to the professional skill of the doctor. It may encompass the hospital's responsibility to maintain adequate infrastructure, employ appropriately qualified personnel, establish reasonable clinical protocols, ensure effective supervision, maintain accurate medical records, facilitate communication between healthcare professionals, provide necessary emergency facilities and respond appropriately to foreseeable risks. The institution's liability arises from its own organisational responsibilities and not merely from the fact that an employee has committed negligence.

This distinction separates institutional negligence from vicarious liability. Under vicarious liability, an employer may be held responsible for the negligent conduct of an employee committed in the course of employment. The underlying wrong remains the employee's negligence; the institution's liability is derivative. Institutional negligence, in contrast, is

concerned with a breach attributable to the institution itself. A hospital may therefore be institutionally negligent even where no individual doctor can be identified as having breached the professional standard of care. For example, if a hospital fails to maintain an adequate system for monitoring patients at risk of deterioration, the legal question is not necessarily whether a particular nurse or doctor failed to observe the patient. It is whether the hospital itself failed to establish a reasonable system for patient monitoring.

The distinction is particularly important because contemporary hospitals operate as organisational systems. Treatment is frequently distributed among several professionals and departments. A patient admitted through an emergency department may be examined by one doctor, undergo diagnostic testing by another department, receive medication administered by nursing staff and subsequently be transferred to an intensive-care unit. The safety of the patient depends upon communication and coordination between these actors. A failure at the institutional level can therefore produce a chain of events culminating in injury, even though each individual participant may have acted reasonably when considered in isolation.

Indian law has not completely ignored this organisational dimension. In *Achutrao Haribhau Khodwa v. State of Maharashtra*, the Supreme Court considered negligence occurring within a government hospital and rejected the argument that the State could avoid liability merely because the hospital was engaged in a public function.⁷ The Court observed that hospitals owe duties to patients and that the State, when operating a hospital, can be held responsible for negligent treatment. The significance of the decision lies in recognising that the operation of a hospital itself creates responsibilities that extend beyond the purely personal relationship between a doctor and patient.

The consumer-protection jurisprudence of the Supreme Court has also facilitated the development of hospital liability. In *Indian Medical Association v. VP Shantha*, the Court held that medical services could, subject to specified exceptions, fall within the definition of “service” under the Consumer Protection Act 1986.⁸ This brought medical treatment within a statutory framework focused upon deficiency in service and enabled patients to pursue remedies against hospitals and medical establishments. Although the Consumer Protection Act 2019 subsequently replaced the 1986 legislation, the basic recognition of medical services

⁷ *Achutrao Haribhau Khodwa v. State of Maharashtra* (1996) 2 SCC 634.

⁸ *Indian Medical Association v. VP Shantha* (1995) 6 SCC 651.

within consumer law remains significant.⁹

The jurisprudence concerning hospital responsibility became particularly important in *Spring Meadows Hospital v. Harjol Ahluwalia*. The case involved a child who suffered severe injury following negligent administration of medication by hospital staff.¹⁰ The Supreme Court held the hospital liable and recognised that a hospital cannot escape responsibility by treating the negligent act as merely that of an employee.¹¹ The case is frequently associated with vicarious liability, but its broader significance lies in recognising the hospital as an entity responsible for the quality and safety of the services delivered through its institutional structure.

A further development appears in *Savita Garg v. Director, National Heart Institute*. The Supreme Court emphasised the special evidentiary position occupied by hospitals in medical-negligence litigation.¹² A patient generally lacks access to information concerning what occurred during treatment, while the hospital possesses medical records and information concerning the conduct of its personnel. The Court therefore recognised that once the complainant establishes an appropriate prima facie case, the burden cannot be treated as though the patient possesses the same knowledge and evidence as the hospital.¹³

This evidentiary principle is particularly relevant to institutional negligence. Organisational failures are often invisible to the patient. A patient may know that treatment was delayed or that necessary equipment was unavailable but may not know whether the underlying cause was inadequate staffing, deficient hospital protocols, poor communication or an administrative decision. The institution, by contrast, ordinarily possesses the records, staffing schedules, internal protocols, incident reports and administrative information necessary to explain what occurred. Consequently, an effective framework for institutional negligence must account for this information asymmetry.

The concept also overlaps with, but should not be confused with, the doctrine of deficiency in service under consumer law. The Consumer Protection Act 2019 defines “deficiency” broadly to include a fault, imperfection, shortcoming or inadequacy in the quality, nature or manner of performance required by law or undertaken to be performed pursuant to a contract or

⁹ Consumer Protection Act 2019, ss 2(11), 2(42).

¹⁰ *Spring Meadows Hospital v. Harjol Ahluwalia* (1998) 4 SCC 39.

¹¹ *Ibid.*

¹² *Savita Garg v. Director, National Heart Institute* (2004) 8 SCC 56.

¹³ *Ibid.*

otherwise.¹⁴ This language provides a potentially useful statutory basis for addressing institutional failures. Nevertheless, deficiency in service and institutional negligence are not necessarily identical concepts. The former operates within consumer law and focuses upon the quality or adequacy of a service, whereas institutional negligence is concerned with the broader tortious and professional duty of care owed by a healthcare institution.

The distinction becomes particularly important where a patient's injury results from multiple contributing failures. Consider, for instance, a patient whose deterioration is not detected because the hospital has inadequate monitoring procedures, whose condition is subsequently communicated late because of deficient internal communication and who ultimately suffers injury because the required emergency equipment is unavailable. It may be artificial to identify one doctor as the sole cause of the injury. The harm may instead be the product of an organisational system that was inadequately designed or implemented. Treating such a case exclusively as individual medical negligence risks failing to capture the actual cause of the patient's injury.

Institutional negligence should therefore be conceptualised around several recurring categories of organisational responsibility. These include inadequate staffing and supervision; failure to maintain appropriate infrastructure and equipment; defective or absent clinical protocols; failures in communication and coordination; inadequate maintenance of medical records; deficient infection-control systems; inappropriate delegation of clinical responsibilities; and failures in emergency preparedness. The presence of any one of these factors should not automatically establish liability. Rather, the question should be whether the institution failed to take precautions that a reasonably organised healthcare provider could have been expected to take in comparable circumstances.

This approach also preserves an important limitation. Hospitals should not become insurers against every adverse medical outcome. Medicine involves uncertainty, inherent risks and complications that cannot always be prevented through reasonable care. The fact that an institution possesses sophisticated facilities does not mean that every unsuccessful treatment demonstrates negligence. The legal inquiry must remain one of reasonableness and foreseeability, requiring a connection between the institutional failure and the injury suffered.

¹⁴ Consumer Protection Act 2019, s 2(11).

The conceptual shift proposed by this paper is therefore modest but significant. Indian law need not abandon the established principles governing professional medical negligence. Instead, it should recognise that the duty of care in modern healthcare has two interconnected dimensions: the professional duty owed by the individual practitioner and the organisational duty owed by the healthcare institution. Where the latter is independently breached, the patient's remedy should not depend upon proving that a particular doctor was personally negligent.

This distinction provides the foundation for examining the next question: how Indian law has historically moved from individual professional liability towards recognition of hospitals as independent legal actors in the delivery of healthcare.

III. Evolution of Hospital Liability in India

The recognition of hospitals as legally responsible actors has developed incrementally within Indian medical-negligence jurisprudence. Earlier disputes concerning medical treatment were predominantly framed around the conduct of individual doctors and the traditional principles of professional negligence. However, the expansion of private healthcare, the emergence of corporate hospitals and the recognition of medical services under consumer-protection law gradually altered the legal relationship between patients and healthcare institutions. The hospital came to be understood not merely as the physical location in which a doctor practises, but as an institution that undertakes responsibility for organising and delivering healthcare.

A significant early development was the Supreme Court's decision in *Achutrao Haribhau Khodwa v. State of Maharashtra*.¹⁵ The case arose from the death of a patient following treatment in a government hospital. The State sought to resist liability by relying, among other things, upon the public character of the hospital. The Supreme Court rejected this approach and held that the State could be liable for negligence in the operation of the hospital.¹⁶ The Court distinguished between sovereign functions and activities such as running hospitals and emphasised that patients receiving treatment in a government hospital are entitled to reasonable care.¹⁷

The importance of *Achutrao Haribhau Khodwa* extends beyond the particular facts of the case.

¹⁵ *Achutrao Haribhau Khodwa v. State of Maharashtra* (1996) 2 SCC 634.

¹⁶ *Ibid.*

¹⁷ *Ibid.*

It established that the institutional character of a hospital does not, by itself, immunise it from legal responsibility. More importantly, the judgment recognised that negligence within a hospital may have consequences for the institution responsible for providing the healthcare service. The case therefore provides an early foundation for moving away from an exclusively doctor-centric conception of medical negligence.

The development of hospital liability was strengthened by the Supreme Court's decision in *Indian Medical Association v. VP Shantha*.¹⁸ The Court considered whether medical practitioners and hospitals providing medical services fell within the scope of the Consumer Protection Act 1986. It held that medical services rendered for consideration generally constituted “service” within the meaning of the legislation, subject to the statutory exceptions identified by the Court.¹⁹ This was a significant transformation in the legal position of patients. Rather than being required to rely exclusively upon conventional civil litigation, patients could seek remedies before consumer fora for deficiencies in medical services.

The consumer-protection framework was particularly significant because it shifted attention from the personal relationship between doctor and patient towards the service-provider relationship. Once a hospital is regarded as a provider of healthcare services, questions concerning the adequacy of the institutional service become legally relevant. The hospital's infrastructure, staff, procedures and administrative arrangements can potentially form part of the service for which the patient has sought treatment.

The Supreme Court subsequently reinforced institutional responsibility in *Spring Meadows Hospital v. Harjol Ahluwalia*.²⁰ The case concerned a child who suffered serious injury following the administration of an incorrect medication by hospital staff. The Court held the hospital responsible and recognised that an institution providing medical treatment cannot avoid liability simply by attributing the negligent conduct to an employee.²¹ The judgment is commonly discussed in terms of vicarious liability, but it also reflects a broader principle: hospitals occupy a position of responsibility for the healthcare services delivered through their organisational structures.

The significance of this development becomes clearer when contrasted with the traditional

¹⁸ *Indian Medical Association v. VP Shantha* (1995) 6 SCC 651.

¹⁹ *Ibid.*

²⁰ *Spring Meadows Hospital v. Harjol Ahluwalia* (1998) 4 SCC 39.

²¹ *Ibid.*

approach to professional negligence. A doctor is ordinarily assessed according to the standard of a reasonably competent medical practitioner. The hospital, however, performs a different function. It creates the environment within which that professional judgment is exercised. It recruits personnel, determines staffing arrangements, provides equipment, establishes administrative procedures and controls the systems through which different medical professionals interact. A hospital may therefore contribute to patient harm without the relevant failure necessarily amounting to a breach by one particular doctor.

The Supreme Court's decision in *Savita Garg v. Director, National Heart Institute* represents another important stage in this development.²² The case concerned allegations of negligence following the death of a patient in a hospital. The Court recognised that patients are frequently unable to establish precisely what occurred during medical treatment because the relevant information remains within the control of the hospital.²³ It observed that medical records and other evidence concerning treatment are ordinarily maintained by the hospital and that the patient cannot reasonably be expected to possess the same information.²⁴

This recognition of information asymmetry has considerable implications for institutional negligence. The internal operation of a hospital is ordinarily opaque to patients. A patient may experience the consequences of a failure without being able to identify its organisational cause. For example, a patient may suffer because a specialist was unavailable, an emergency procedure was not followed, a critical piece of equipment was non-functional, or relevant information was not communicated between departments. The hospital, however, will generally possess the records necessary to determine why the failure occurred.

Consequently, the evidentiary approach adopted in *Savita Garg* can support a broader conception of institutional responsibility. It would be inconsistent with the realities of healthcare to require patients to identify the precise employee responsible for a systemic failure where the relevant evidence is exclusively controlled by the hospital. The law must instead permit appropriate inferences to be drawn from the circumstances and require the institution to explain matters that lie particularly within its knowledge.

The Supreme Court also addressed the nature of professional medical negligence in *Jacob*

²² *Savita Garg v. Director, National Heart Institute* (2004) 8 SCC 56.

²³ *Ibid.*

²⁴ *Ibid.*

Mathew v. State of Punjab.²⁵ Although the case primarily concerned criminal liability of medical professionals, its importance extends to the broader architecture of medical-negligence law. The Court emphasised that negligence in the medical context cannot be inferred merely from an unsuccessful outcome and that a doctor should not be subjected to criminal prosecution simply because the treatment was unsuccessful.²⁶ The Court's insistence upon a meaningful threshold for professional negligence reflects the need to distinguish genuine departures from reasonable medical practice from unavoidable risks and errors of judgment.

This principle is equally relevant to institutional negligence. Recognition of an independent duty owed by hospitals must not transform every adverse medical outcome into institutional liability. Healthcare institutions operate in circumstances involving uncertainty, resource limitations and medical risks that cannot always be eliminated. The appropriate question should therefore remain whether the hospital failed to take reasonable precautions against a foreseeable risk of harm.

The evolution of Indian law can consequently be understood as involving three overlapping stages. First, the law focused predominantly upon the professional conduct of individual doctors. Secondly, consumer-protection jurisprudence recognised hospitals and medical establishments as providers of services and consequently subjected them to institutional responsibility. Thirdly, judicial decisions increasingly acknowledged the evidentiary and structural realities of hospital-based treatment, thereby creating space for a more independent conception of hospital responsibility.

The Consumer Protection Act 2019 provides an important statutory continuation of this development. The Act defines “service” broadly and specifically includes facilities connected with the provision of services.²⁷ It also defines “deficiency” to include fault, imperfection, shortcoming or inadequacy in the quality, nature or manner of performance required under law or undertaken by the service provider.²⁸ These provisions create substantial scope for addressing failures that are not necessarily reducible to an individual doctor's clinical decision.

Nevertheless, the statutory framework does not expressly formulate a separate doctrine of institutional medical negligence. A patient may establish a claim against a hospital through

²⁵ *Jacob Mathew v. State of Punjab* (2005) 6 SCC 1.

²⁶ *Ibid.*

²⁷ Consumer Protection Act 2019, s 2(42).

²⁸ Consumer Protection Act 2019, s 2(11).

deficiency in service, vicarious liability or general principles of negligence, but Indian law lacks a clearly articulated test for determining when a hospital's own organisational conduct constitutes negligence independently of the conduct of its employees.

This gap is increasingly significant. Contemporary healthcare involves highly specialised departments, multidisciplinary treatment and sophisticated technological infrastructure. The possibility of harm arising from organisational failures has consequently increased. A patient can be harmed by a defective system of communication, inadequate infection-control procedures, failure to maintain essential equipment or insufficient supervision even when the doctors involved have individually acted within the accepted professional standard.

The existing jurisprudence therefore contains the building blocks of institutional medical negligence without fully consolidating them into an autonomous doctrine. Indian courts have recognised hospital responsibility, subjected medical services to consumer law, imposed evidentiary obligations upon hospitals and acknowledged that institutions may be responsible for the conduct of their staff. What remains insufficiently developed is a principled framework for distinguishing ordinary vicarious liability from direct institutional negligence.

That distinction becomes crucial because vicarious liability and direct institutional liability serve different purposes. Vicarious liability asks whether the institution should answer for the wrongful conduct of a person acting on its behalf. Institutional negligence asks whether the institution itself failed to discharge the standard of care reasonably expected from a healthcare provider. Treating the two as interchangeable may obscure important categories of patient harm and leave systemic failures inadequately addressed.

IV. From Individual Negligence to Institutional Responsibility: The Need for a Distinct Legal Framework

The preceding analysis demonstrates that Indian law has progressively recognised hospitals as responsible participants in the provision of healthcare. However, the existing jurisprudence remains largely fragmented. Hospital liability is commonly explained through vicarious liability, consumer protection or the evidentiary principles applicable to medical negligence. These doctrines provide important remedies, but they do not adequately answer a central question: when should a hospital itself be considered negligent because of the way in which it organises and delivers healthcare, irrespective of whether the negligence of an individual

doctor can be established?

The answer requires recognition of an independent institutional duty of care. Such a duty would arise from the hospital's own position as a provider of healthcare rather than solely from its relationship with doctors employed or engaged by it. The duty would require the institution to take reasonable steps to ensure that its systems, personnel and infrastructure are capable of providing safe treatment. This would include appropriate staffing, supervision, maintenance of essential equipment, communication systems, record-keeping, emergency preparedness and reasonable clinical protocols.

A distinction must therefore be maintained between individual professional negligence, vicarious liability and direct institutional negligence. Individual negligence concerns the conduct of the doctor or other healthcare professional. Vicarious liability attributes responsibility to the hospital for the negligent conduct of an employee or agent. Direct institutional negligence, however, arises from the hospital's own failure to discharge the organisational standard reasonably expected of a healthcare provider. The third category is the most significant for the development of Indian law because it addresses circumstances in which the hospital's systems themselves contribute to patient harm.

The Supreme Court's jurisprudence provides a foundation for such an approach. In *Savita Garg v. Director, National Heart Institute*, the Court acknowledged that the patient is ordinarily unable to know the internal circumstances surrounding treatment and that relevant information remains with the hospital.²⁹ This principle should be developed beyond merely facilitating proof of conventional negligence. Where the hospital possesses exclusive information concerning staffing, protocols, equipment or internal procedures, the institution should be required to provide an adequate explanation where the circumstances raise a prima facie inference of systemic failure.

A similar logic can be drawn from *Nizam Institute of Medical Sciences v. Prasanth S Dhananka*,³⁰ where the Supreme Court dealt with a patient who suffered severe disability following medical treatment and emphasised the serious consequences of medical negligence and the need for appropriate compensation.³¹ Although the case principally concerned the

²⁹ *Savita Garg v. Director, National Heart Institute* (2004) 8 SCC 56.

³⁰ *Nizam Institute of Medical Sciences v. Prasanth S Dhananka* (2009) 6 SCC 1.

³¹ *Ibid.*

assessment of compensation, it demonstrates why medical-negligence law must account for the actual consequences of institutional failures rather than treating patient injury as merely an isolated professional error.

An institutional duty should nevertheless be subject to a reasonableness standard. Hospitals should not be required to guarantee successful treatment or eliminate every foreseeable medical risk. Such an approach would effectively convert medical negligence into strict liability. Instead, liability should arise where the hospital fails to adopt precautions, systems or safeguards that a reasonably competent healthcare institution could have been expected to maintain in comparable circumstances.

Four broad categories of institutional failure provide a useful framework.

First, hospitals should bear responsibility for inadequate staffing and supervision. A hospital that accepts patients requiring specialised or emergency care should reasonably ensure that appropriately qualified personnel are available. Where foreseeable patient needs are systematically greater than the institution's staffing capacity, the resulting risk should not automatically be characterised as an individual doctor's failure. The institution's decision to operate without adequate personnel may itself constitute a breach of its duty of care.

Secondly, hospitals should have an obligation concerning infrastructure and essential equipment. A healthcare institution that undertakes to provide a particular category of treatment should possess the facilities reasonably necessary to provide that treatment safely. Failure to maintain essential equipment, failure to ensure its availability in emergencies or failure to maintain functioning diagnostic facilities may constitute direct institutional negligence. This is particularly relevant where the absence of equipment is attributable to administrative decisions rather than the conduct of treating doctors.

Thirdly, institutions should be responsible for clinical governance and communication systems. Modern healthcare is multidisciplinary, and patient safety often depends upon information being communicated between doctors, nurses, laboratories and departments. A hospital that lacks reasonable systems for communicating critical test results, documenting changes in a patient's condition or transferring information between treating teams may create a foreseeable risk of injury. Such failures cannot always be satisfactorily addressed through vicarious liability because the harm may arise from the absence of a system rather than the misconduct of one

individual.

Fourthly, hospitals should bear responsibility for record-keeping and internal accountability. Medical records are essential not only for continuing treatment but also for determining whether appropriate care was provided. In *Savita Garg*, the Supreme Court recognised the importance of medical records in the context of establishing negligence.³² A hospital's failure to maintain accurate and contemporaneous records should therefore carry legal significance, particularly where the missing information concerns matters exclusively within the hospital's control.

The proposed framework must also address the concern that institutional liability could encourage defensive medicine. Doctors may already face substantial professional and legal pressures, and hospitals could respond to expansive liability by increasing costs or adopting unnecessarily cautious treatment practices. The answer, however, is not to deny institutional responsibility. Rather, courts should require a demonstrable causal relationship between the organisational failure and the injury. A mere technical deficiency should not result in liability unless it materially contributed to the harm suffered.

The standard should consequently involve three elements: a foreseeable institutional risk, a failure to adopt reasonable organisational precautions, and a causal connection between that failure and the patient's injury. This would prevent the doctrine from becoming an unrestricted mechanism for compensation while ensuring that systemic failures are not ignored simply because no single doctor's negligence can be established.

Such a framework would also complement, rather than undermine, the principles laid down in *Jacob Mathew v. State of Punjab*.³³ The Supreme Court's caution against imposing criminal liability upon doctors for ordinary errors of judgment remains important. Institutional negligence should therefore ordinarily operate within civil and consumer law rather than being automatically converted into criminal responsibility. Criminal liability should continue to require the significantly higher threshold applicable to gross negligence.³⁴ This distinction would protect medical professionals from unjustified criminal prosecution while permitting patients to obtain appropriate civil remedies against institutions responsible for systemic

³² *Savita Garg* (n 29).

³³ *Jacob Mathew v. State of Punjab* (2005) 6 SCC 1.

³⁴ *Ibid.*

failures.

The Consumer Protection Act 2019 offers an existing statutory mechanism through which such institutional responsibility can be operationalised. The statutory definition of “deficiency” encompasses inadequacies in the quality, nature or manner of performance of a service.³⁵ A hospital's failure to maintain adequate systems may therefore potentially constitute a deficiency even where the patient cannot demonstrate that a particular doctor breached the professional standard. The consumer-law framework could thus serve as an important vehicle for developing direct institutional responsibility without requiring the creation of an entirely new statutory cause of action.

However, judicial development alone may not be sufficient. A more comprehensive framework could require healthcare institutions to maintain minimum standards relating to staffing, emergency response, equipment maintenance, medical records, infection control and internal reporting of adverse events. Regulatory standards could then provide courts with objective evidence when determining whether a hospital complied with its institutional duty. Such standards would also reduce uncertainty for healthcare providers by making clear what organisational precautions are reasonably expected.

Ultimately, the central objective should be to shift the legal inquiry from “Which doctor made the mistake?” to the broader question of “Did the healthcare institution maintain a system reasonably capable of preventing the harm that occurred?” This does not diminish the responsibility of individual doctors. Rather, it recognises that modern healthcare is delivered collectively and that patient safety is often determined by institutional structures beyond the control of any single practitioner.

Indian medical-negligence law has already moved sufficiently far to justify this development. The recognition of hospital liability in *Achutrao Haribhau Khodwa*, the treatment of medical services under consumer law in *Indian Medical Association v. VP Shantha*, the recognition of hospital responsibility in *Spring Meadows Hospital* and the evidentiary principles developed in *Savita Garg* collectively demonstrate that the hospital is not merely a passive setting for individual medical practice. It is itself a healthcare provider with corresponding legal responsibilities.³⁶ What remains is to articulate these responsibilities as an independent

³⁵ Consumer Protection Act 2019, s 2(11).

³⁶ *Achutrao Haribhau Khodwa v. State of Maharashtra* (1996) 2 SCC 634; *Indian Medical Association v. VP*

institutional duty of care.

V. Conclusion

Medical negligence law must reflect the realities of the healthcare system it regulates. In contemporary India, treatment is rarely the product of an isolated interaction between one doctor and one patient. It is delivered through complex institutions whose infrastructure, staffing, protocols, communication systems and administrative decisions directly influence patient safety. A legal framework that focuses predominantly upon the conduct of individual medical professionals therefore risks overlooking an important source of patient harm: institutional failure.

Indian jurisprudence has already laid the foundation for recognising this broader responsibility. The Supreme Court has imposed liability upon hospitals, recognised medical treatment as a service for consumer-law purposes, acknowledged the evidentiary difficulties faced by patients and required hospitals to account for information within their exclusive control. Yet these principles have not been fully consolidated into a distinct doctrine of institutional medical negligence.

This paper argues that Indian law should recognise an independent institutional duty of care requiring hospitals to maintain reasonably adequate systems for the safe delivery of healthcare. Such a duty should encompass staffing, supervision, infrastructure, equipment, communication, medical records, emergency preparedness and clinical governance. Liability should arise only where an identifiable institutional failure creates a foreseeable risk of harm and materially contributes to the patient's injury.

The proposed approach would not make hospitals insurers against unsuccessful treatment, nor would it dilute the heightened threshold applicable to criminal liability for medical professionals. Instead, it would distinguish legitimate medical uncertainty from organisational failures that a reasonably managed healthcare institution could have prevented.

The principal justification for such a development is simple: where healthcare is institutional, responsibility for patient safety must also be institutional. The law should not require an injured patient to identify a single negligent doctor where the real cause of harm lies in the hospital's

Shantha (1995) 6 SCC 651; *Spring Meadows Hospital v. Harjol Ahluwalia* (1998) 4 SCC 39; *Savita Garg* (n 29).

own systems. Recognising direct institutional medical negligence would therefore represent not a departure from established Indian medical-negligence principles, but their necessary evolution in response to the realities of modern healthcare.