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Duty, Consent and Liability: Medical Negligence in Indian Medical Jurisprudence

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***Abstract*—Medical jurisprudence sits where clinical judgment meets legal accountability, and Indian courts have spent several decades deciding how far the second may examine the first. This paper follows that effort through four connected questions: what standard of care a doctor owes, when a medical error becomes a crime, how much a patient must be told before consent counts as consent, and whether a patient can seek redress before a consumer commission. It reads the leading decisions of the Supreme Court of India against English, Australian and American authority, and against the Bharatiya Nyaya Sanhita, 2023 and the Consumer Protection Act, 2019. The paper argues that Indian law shields practitioners from careless prosecution reasonably well, but that its treatment of disclosure still leans on professional custom more than on the patient's own view of the risks. It closes with modest and practicable suggestions for courts, regulators and hospitals.**

***Index Terms*—Bolam test, informed consent, medical jurisprudence, medical negligence, patient autonomy.**

I. INTRODUCTION

Every clinical encounter creates a legal relationship, whether or not anyone in the room thinks of it in those terms. A patient who agrees to a biopsy, a surgeon who picks one incision over another, a casualty officer who has ninety seconds to decide whether to operate: each is acting inside a set of rules that a court will later read, usually in hindsight and usually because something went wrong. Medical jurisprudence is the name given to that body of rules. In older Indian textbooks the term also takes in forensic medicine, meaning the medical side of injuries, poisoning and the investigation of death. This paper uses it in the narrower sense of the law that governs the doctor–patient relationship and the liability that flows from it.

The subject deserves fresh attention for a plain reason. Complaints against doctors and hospitals now sit comfortably beside other disputes in consumer commissions, High Courts and police stations, and the profession often says that it practises under the shadow of prosecution. Patients, for their part, say that professional solidarity makes it hard to find a doctor willing to speak against a colleague. Both complaints have some truth in them, and the law's answer to each is worked out case by case rather than in one place. A reader who wants to know where an Indian doctor's duties begin and end has to assemble the answer from tort decisions, criminal appeals, consumer rulings and a small group of constitutional cases.

This paper attempts that assembly. It follows a doctrinal method, reading statutes and reported decisions of the Supreme Court of India and setting them beside English, Australian and American authority where Indian courts have borrowed from it or where the comparison sharpens a point. Sections II to VI take up, in turn, the standard of care, criminal liability, informed consent, the reach of consumer law and end-of-life decisions. Section VII lists some gaps and proposes ways of closing them. No empirical data on litigation outcomes is used, and the conclusions should be read with that limit in mind.

II. DUTY AND THE STANDARD OF CARE

A. Where the duty comes from

The Supreme Court described the content of a doctor's duty early. In *Laxman Balkrishna Joshi* it said that a person who offers medical advice or treatment impliedly undertakes to bring a reasonable degree of skill and knowledge, and reasonable care, to the task [1]. The duty arises at three points: when deciding whether to take the case, when deciding what treatment to give, and when giving it. A breach at any of the three can found an action in tort or in contract.

Emergencies add a constitutional layer. *Parmanand Katara* concerned an injured scooterist who was turned away from the nearest hospital because of medico-legal formalities, and who died. The Court treated the preservation of life as the first obligation of every doctor, in government service or private practice, and held that procedural requirements cannot be used to delay urgent care [2].

B. The Bolam test and its limits

English law supplied the working test. In *Bolam*, McNair J told the jury that a doctor is not negligent if he acted in accordance with a practice accepted as proper by a responsible body of medical opinion, even though another body would have acted differently [3]. The rule protects ordinary clinical judgment from a court that would otherwise substitute its own. Its weakness is just as plain: if the profession's practice is the measure, the profession in effect sets the legal standard. *Bolitho* tempered this by requiring that the opinion relied upon be capable of withstanding logical analysis [4]. A court need not accept a practice merely because some respected doctors follow it.

The Supreme Court took over this framework in *Jacob Mathew*. It added that a doctor is judged against an ordinarily competent practitioner in the same field and not against the best specialist available, and that a genuine error of judgment, or the choice of one of two accepted courses, is not negligence in itself [5]. Hindsight is the standing enemy of such cases. A complication that looks obvious in the post-mortem report was often one possibility among several when the decision was made, and the insistence on judging the doctor at the time of acting is the part of the test that most deserves protection.

C. Proving the breach

Proof is where theory meets difficulty. The patient usually has no access to expertise, while the hospital holds the records. *Martin F. D'Souza* directed that a complaint of negligence should ordinarily be referred to a competent doctor or a medical board before notice goes to the doctor [6]. The direction was later qualified. In *V. Kishan Rao* the Court said it should not be read as a rule that expert evidence is needed in every case, and that where the facts speak for themselves, as with an instrument or swab left inside the body, the maxim *res ipsa loquitur* can carry the case [7]. Taken together, the two decisions describe a sensible middle: expert scrutiny where the question is technical, and no demand for it where the error is plain to any lay observer.

III. WHEN NEGLIGENCE BECOMES A CRIME

Civil and criminal responsibility rest on different thresholds. The Supreme Court made the point firmly in *Jacob Mathew*, holding that a doctor can be prosecuted for causing death by negligence only where the negligence is gross or the conduct reckless. The lesser carelessness that is enough to win damages in a civil suit will not do [5]. The Court also laid down safeguards, and they are worth stating because they are the working law at every police station. A private complaint should not ordinarily be entertained unless the complainant produces credible opinion from another competent doctor supporting the charge. The investigating officer should, before proceeding, obtain an independent and competent medical opinion, ordinarily from a government doctor qualified in the relevant branch. And a doctor should not be arrested as a matter of routine.

Kusum Sharma v. Batra Hospital gathered these strands into a set of working principles and repeated the warning that a doctor should not be harassed merely because a family is grieving, though a careless one should not be shielded either [8].

The Bharatiya Nyaya Sanhita, 2023 now deals with death by negligence in section 106. Sub-section (1) keeps the earlier general offence, and its proviso prescribes a lower maximum, two years' imprisonment with fine, where the act is done by a registered medical practitioner while performing a medical procedure [9]. The proviso is a legislative acknowledgment that medical cases are different. Its limit is worth noticing, though. It reduces the quantum of punishment; it does not say when an offence is made out. The *Jacob Mathew* threshold of gross negligence, and the safeguards around complaint and investigation, remain judicial rather than statutory. They bind only so far as police officers and magistrates know of them and follow them. A doctor who is arrested first and defended afterwards has already lost much of what the guidelines were meant to preserve.

IV. INFORMED CONSENT

A. Consent as a precondition

Treatment without valid consent is, in tort, a battery, however skilfully it is performed and however well it turns out. Indian criminal law reflects the same idea in a more qualified way. Section 26 of the Bharatiya Nyaya

Sanhita protects an act, not intended to cause death, that is done in good faith and with consent for a person's benefit. Section 30 protects a good-faith act done for someone's benefit without consent where consent cannot be obtained, as in an emergency [9]. Both provisions assume that consent is the rule and that its absence needs justifying.

B. The Kohli decision

Samira Kohli v. Dr. Prabha Manchanda is the leading Indian authority. The patient had agreed to a diagnostic procedure, and the surgeon went on to do more than that. The Court drew a line between consent to diagnosis and consent to treatment: the first does not stretch to cover the second, except where an unexpected condition turns up in the course of the procedure and immediate action is needed to save life or health [10]. It also said that consent has to be real, meaning the patient must have been given enough information about the nature of the procedure, its risks and the alternatives to make an intelligent choice. A signature on a printed form does not, on this reasoning, settle anything by itself.

C. How much must be disclosed?

The harder question is the standard by which disclosure is measured. English law for years answered it with *Bolam*, so that what a patient was told depended on what a body of doctors would have said. Other systems moved earlier. The American court in *Canterbury v. Spence* asked what a reasonable patient would want to know [11], and the High Court of Australia in *Rogers v. Whitaker* held that a doctor must warn of material risks, including those a reasonable person in the patient's position would think significant [12]. The UK Supreme Court reached much the same place in *Montgomery*, saying that a doctor must take reasonable care to ensure that the patient knows of material risks and of reasonable alternatives, and that materiality is judged from the patient's side of the desk and not only the profession's [13].

Kohli leans in the same direction without adopting a precise test. The Court did not treat the adequacy of disclosure as something professional practice alone can settle, but it stopped short of a formula as crisp as that in *Montgomery* [10]. The result is that courts, hospitals and doctors lack clear guidance. A surgeon asking herself what to say about a one-in-two-hundred risk of nerve injury has nothing to measure her answer against except a general instruction to be adequate. This paper suggests that Indian courts adopt the material-risk formulation openly, because it poses a question the doctor can answer at the bedside: would this patient, being who she is, want to know?

Documentation compounds the problem. Consent forms in many hospitals are printed in one language, signed in a hurry and worded to cover everything. A form is evidence that a conversation took place; it cannot stand in for the conversation, and a court reading one should ask what was actually explained, in which language, and to whom. Where a husband signs for his wife, or an elderly patient's son answers every question, the issue of whose consent was taken can become a live one.

V. MEDICAL SERVICES AND CONSUMER LAW

For many patients the practical forum is a consumer commission and not a civil court. In *Indian Medical Association v. V.P. Shantha*, a three-judge Bench held that medical practitioners and hospitals come within the Consumer Protection Act, 1986 when they render service for a consideration, though not where treatment is offered free to everyone, and not under a contract of personal service [14]. The Consumer Protection Act, 2019 replaced the earlier statute, and complaints against doctors and hospitals continue to be brought under it [15].

The position was briefly shaken in 2024. Holding in *Bar of Indian Lawyers v. D.K. Gandhi* that advocates fall outside the Act, a two-judge Bench doubted whether *Shantha* had been rightly decided and sent the question to the Chief Justice for a larger Bench [16]. On 7 November 2024 a three-judge Bench declined the reference, observing that the issue before the Court had concerned the legal profession alone and that the reference was unnecessary. It added that the wider question about other professionals could be taken up in an appropriate case with a proper factual foundation [17].

For now, then, *Shantha* stands, and a paying patient can still approach a consumer commission. Whether that is desirable is argued both ways. Commissions are cheaper and quicker than civil suits, which matters to a patient of limited means. Doctors' associations answer that commissions lack medical expertise and that summary procedure suits technical questions badly. The fair reading is that the forum is open but the substance is unchanged: the standard of care discussed above does

not shift with the choice of forum, so what the choice alters is procedure far more than duty.

VI. END-OF-LIFE DECISIONS

Consent doctrine has one more frontier, which is consent given in advance. In *Aruna Shanbaug*, concerning a nurse who had lived for decades in a persistent vegetative state, the Court accepted passive euthanasia, meaning the withdrawal of life support, for patients unable to decide for themselves, subject to oversight by the High Court [18]. Seven years later a Constitution Bench in *Common Cause v. Union of India* held that the right to live with dignity under Article 21 includes a dignified death, recognised advance medical directives, commonly called living wills, and issued guidelines on making and acting on them [19]. The Court revised that procedure in January 2023 to make it easier to follow in practice [20]. Separately, the Mental Healthcare Act, 2017 allows an adult to make an advance directive about treatment for mental illness [21].

Read together, these developments suggest that informed consent is no longer confined to the moment before a procedure. A living will is consent projected into a future the patient cannot yet see, and the same questions apply to it as to any other consent: was the person informed, was the choice voluntary, and is there proof of it? Whether hospitals outside the large cities have the machinery to answer those questions is a different matter.

VII. GAPS AND SUGGESTIONS

Four modest proposals follow from the discussion above. First, the disclosure standard should be stated clearly. A material-risk test of the *Montgomery* kind, adopted by the Supreme Court or written into the professional conduct regulations of the National Medical Commission, would give doctors something concrete to work to.

Second, the *Jacob Mathew* safeguards need institutional support. If every State kept a standing panel of specialists to give an early, independent opinion on a complaint, the requirement of a prior medical opinion would stop depending on which police officer happens to receive the complaint.

Third, hospitals should treat consent as a process and not as a form. That means a recorded discussion in a language the patient understands, with risk information tailored to the procedure instead of copied from a template.

Fourth, researchers and the courts themselves should gather data. Statements about defensive medicine, and about the difficulty of proving negligence, are usually made with confidence and little evidence, and nobody can say with any precision how often complaints against doctors succeed.

VIII. CONCLUSION

Indian medical jurisprudence has settled several things well. The standard of care is a professional one, measured at the time of the act. Criminal liability is reserved for gross negligence. Emergencies carry a duty that formalities cannot suspend, and consumer remedies remain open to paying patients. What stays unsettled is consent, especially how much a patient must be told, and how the protections the law offers doctors are to reach the police station and the magistrate's court in practice. These are less problems of doctrine than of implementation, and clearer judicial statements and better institutional design could solve a good part of them. The law cannot make medicine free of error. It can insist that when error occurs it is judged fairly, neither by the angry hindsight of a grieving family nor by the unexamined loyalty of colleagues.

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