



Medical Negligence in India: Law, Liability and Judicial Approach

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ABSTRACT

Medical negligence in India represents a critical intersection of healthcare delivery, patient rights, and legal accountability, where failures in the standard of care can lead to severe harm or death. This research paper critically examines the multifaceted legal framework governing medical negligence, including criminal, civil, and consumer protection mechanisms. Under criminal law, provisions such as Section 304A of the Indian Penal Code (IPC) (now Section 106 of the Bharatiya Nyaya Sanhita, 2023) address causing death by rash or negligent acts, while Sections 337 and 338 IPC cover negligent acts causing hurt or grievous hurt. Criminal liability requires a high threshold of “gross” or “reckless” negligence, as clarified by the Supreme Court in *Jacob Mathew v. State of Punjab* (2005), which adopted the Bolam test (from English law) to assess whether the doctor’s actions aligned with accepted professional standards and mandated preliminary expert opinion before prosecution to prevent harassment. Civil remedies are primarily pursued through the Consumer Protection Act, 2019, following the landmark ruling in *Indian Medical Association v. V.P. Shantha* (1995), which brought medical services within the definition of “service” and patients within the ambit of “consumers.” This enables faster, cost-effective redressal via consumer forums for deficiency in service, compensation for harm, and informed consent violations. Key judgments like *Martin F. D’Souza v. Mohd. Ishfaq* (2009) extended Jacob Mathew guidelines to



civil cases, emphasizing that errors of judgment or unsuccessful outcomes do not automatically constitute negligence. Recent Supreme Court observations (including 2025 rulings) reinforce that not every adverse medical result implies negligence, while highlighting evolving challenges under new criminal laws, rising litigation, defensive medicine practices, and the need for expert evidence. The paper concludes that while the framework protects patients and holds professionals accountable, reforms are essential to balance speedy justice, reduce frivolous claims, promote ethical practices, and safeguard medical autonomy in India's overburdened healthcare system. This analysis underscores the judiciary's role in evolving standards to ensure equitable outcomes for all stakeholders.

1. History of Medical Negligence and Law in India

The concept of medical negligence in India has deep historical roots and has evolved through ancient customs, colonial legal influence, statutory reforms, and judicial interpretation. Ancient texts such as the *Sushruta Samhita* and *Yajnavalkya Smriti* recognised liability for negligent treatment and prescribed penalties for physicians. During the British period, Indian medical law developed under English common law principles, introducing professional regulation and general criminal liability for negligence.

The **Indian Penal Code, 1860** provided the principal legal basis through **Section 304A** for causing death by negligence and **Sections 337 and 338** for causing hurt or grievous hurt. These provisions, though general in nature, were applied to medical professionals. Civil remedies were pursued under tort principles, guided by the **Bolam v. Friern Hospital Management Committee (1957)** test, which assessed whether the doctor acted according to accepted professional standards.

A major change occurred with the **Consumer Protection Act, 1986**, later replaced by the **Consumer Protection Act, 2019**. In **Indian Medical Association v. V.P. Shantha (1995)**, the Supreme Court held that medical services constitute "service" under consumer law, enabling patients to seek compensation before consumer forums that are faster and more accessible than civil courts. This significantly expanded patient remedies.

Judicial safeguards were later introduced to prevent harassment of doctors. In **Dr. Suresh Gupta v. Government of NCT of Delhi (2004)** and **Jacob Mathew v. State of Punjab (2005)**, the Supreme



Court held that criminal prosecution requires proof of “gross” or reckless negligence and preliminary expert opinion. The Court adopted the Bolam test and clarified that errors of judgment or unsuccessful treatment do not automatically amount to negligence. Subsequent cases such as **Martin F. D’Souza v. Mohd. Ishfaq (2009)** and the **Anuradha Saha case (2013)** further shaped civil liability and compensation standards.

With the enactment of the **Bharatiya Nyaya Sanhita, 2023**, **Section 106** replaced **Section 304A IPC**, prescribing imprisonment up to five years for death by negligence, while limiting punishment to two years with fine for registered medical practitioners during medical procedures. This reflects an attempt to balance accountability with protection from frivolous claims.

Overall, Indian law has moved from punitive approaches to a balanced framework that combines criminal liability, civil remedies, and consumer protection while emphasising professional standards and patient safety.

2. Concept of Medical Negligence

Medical negligence arises when a healthcare professional fails to exercise the reasonable skill and care expected in medical practice, resulting in patient harm. It is treated as a form of professional negligence and requires proof that the doctor deviated from accepted standards. Courts have consistently held that not every adverse outcome constitutes negligence. Differences of opinion, reasonable choices of treatment, or unsuccessful results do not create liability.

In **Jacob Mathew v. State of Punjab (2005)**, the Supreme Court applied the Bolam test, holding that a practitioner is not negligent if supported by a responsible body of medical opinion, even if other views exist. Criminal liability arises only in cases of gross or reckless conduct.

2.1. Meaning and Nature of Negligence

Negligence generally means breach of a duty of care that a reasonable person would observe, causing foreseeable harm. It includes omission of reasonable care or doing something a prudent person would avoid. In medicine, the standard is higher due to specialised knowledge. Civil negligence leads to compensation, while criminal negligence requires a much greater degree of culpability.

2.2. Medical Negligence as Professional Negligence



Medical negligence is a subset of professional negligence. Doctors are judged not by the standard of an ordinary person but by that of a reasonably skilled medical practitioner. Courts recognise the uncertainties of medical science and protect practitioners from liability based on hindsight, while still holding them accountable for clear deviations from accepted practice.

2.3. Essential Elements of Medical Negligence

To establish liability, the claimant must prove four elements:

1. **Duty of Care:** A doctor patient relationship creating an obligation to provide proper treatment and advice.
2. **Breach of Duty:** Failure to meet the standard of a reasonably competent practitioner, assessed using the Bolam test. Gross breach is required for criminal cases.
3. **Causation:** A direct link between the breach and the injury, often determined by the “but for” test.
4. **Damage:** Actual harm such as death, disability, financial loss, or suffering.

These elements must be proved on the balance of probabilities in civil cases and beyond reasonable doubt in criminal proceedings.

The law of medical negligence in India seeks to balance patient protection with safeguards for medical professionals. Through statutory reforms and judicial interpretation, liability is imposed only for clear and serious departures from accepted medical standards, promoting accountability without encouraging defensive medicine.

Medical negligence, also known as medical malpractice, poses a serious challenge to India’s healthcare system, where breach of professional duty by healthcare providers causes harm ranging from prolonged suffering to death. In a populous country dependent on an overburdened medical infrastructure, allegations of negligence have increased significantly, with reports estimating nearly 5.2 million cases annually and a steady rise in litigation. This trend weakens public confidence in medical professionals and raises concerns about balancing patient rights with professional accountability, while avoiding defensive practices that increase costs and reduce the quality of care.



3. Legal Framework

The legal response in India is comprehensive and derives from criminal, civil, and consumer protection laws rather than a single statute. Earlier, medical negligence was addressed under the **Indian Penal Code, 1860**, particularly **Section 304A, Sections 337 and 338**. With the enforcement of the **Bharatiya Nyaya Sanhita, 2023, Section 106(1)** now governs death caused by rash or negligent acts. It prescribes imprisonment up to five years in general cases but limits punishment to two years with fine for registered medical practitioners during medical procedures, thereby recognising the special nature of medical decision making.

Civil liability expanded after **Indian Medical Association v. V.P. Shantha (1995)**, where the Supreme Court included medical services within the scope of the **Consumer Protection Act**, enabling patients to claim compensation for deficiency in service. In **Jacob Mathew v. State of Punjab (2005)**, the Court required proof of gross negligence and expert opinion before criminal prosecution and applied the Bolam test to assess professional standards. Later decisions have clarified that mere errors of judgment or unsuccessful outcomes do not amount to negligence without proof of reckless conduct.

Despite these safeguards, rising claims reveal persistent problems such as inadequate informed consent, poor documentation, and resource constraints. Recent judicial observations and debates on criminal liability highlight the need for balanced reforms.

This research paper examines the legal framework governing medical negligence in India, analyses leading judicial interpretations, and identifies emerging challenges under the new criminal regime. It advocates preventive measures, stronger ethical oversight, and fair compensation mechanisms to protect patients while preserving medical autonomy and promoting a culture of safety in healthcare.

3.1. History of Medical Negligence and Law in India

The law of medical negligence in India has gradually evolved from general tort and criminal principles derived from English common law to a more patient centric and accessible system supported by consumer protection law. This transformation has been guided by judicial interpretation and the need to balance accountability of doctors with safeguards against unwarranted litigation.

3.2. Early Judicial Approach

Initially, medical negligence was governed by general provisions of the **Indian Penal Code, 1860**, particularly **Section 304A, Section 337**, and **Section 338**. These provisions were not specific to medicine



but were applied to negligent acts causing death or injury. Civil claims were filed in ordinary courts under tort law, which was slow and expensive. Courts treated medical negligence as ordinary negligence and lacked clear standards distinguishing bona fide errors from culpable conduct. Criminal prosecutions were sometimes initiated even for honest mistakes.

3.3. Influence of English Law

Indian courts adopted English common law principles, especially the Bolam v. Friern Hospital Management Committee (1957) test. Under this rule, a doctor is not negligent if the treatment conforms to a responsible body of medical opinion. This approach recognised the specialised nature of medical practice and protected professionals from liability based merely on adverse outcomes.

3.4. Shift through Consumer Protection Law

A major shift occurred with the Consumer Protection Act, 1986, later replaced by the Consumer Protection Act, 2019. In Indian Medical Association v. V.P. Shantha (1995), the Supreme Court held that medical services constitute “service” and patients are “consumers,” allowing them to approach consumer forums for quicker and cheaper remedies. This decision greatly expanded patient access to justice and increased accountability of hospitals and doctors.

Further safeguards were introduced in Dr. Suresh Gupta v. Government of NCT of Delhi (2004) and Jacob Mathew v. State of Punjab (2005). The Court required proof of “gross” or reckless negligence for criminal prosecution, mandated preliminary expert opinion, and clarified that errors of judgment or unsuccessful treatment do not automatically amount to negligence. Subsequent cases such as Martin F. D’Souza v. Mohd. Ishfaq (2009) and the Kunal Saha case (Balram Prasad v. Kunal Saha) strengthened standards of liability and compensation.

The Bharatiya Nyaya Sanhita, 2023 replaced Section 304A IPC with Section 106, prescribing imprisonment up to five years for causing death by negligence but limiting punishment to two years with fine for registered medical practitioners during medical procedures. This reflects an effort to balance deterrence with protection of medical professionals.

4. Medical Negligence under Civil Law

Civil liability treats medical negligence as a tort. The objective is compensation rather than punishment. Doctors and hospitals may be directly or vicariously liable for breach of duty. Most claims are now filed



before consumer forums under the Consumer Protection Act, 2019, as affirmed in *Indian Medical Association v. V.P. Shantha* (1995).

Liability is determined by applying the Bolam test. Doctors are not responsible for every unsuccessful outcome but only for conduct falling below the standard of a reasonably competent practitioner. Courts in *Kusum Sharma v. Batra Hospital* (2010) and similar cases have reiterated this principle.

4.1. Burden of Proof and Damages

The complainant must prove duty, breach, causation, and damage on the balance of probabilities. Expert evidence is generally required. In obvious cases, the principle of *res ipsa loquitur* may shift the burden of explanation.

Damages include medical expenses, loss of income, pain and suffering, and future losses. Substantial awards, such as in *Kunal Saha v. AMRI Hospital* (2013), demonstrate the compensatory focus of civil law.

5. Medical Negligence under Criminal Law

Criminal liability arises only when negligence is gross or reckless and results in death. Under Section 106(1) of the *Bharatiya Nyaya Sanhita, 2023*, death caused by rash or negligent acts is punishable with imprisonment up to five years, while registered medical practitioners face a maximum of two years with fine during medical procedures.

The Supreme Court in *Jacob Mathew v. State of Punjab* (2005) clearly distinguished civil and criminal negligence, holding that criminal prosecution requires a much higher degree of culpability. Mere carelessness or error of judgment may attract civil liability but not criminal punishment. Preliminary expert opinion is necessary before prosecution to prevent harassment of doctors.

The historical development of medical negligence law in India shows a shift from general criminal provisions to a balanced framework combining tort principles, consumer protection remedies, and limited criminal liability. The system aims to protect patients while ensuring that medical professionals are not penalised for honest or unavoidable errors, thereby promoting both accountability and professional autonomy.



5.1. Degree of Negligence Required for Criminal Liability

Criminal liability for medical negligence under Section 106 of the Bharatiya Nyaya Sanhita, 2023 (earlier Section 304A of the Indian Penal Code, 1860) arises only when negligence is gross, reckless, or amounting to criminal rashness. Ordinary carelessness or error is insufficient. In *Jacob Mathew v. State of Punjab* (2005), the Supreme Court held that negligence becomes criminal only when the act shows a conscious disregard for patient safety and such serious deviation from accepted standards that no reasonably competent doctor would have acted similarly.

The Court clarified that simple lack of care, accident, or unsuccessful treatment does not attract criminal punishment. It adopted the Bolam test for professional standards but required proof of gross incompetence for criminality. Safeguards include prior expert medical opinion, avoidance of routine arrests, and clear distinction between civil and criminal thresholds. Consequently, criminal prosecutions remain rare and are reserved for egregious cases.

6. Medical Negligence under Consumer Protection Law

The inclusion of medical services within the Consumer Protection Act, 2019² transformed medical negligence into a consumer rights issue by providing quicker and affordable remedies. In *Indian Medical Association v. V.P. Shantha* (1995), the Supreme Court held that paid medical services constitute “service,” and patients are “consumers.” Only wholly gratuitous services are excluded.

Patients can claim compensation for deficiency in service such as negligent diagnosis, improper treatment, lack of informed consent, or poor infrastructure. Rights include safety, information, and redress. Liability is compensatory rather than punitive.

Consumer disputes are handled by a three tier system comprising the District, State, and National Commissions, which offer summary procedures, low costs, and faster resolution. Expert medical evidence is generally required to prove breach and causation, though in obvious cases the principle of *res ipsa loquitur* may shift the burden.

7. Judicial Approach to Medical Negligence in India

Indian courts have developed a balanced framework that protects patients while preventing harassment of doctors. The judiciary has clarified standards of care, adopted the Bolam test, and distinguished civil and criminal liability through several landmark cases.



In *Indian Medical Association v. V.P. Shantha* (1995), medical services were brought under consumer law, expanding access to compensation. In *Dr. Suresh Gupta v. Govt. of NCT of Delhi* (2004), the Court held that criminal prosecution requires gross or reckless negligence, not mere error. The Constitution Bench in *Jacob Mathew v. State of Punjab* (2005) provided detailed safeguards, requiring expert opinion before prosecution and emphasizing that adverse outcomes alone do not prove negligence. In *Kusum Sharma v. Batra Hospital* (2010), the Court reiterated that doctors are judged by the standard of a reasonably competent professional and that negligence must be affirmatively proved.

Medical negligence law in India now rests on three pillars: civil compensation, consumer redressal, and limited criminal liability. Criminal punishment is confined to cases of gross recklessness, while civil and consumer forums provide accessible remedies for patients. This approach seeks to balance patient protection with professional autonomy and discourages unnecessary criminalization of medical practice.

8. Defences Available to Medical Professionals

Indian law provides several recognised defences to medical professionals in both civil and criminal proceedings. These safeguards acknowledge the complexity and uncertainty of medical practice and protect doctors from liability for honest mistakes or unavoidable risks. Courts consistently hold that doctors are not guarantors of success and are liable only for proven breach of duty. Important defences include error of judgment, valid consent, therapeutic misadventure, and the Bolam test.

8.1. Error of Judgment

A mere error of judgment does not amount to negligence if reasonable care and accepted practices are followed. In ***Jacob Mathew v. State of Punjab (2005)***, the Supreme Court held that deviation from normal practice or an honest professional error is not negligence per se. Liability arises only when conduct shows gross incompetence or recklessness. This view was reaffirmed in ***Martin F. D'Souza v. Mohd. Ishfaq (2009)***, where the Court stated that mischance, misadventure, or a reasonable error does not create liability. Thus, errors in diagnosis or treatment choice supported by medical reasoning are protected, though criminal liability still requires proof of gross negligence.

8.2. Consent of the Patient

Valid informed consent is a strong defence against claims of unauthorized or negligent treatment. Consent must be voluntary and based on disclosure of the nature, risks, and alternatives of the procedure. In ***Samira Kohli v. Dr. Prabha Manchanda (2008)***, the Court adopted the Bolam standard for



disclosure and recognised “real consent” rather than exhaustive disclosure of every risk. When known risks are properly explained and accepted, doctors are not liable if those risks materialise. In emergencies, implied consent may apply. Proper documentation therefore remains essential.

8.3. Therapeutic Misadventure

Therapeutic misadventure refers to an adverse outcome occurring despite adherence to accepted standards of care. Courts recognise that medicine is not an exact science and complications may arise even with due diligence. In **Jacob Mathew (2005)** and **Martin F. D’Souza (2009)**, the Supreme Court clarified that mischance or unavoidable complications do not constitute negligence. Harm resulting from inherent risks, rare reactions, or unpredictable outcomes is not actionable if protocols were followed.

8.4. Bolam Test

The Bolam test, from **Bolam v. Friern Hospital Management Committee (1957)**, remains the central defence. A doctor is not negligent if the treatment conforms to a responsible body of medical opinion. The Supreme Court adopted this test in **Jacob Mathew (2005)** and applied it in **Martin F. D’Souza (2009)** and **Kusum Sharma v. Batra Hospital (2010)**. Courts rely heavily on expert evidence and avoid substituting their own judgment for that of medical professionals. Thus, conduct supported by accepted professional practice is generally protected.

Collectively, these defences ensure that doctors are held liable only for genuine negligence and not for unavoidable risks or honest errors. The law therefore balances patient protection with professional autonomy.

9. Challenges in Proving Medical Negligence

Despite legal remedies, proving medical negligence remains difficult for complainants due to high evidentiary standards and practical barriers.

9.1. Complexity of Medical Science

Medicine involves multiple variables and uncertain outcomes, making it difficult to prove that harm was caused by negligence rather than inherent risk. Courts recognise this limitation. In **Jacob Mathew (2005)** and **Martin F. D’Souza (2009)**, the Supreme Court cautioned that unsuccessful treatment or complications do not automatically imply negligence. The Bolam test further requires deference to accepted medical opinion, often resulting in benefit of doubt to doctors.



9.2. Lack of Expert Testimony

Expert evidence is essential to prove breach and causation, yet obtaining independent experts is challenging. Doctors are often reluctant to testify against colleagues, independent specialists are costly, and conflicting opinions weaken cases. Courts insist on credible expert reports, and without such evidence many claims fail.

9.3. Delay in Justice

Litigation is slow across forums. Consumer cases often take years despite summary procedures. Civil suits may last a decade or more, while criminal proceedings under Section 106 of the Bharatiya Nyaya Sanhita, 2023 (formerly Section 304A IPC) are similarly prolonged. Such delays reduce the practical value of compensation and discourage victims.

9.4. Defensive Medicine

Fear of litigation has encouraged defensive medicine, where doctors order unnecessary tests or avoid high risk procedures to protect themselves. This increases costs, strains resources, and weakens the doctor patient relationship. The Supreme Court acknowledged this concern in *Jacob Mathew (2005)*, noting that excessive criminalization may deter effective care.

Scientific complexity, limited expert support, prolonged litigation, and defensive practices create serious hurdles for genuine claimants. Systemic reforms such as independent expert panels and faster adjudication are necessary to ensure fair justice.

10. Recent Developments and Emerging Trends

Medical negligence law continues to evolve with judicial refinement and new criminal provisions.

10.1. Changing Judicial Standards

Recent decisions reaffirm that adverse outcomes alone do not establish negligence. Courts require proof of substandard care and rely on expert evidence. In *Deep Nursing Home v. Manmeet Singh Mattewal (2025 SCC OnLine SC 1934)*, the Supreme Court held that consumer forums cannot exceed pleadings or ignore expert findings, signalling stricter procedural discipline. Debates have also emerged on the scope of professional services under consumer law after *Bar of Indian Lawyers v. D.K. Gandhi (2024)*, though medical services remain covered under *Indian Medical Association v. V.P. Shantha (1995)*.



10.2. Impact of New Criminal Laws

The Bharatiya Nyaya Sanhita, 2023, effective July 1, 2024, replaced Section 304A IPC with Section 106. It prescribes up to five years' imprisonment for general negligence but limits punishment to two years with fine for registered medical practitioners during medical procedures. While intended to reduce fear among doctors, concerns persist about criminalization and defensive medicine. Professional bodies continue to seek clearer prosecution guidelines.

Current trends show a careful balance between accountability and protection of medical professionals. Courts aim to prevent frivolous claims while preserving patient rights, but continued reforms are needed for clarity and efficiency.

11. Comparative Perspective

A comparative study of medical negligence law in India with England and the United States highlights different approaches to balancing patient protection and professional autonomy. India derives its principles largely from English common law, while the United States follows a more plaintiff oriented and highly litigious model. These contrasts offer useful lessons for reform.

11.1. Comparison with English Law

India and England share similar foundations. Both rely on the Bolam v. Friern Hospital Management Committee (1957) principle, under which a doctor is not negligent if supported by a responsible body of medical opinion. Indian courts adopted this test in Jacob Mathew v. State of Punjab (2005) and continue to apply it across civil, consumer, and criminal cases.

However, English law has progressed further. In Bolitho v. City and Hackney Health Authority (1997), courts required that professional opinion must be logical and defensible, not merely peer supported. India largely follows the original Bolam formulation with limited scrutiny.

On consent, England adopted a patient centred approach in Montgomery v. Lanarkshire Health Board (2015), mandating disclosure of material risks important to a reasonable patient. India, through Samira Kohli v. Dr. Prabha Manchanda (2008), follows a professional standard of disclosure, giving doctors greater discretion.

England also encourages mediated or institutional settlements through NHS mechanisms, whereas India relies on criminal prosecution, tort claims, and consumer forums, often resulting in prolonged litigation.



11.2. Comparison with United States Law

The United States adopts a more adversarial and compensation driven system. The standard of care is often judged by juries using the “reasonable physician” rule, with less deference to professional opinion than the Bolam approach.

Informed consent follows a strict patient autonomy model under *Canterbury v. Spence* (1972), requiring detailed disclosure of risks and alternatives. This standard is stricter than India’s.

The US system allows large compensatory and punitive damages, frequent jury trials, and high malpractice insurance costs. While this empowers patients, it also leads to defensive medicine and increased healthcare expenses. India avoids punitive damages and imposes lower criminal penalties, making it less costly but slower and procedurally complex.

12. Suggestions and Reforms

The Indian legal framework for medical negligence, while progressive in many respects, faces persistent challenges such as protracted litigation, inconsistent application of standards, reluctance of experts to testify, rising defensive medicine, and perceived imbalance between patient redress and professional protection. To address these systemic issues and align the system with modern healthcare realities, the following targeted reforms are widely advocated by legal scholars, medical associations, patient rights groups, and judicial observations (including Supreme Court remarks in 2024–2025 PILs and NCDRC trends).

12.1. Need for Specialized Medical Tribunals

Establishing dedicated Medical Tribunals or specialized benches within existing consumer or civil courts would significantly improve adjudication quality and efficiency.

12.1.1. Key advantages include:

1. Tribunals staffed by a combination of judicial members, medical experts (senior clinicians from different specialties), and legal professionals with experience in medical law.
2. Faster fact-finding through in-house medical expertise, reducing heavy reliance on external (often reluctant) witnesses.
3. Uniform application of standards (Bolam test, causation principles, informed consent thresholds) across cases.



4. Precedent-setting ability specific to medical negligence, avoiding conflicting decisions seen in some district/state commissions.

12.1.2. Models to consider:

- A national-level apex Medical Tribunal (similar to the proposed National Medical Tribunal in earlier drafts) for appeals.
- State-level benches integrated with Consumer Commissions or separate entities under the National Medical Commission Act, 2019 framework.
- Precedents: The United Kingdom's NHS Resolution and clinical negligence panels, or proposals
- In India's earlier Clinical Establishments Act discussions.
- Such tribunals would filter frivolous claims early, provide reasoned expert-backed decisions, and reduce the burden on regular courts.

12.2. Clear Statutory Guidelines

The current reliance on judicial guidelines (primarily *Jacob Mathew v. State of Punjab*, 2005) creates uncertainty, as implementation varies across police stations, magistrates, and consumer forums. Enacting clear statutory guidelines would bring predictability and uniformity.

12.2.1. Suggested legislative measures:

- Codify *Jacob Mathew* safeguards into law: mandatory preliminary expert opinion from an independent medical board before FIR registration or prosecution under Section 106 BNS.
- Define "gross negligence" in the medical context with illustrative examples (e.g., blatant disregard for protocols, gross ignorance of basic standards, reckless indifference to life).
- Prescribe standardized protocols for informed consent documentation, record maintenance, and adverse event reporting.
- Mandate referral of all alleged medical negligence deaths to a district/state medical board for prima facie opinion before criminal proceedings.
- Introduce statutory timelines for investigation and trial in medical cases. The Indian Medical Association, legal experts, and pending PILs (including the 2025 Supreme Court notice) have repeatedly urged Parliament and the Ministry of Health to frame such rules in consultation with stakeholders, fulfilling the long-pending directive from *Jacob Mathew*.



12.3. Balance between Patient Rights and Protection of Doctors

Achieving equilibrium remains the central reform goal. Current trends show excessive protection for doctors in some cases (leading to impunity concerns) and over-exposure in others (fueling defensive medicine).

12.3.1. Reform proposals include:

- Strengthen patient rights through mandatory implementation of the National Human Rights Commission's Charter of Patients' Rights (informed consent, second opinion, access to records, grievance redressal).
- Introduce calibrated non-punitive mechanisms for minor lapses (e.g., mediation, counseling, continuing medical education instead of immediate compensation or prosecution).
- Protect doctors from routine arrests and media trials by enforcing anticipatory bail norms and guidelines against sensational FIRs.
- Create a no-fault compensation fund for certain categories of severe harm (e.g., birth injuries, surgical complications from unavoidable risks), funded by a small levy on healthcare providers or insurance, inspired by New Zealand's Accident Compensation Corporation model.
- Promote error-reporting systems (non-punitive, learning-oriented) similar to aviation's "just culture" to improve patient safety without fear of litigation.

This balanced approach would uphold patient autonomy and safety while preserving medical autonomy and reducing fear-driven over-investigation.

12.4. Speedy Dispute Resolution

Protracted proceedings remain the single biggest barrier to justice for patients and peace of mind for doctors.

12.4.1. Reforms for expedition:

- Enforce stricter timelines in consumer forums (e.g., mandatory disposal within 6–12 months, with automatic escalation for delays).
- Introduce mandatory pre-litigation mediation for all medical negligence claims before filing in consumer or civil courts.



- Enable electronic filing, virtual hearings, and digital record submission across all tiers (already partially implemented under CPA 2019 but inconsistently followed).
- Create fast-track benches in high-volume states for medical negligence cases.
- Limit appeals to one level (e.g., from State Commission directly to Supreme Court in exceptional cases) to reduce multi-stage litigation.
- Incentivize early settlement through structured compensation guidelines or presumptive awards
- in clear *res ipsa loquitur* cases. These measures, if combined, could reduce average resolution time from years to months, restoring faith in the system.

13. Conclusion

In conclusion, India stands at a critical juncture where incremental judicial safeguards must be complemented by bold legislative and institutional reforms. Specialized tribunals, codified guidelines, balanced liability mechanisms, and accelerated processes would collectively create a more equitable, efficient, and trustworthy framework that genuinely protects patients from harm while enabling doctors to practice medicine without constant fear of litigation. Implementing these changes requires coordinated action by Parliament, the Supreme Court, the National Medical Commission, state governments, and civil society to build a healthcare jurisprudence that serves both justice and public health in the 21st century.

Medical negligence in India represents a complex and evolving domain at the intersection of healthcare delivery, patient rights, professional accountability, and judicial oversight. This research paper has examined the multifaceted legal landscape governing medical negligence, tracing its historical roots, conceptual foundations, statutory provisions across criminal, civil, and consumer protection domains, landmark judicial interventions, available defences, practical challenges in proof, recent developments, comparative perspectives, and suggested reforms.

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