

Medical Negligence and Criminal Liability: A Jurisprudential Analysis of Supreme Court Decisions

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Abstract

Medical negligence engages a subtle intersection between tortious liability and criminal culpability. This article presents a comprehensive analysis of how courts – particularly the Supreme Court of India – have approached the criminal liability of medical professionals for negligence. It examines the doctrinal foundations distinguishing civil negligence from criminal negligence, and explains the higher threshold of fault i.e., “gross” negligence or recklessness, required for penal consequences. Key Indian Supreme Court decisions, from early precedents to landmark judgments like *Dr. Suresh Gupta v. NCT of Delhi* (2004)¹ and *Jacob Mathew v. State of Punjab* (2005)², are analyzed to reveal evolving judicial standards. Comparative perspectives from the UK, US, and Canada highlight how other common law jurisdictions tackle with similar issues – notably the doctrine of gross negligence manslaughter in the UK, sporadic prosecutions in the US for egregious malpractice, and Canada’s “wanton or reckless disregard” standard. The article discusses underlying jurisprudential theories, including the role of mens rea in negligence-based crimes and the policy balance between patient safety and physicians’ protection. It further considers practical implications: the chilling effect of criminal prosecution on medical practice, the safeguards (such as expert opinions) instituted to prevent frivolous charges, and the impact on professional conduct. The article concludes with recommendations for greater doctrinal clarity and systemic reforms aimed at reconciling the need for accountability in gross malpractice cases with the broader goals of healthcare efficacy and justice.

Introduction

When can an act of medical negligence transcend the realm of civil liability and attract criminal punishment? This question has annoyed jurists and policymakers, as it advances the need to hold grossly errant medical practitioners accountable against the imperative to avoid criminalizing inadvertent medical errors. The doctor-patient relationship, traditionally based on trust, has in recent decades come under strain amidst increased awareness of patients’ rights, a series of negligence claims, and even incidents of violence against doctors. Courts have been called upon to delineate the circumstances under which a physician’s lapse in care, ordinarily remediable through civil negligence or consumer claims, becomes so egregious that it constitutes a crime against the state. In India, this debate gained prominence with a surge of prosecutions under Section 304A³ of the Indian Penal Code (IPC), which penalizes death caused by a rash or negligent act. The Supreme Court of India has since developed a nuanced jurisprudence to ensure that only gross negligence – reflecting a high degree of culpability – is criminally sanctioned, while ordinary negligence remains within the domain of civil law. This article undertakes a jurisprudential analysis of criminal liability for medical negligence, with a focus on Supreme Court decisions in India and comparative insights from other common law jurisdictions. Part I explains the doctrinal underpinnings of negligence and criminal liability, highlighting the distinction between civil and criminal negligence and the role of mens rea. Part II examines the evolution of Indian case law, from early precedents to landmark Supreme Court judgments that have effectively raised the bar for prosecuting medical professionals. Part III surveys how foreign courts in the UK, US, and Canada address similar issues – from the English doctrine of gross negligence manslaughter to high-profile prosecutions in North America – thereby situating the Indian approach in a broader context. Part IV discusses the theoretical frameworks that inform why legal systems treat medical mistakes differently depending on context, and Part V explores practical implications and proposes reforms. Throughout, the analysis underscores an academic yet pragmatic understanding: criminalizing inadvertent medical errors can have far-

¹ (2004) 6 SCC 422

² (2005) 6 SCC 1

³ “Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both”

reaching consequences for healthcare delivery, and thus the law must strive for a balance that deters truly reckless conduct without stifling medical innovation or decision-making. The findings and recommendations aim to clarify doctrine and guide policy so that the legal system can both uphold patient safety and maintain fairness for healthcare providers.

Doctrinal Foundations: Negligence, Mens Rea, and Liability

Negligence in Civil vs. Criminal Law: Negligence generally denotes a breach of a duty of care resulting in harm. In civil law (tort or consumer protection), a doctor may be held liable if their care fell below the standard expected of a reasonably competent practitioner, causing injury to the patient. The focus is compensatory – to make the injured party whole – and the threshold is relatively lower (preponderance of evidence showing a deviation from ordinary professional standards). In criminal law, by contrast, negligence takes on a narrower, more culpable character. Criminal negligence implies gross negligence – a negligence so extreme that it reflects a “gross and culpable neglect or failure” to exercise due care. As the Supreme Court of India has emphasized, an act that is negligent in the civil sense will not necessarily be considered criminal. To amount to a crime, the negligence must be of a much higher degree, bordering on recklessness. In the oft-cited words of English jurist Baron Rolfe, approved by Indian courts, negligence in criminal cases must show such a degree of disregard for life and safety of others that it can be treated as a crime, rather than merely a matter for compensation. Interestingly the combined words “any rash or gross act” envisaged synonymously Under IPC and BNS⁴ are not defined anywhere in the Acts, even in the successor ones, leave the Court to interpret as per the weight of deviation. The mere deviation only attracts civil liability whereas the degree of deviation proven as negligent without standard care and qualified in terms of gross and rash behaviours result in Criminal culpability. This differentiating feature enables the limited Criminal prosecution of Medical Practitioners.

Mens Rea and “Gross” Negligence: A cornerstone of criminal jurisprudence is that guilt requires a guilty mind (mens rea) in addition to a wrongful act (actus reus). How can a crime exist when the doctor did not intend harm? Jurisprudentially, criminal negligence is one of the exceptional areas where mens rea is imputed from extreme carelessness. The Indian Penal Code acknowledges this through provisions like Section 304A (causing death by negligence) and related sections (Sections 336–338⁵ dealing with endangering life or causing hurt by rash or negligent acts). The Supreme Court of India in *Jacob Mathew* observed that even in negligence-based offenses, the element of mens rea cannot be ignored; it is satisfied if the negligence is of such a degree that it reflects a reckless state of mind or utter indifference to consequences. In other words, where a doctor’s conduct exhibits a wanton disregard for patient safety – essentially an attitude so apathetic or callous that it approximates intentional wrongdoing – the law treats it as equivalent to having a guilty mind. Common law courts have similarly described this as negligence that goes beyond a mere lapse and instead constitutes behavior “so bad, so obviously wrong, that it warrants criminal punishment.” For instance, the House of Lords in *R. v. Adomako*⁶ – a case later relied on by the Indian Supreme Court – held that a doctor is criminally liable only if the negligence showed “such disregard for life and safety of his patient as to amount to a crime against the state”. This language captures the essence of gross negligence as a substitute for mens rea in these cases. This case is a classic example of Manslaughter by breach of duty⁷ where the patient died of fatal cardiac arrest during an eye surgery. The disconnection of a crucial tube from the ventilator was considered as the cause of the death which associate with the carelessness on the part of Doctor who was supposed to ensure due care. The ultimate question for the jury to decide here was that “whether the defendant’s conduct so bad in all the circumstances that it ought to amount to criminal?”⁸ The court dismissed the appeal. It clearly laid down the gross negligence as an alternate to

⁴ The Bharatiya Nyaya Sanhita, 2023(Act 45 of 2023), s. 106(1)

⁵ Sec 336: “Whoever does any act so rashly or negligently as to endanger human life or the personal safety others....”; Sec 337: Whoever causes hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others.....”; Sec 338: Whoever causes grievous hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others.....”

⁶ [1995] 1 AC 171

⁷ Business Bliss Consultants FZE, ‘R v Adomako – 1995’ (September 2025), Lawteacher.net, available at <https://www.lawteacher.net/cases/r-v-adomako.php?vref=1> (last visited on 29 September, 2025)

⁸ *Ibid.*

constitute the offence, instead of proving the bad intention or criminal mind accompanied the act. This helps to reduce the unnecessary acquittal of Doctors pleading ‘absence of intention’.

Statutory Framework (India): Section 304A IPC is the primary provision under which criminal medical negligence cases are charged. It reads: “*Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide shall be punished with imprisonment up to two years, or fine, or both.*” Other IPC sections cover non-fatal negligence (e.g. causing hurt by rash/negligent act under Sections 337–338). Additionally, the IPC provides defenses and exemptions that are particularly relevant to medical practitioners: Section 80 exempts accidents done without criminal intent with due care; Section 88 exempts acts not intended to cause death done in good faith for a person’s benefit with consent; Section 92 exempts acts done in good faith in an emergency without consent to prevent death or serious harm, etc.. These provisions enshrine in statute the principle that good faith medical treatment – even if unsuccessful – should not be branded as criminal. Indian courts have invoked these sections to protect doctors who act in emergencies or in the patient’s best interest without any malicious motive.

The “Reasonable Doctor” Standard: To judge negligence, courts use the yardstick of a reasonably skilled and prudent doctor.

The famous *Bolam* test in civil law from *Bolam v. Friern Hospital Management Committee*, 1957⁹ holds that a doctor is not negligent if their treatment is in accord with a practice accepted as proper by a responsible body of medical professionals. The Indian Supreme Court has endorsed this approach, noting that a medical professional’s conduct should be measured against the standards of his/her peers in the field. In criminal cases, this standard is coupled with the requirement of gross deviation: *Would any reasonable doctor in the same situation, with the same knowledge, be likely to have committed the same act or omission?* If the answer is no – that the conduct was not merely a lapse that some competent doctors might make, but rather a truly inexplicable or inexcusable deviation – only then can it be labelled grossly negligent. As one scholarly response put it, a physician should not be criminally judged for a slip that is “inevitable in human actions”; the legal test is whether the error was “*so bad that no reasonable doctor of the same level of experience, in the same situation, would have made that error.*” This effectively merges the *Bolam* yardstick with the gross negligence threshold.

In *Jacob Mathew*, the Supreme Court articulated it thus: to prosecute a medical professional criminally, it must be shown that the doctor’s conduct was such that “no medical professional in his ordinary senses and prudence” would have done or omitted to do under the circumstances – and moreover, that the risk taken was of such nature that the injury was almost imminent. This formulation underscores that criminal negligence is not established by showing just any departure from ordinary care, but an extreme departure that bespeaks profound incompetence or indifference. Here the gravity of deviation will be analysed to constitute Criminal liability and laid down the specific criteria to determine the Medical negligence cases i.e. Peer review where the deviation was assessed for its acceptance among the Medical fraternity and if the act is beyond the generally accepted procedures or rules which included the absence of standard care on the part of a Doctor, the case will be eligible to prosecute under Criminal charges. This prerequisite marks the uniqueness of medical negligence cases from the pool of ordinary negligence, which only mandate a test with respect to the reasonable or prudent man’s skill or knowledge. The *Bolam* test explicitly mentioned the need of standard care from doctors instead of which results in the deviation and not in any way underpins any expert level skill or care.

With these principles in mind, we turn to how the Indian judiciary, led by the Supreme Court, has applied them in concrete cases, and how the law has evolved to guard against overzealous prosecution of healthcare professionals while still permitting accountability in truly egregious cases.

⁹ [1957] 1 WLR 583

Medical Negligence in Indian Jurisprudence

Early Precedents: In the early post-independence decades, Indian courts dealt with a few criminal cases involving doctors, laying the groundwork for later doctrine. An illustrative case is *Juggan Khan v. State of Madhya Pradesh*¹⁰, where a physician was accused of causing a patient's death by administering a potentially poisonous indigenous remedy (extracts of *dhatūra*, a toxic plant). The Supreme Court concluded that while the doctor's actions were misguided, they did not amount to murder (requiring intent), but did justify conviction under Section 304A IPC. Implicit in this and similar early cases was the notion that utter lack of skill or doing something patently hazardous without knowledge could be criminal. Indeed, courts sign allied that a person "totally ignorant of the science" who purports to treat patients could be held criminally negligent if such quackery causes death. If we apply Bolam test here, it could be evident that standard of care is not administered by the Doctor and he does not have any knowledge or skill on the treatment he applied on the patient where it clearly beyond his expertise as there is no treatment using *dhatūra* plant anywhere in Homoeopathy. Therefore the court came to the conclusion that it is a *rash and negligent act to prescribe poisonous medicines without studying their probable effect*.¹¹ In another notable case, *Dr. A. S. Mittal v. State of U.P.*¹², arose from a tragic mass blindness caused by an eye surgeon's procedural lapses at an eye camp the Supreme Court observed that a mistake of a reasonably competent and careful practitioner would not have committed is a negligent one – although *Mittal* was primarily concerned with civil liability and compensation, it reinforced the baseline standard of care expected. A mistaken diagnosis did not amount to Medical negligence if the doctor exercises standard care which is settled earlier in *Philips India Ltd. V. Kunju Ponnu*¹³. During the 1990s, the landscape shifted with the advent of the Consumer Protection Act, 1986. In *Indian Medical Assn. v. V.P. Shantha*¹⁴, the Supreme Court held that medical services are covered by the Consumer Protection Act, opening the door to civil claims in consumer fora. While *Shantha* was about civil liability, it reflected the judiciary's growing engagement with medical negligence. Around the same time, *Poonam Verma v. Ashwin Patel*¹⁵ dealt with a homeopath that treated a patient with allopathic medicine, leading to the patient's death. The Supreme Court in that case labelled the act of practicing in an unqualified branch of medicine as "negligence per se," observing that such conduct could invite criminal liability as well. *Poonam Verma* exemplified that if a practitioner wilfully ventures beyond his competence – essentially an act of gross negligence through "crosspathy" – it may be viewed as criminally culpable, since no qualified doctor would reasonably commit such an error. Moreover it is not an accepted practice among the Medical Community.

Despite these hints, actual convictions of doctors remained rare. Courts were cautious, often emphasizing the need for strong proof of gross negligence. An important general precedent came in *Syad Akbar v. State of Karnataka*¹⁶, not a medical case but a motor accident case, where the Supreme Court bench lucidly explained the difference between negligence under civil and criminal law. Citing English authority, the Court noted that in civil suits a mere preponderance of evidence suffices to prove negligence, whereas in criminal trials the proof must be beyond reasonable doubt and the negligence "should be of such a high degree as to be gross". This dictum from *Syad Akbar*, repeatedly invoked in later medical negligence cases, firmly established that criminal liability demands a qualitatively higher degree of negligence than civil liability. It set the stage for the jurisprudence of the 2000s, when the issue of doctors facing criminal prosecution gained national attention.

The 2004–2005 Watershed: The mid-2000s proved to be a turning point in Indian law on medical negligence, triggered by a series of cases that reached the Supreme Court in quick succession. First, in early 2004, the case of *Mohanan v. Prabha G. Nair*¹⁷ came before the Court. There, a pregnant woman had died under a doctor's care, and the Kerala High Court had quashed the ensuing Section 304A prosecution, reasoning that mere death in a hospital is not proof of criminal negligence. The Supreme Court reversed that quashing, holding that whether the doctor's negligence was gross could

¹⁰ 1965 AIR 831

¹¹ Available at, <https://nearlaw.com/PDF/MumbaiHC/1964/1964-ALLMR-ONLINE-261.html> (last visited on 29 September 2025)

¹² AIR 1989 SC 1570

¹³ AIR 1975 Bom. 306

¹⁴ 1996 AIR 550

¹⁵ 1996 AIR 2111

¹⁶ 1979 AIR 1848

¹⁷ 2004 (3) SCC 391

only be determined after examining evidence at trial, and that the High Court should not short-circuit the process under its inherent powers. In effect, *Mohan* suggested that an allegation of serious negligence should normally go to full trial rather than being dismissed at the threshold, signalling a victim-centric approach.

However, only a few months later, a seemingly contrary approach emerged in *Dr. Suresh Gupta v. Government of NCT of Delhi*. Dr. Suresh Gupta, a plastic surgeon, was criminally charged after a patient died during a routine nasal septum surgery – allegedly due to the doctor’s failure to use a proper endotracheal tube, causing fatal asphyxia. The Supreme Court, this time, took a distinctly pro-doctor stance. It quashed the proceedings against Dr. Gupta at the outset, pronouncing that to hold a medical professional criminally liable, the negligence must be “so high” as to be gross – a mere lack of proper care or an error of judgment is not enough. In a pivotal passage, the Court said:

“To fix criminal liability on a doctor or surgeon, the standard of negligence required to be proved should be so high as can be described as ‘gross negligence’ or ‘recklessness’... It can be termed ‘criminal’ only when the medical man exhibits a gross lack of competence or inaction and wanton indifference to the patient’s safety, which has arisen from gross ignorance or gross negligence. Where a patient’s death results merely from an error of judgment or an accident, no criminal liability should be attached. Mere inadvertence or some degree of want of adequate care and caution might create civil liability but would not suffice for criminal liability.”¹⁸

Applying this standard, the Court found that Dr. Gupta’s alleged lapse (not intubating with a cuffed tube) might amount to negligence in tort, but was not so flagrantly wrong as to be criminal. It noted the surgery was not extraordinarily complex and that the doctor had at worst been careless – which fell short of the *mens rea*-like gross negligence needed for Section 304A. The criminal case was therefore quashed without trial.

The *Suresh Gupta* decision marked a drastic change (and arguably a conflict with *Mohan*). It underscored policy concerns: that if every medical misadventure were treated as potential crime, doctors would become fearful and defensive in practice. The Court explicitly warned that extending criminal law into the medical domain for anything less than gross negligence would “do a great disservice to the community” – doctors would be afraid to take necessary risks or employ innovative treatments, and the doctor-patient relationship would suffer. Notably, *Suresh Gupta* drew on English law (*R. v. Adomako*) and academic commentary (the Court even quoted from the book *Errors, Medicine and the Law* by Merry & McCall Smith) to affirm that criminal punishment is reserved for truly blameworthy conduct, not mere mishap.

Given the apparent divergence between *Mohan* and *Suresh Gupta*, clarity was needed. The opportunity came with *Jacob Mathew v. State of Punjab*. This case arose from the death of a terminally-ill cancer patient in a Punjab hospital, allegedly due to an empty oxygen cylinder when the patient developed breathing difficulty. The deceased’s family lodged an FIR accusing two doctors of criminal negligence for not ensuring a filled oxygen tank was available. The trial court framed charges under IPC 304A/34, and the High Court refused to quash them. By the time the matter reached the Supreme Court, two judges hearing the appeal noted the conflicting precedent and referred the case to a three-judge bench for authoritative resolution. Chief Justice R.C. Lahoti led the bench, and the Court framed two key questions: (i) Is there a difference between civil and criminal negligence, and (ii) is a different standard applicable when the alleged negligent act is by a professional (especially a doctor).¹⁹ These questions were answered with a resounding yes – aligning with the logic of *Suresh Gupta* but giving it the imprimatur of a larger bench and adding important guidelines.

In its judgment, the Supreme Court in *Jacob Mathew* reaffirmed that only gross negligence or recklessness warrants criminal liability in medicine. The bench agreed with the standard set in *Suresh Gupta* (which it quoted extensively) and explicitly overruled any notion to the contrary. It observed that allegations of medical negligence must be examined carefully; otherwise, the threat of criminal prosecution would demoralize doctors and harm society at large. The Court answered the reference by holding that there *is* a clear difference between negligence sufficient for civil liability and

¹⁸ *Supra* at 1.

¹⁹ Nair MR Hariharan, ‘Supreme Court judgement on criminal medical negligence: a challenge to the profession’ (2005) 2(4) Indian Journal of Medical Ethics 110, available at : <https://ijme.in/articles/supreme-court-judgement-on-criminal-medical-negligence-a-challenge-to-the-profession/?galley=print> (last visited on 29 September 2025)

that required for criminal liability – the latter being much higher (a degree of negligence that indicates a mental state of recklessness). It also confirmed that this standard is particularly pertinent for professionals: a simple lack of success or an error in treatment does not imply negligence if the doctor acted with reasonable competence, and certainly not criminal negligence.

Jacob Mathew Guidelines and Impact: Beyond settling the law, the *Jacob Mathew* verdict is famous for issuing practical guidelines to prevent arbitrary or unjustified criminal accusations against doctors. Noting the absence of statutory rules then, the Court directed that until the government framed appropriate rules, the following guidelines should govern prosecutions (especially private complaints) against medical professionals:

1. **Prima Facie Credible Opinion Required:** No criminal court should entertain a private complaint of medical negligence unless the complainant produces prima facie evidence of guilt in the form of a credible and independent medical opinion supporting the charge. In other words, a qualified doctor's affidavit or testimony must attest that the accused's conduct was grossly negligent or rash by professional standards. This prevents frivolous complaints based solely on patient or relative grievances without medical substantiation.
2. **Prior Scrutiny by Expert Panel:** Police investigating a medical negligence allegation under 304A IPC must first obtain an independent medical opinion from a doctor or panel of doctors with relevant expertise (preferably in government service) before proceeding. The expert should apply the Bolam test (standard professional practice) to the facts collected. This ensures an unbiased assessment by peers of the accused, filtering out cases where the outcome was unfortunate but the treatment was in line with accepted practice.
3. **No Immediate Arrest:** Doctors should not be arrested in a routine manner upon a negligence accusation unless such arrest is necessary for the investigation (for example, if there is a risk the doctor will flee or destroy evidence). In most cases, since evidence in medical cases is document-based and the doctor's identity/location are known, arrest is unwarranted during inquiry. This guideline responded to reports of abrupt arrests of doctors which caused outrage in the medical community.

These guidelines had an immediate effect. They tipped the balance towards protecting medical professionals from the criminal process unless a preliminary vetting indicated gross negligence. In *Jacob Mathew* itself, after applying the above principles, the Supreme Court concluded that even if all the allegations were true, the case amounted at best to systemic or civil negligence (an empty oxygen cylinder for which the hospital could be civilly liable), but not to criminal negligence by the doctors. The Court noted there was no accusation that the doctors lacked qualification or failed to attend the patient; the crux was unavailability of oxygen, which pointed more to administrative lapse than personal recklessness. Thus, it quashed the prosecution against the doctors. The *Jacob Mathew* ruling was lauded by the medical fraternity and is considered a landmark that brought clarity and a semblance of balance to the law. Indeed, in the wake of *Jacob Mathew*, High Courts across India have routinely quashed criminal cases against doctors where the Jacob guidelines were not followed or where the alleged negligence did not meet the grossness standard.

After Jacob Mathew's case, recently the Kerala High Court in *Dr. Mohamed Rizwan T. v. State of Kerala & Ors*²⁰ has issued a well-crafted set of 12 guidelines towards prosecution and handling of Medical negligence cases which shall enhance the existing framework by fixing the void and vague. The guidelines listed as follows:-

1. When a complaint of medical negligence is lodged, the Investigating Officer must promptly collect the preliminary documents such as doctor's notes, nurse's records, duty rosters, shift logs, attendance registers, patient assessment sheets, consent forms, diagnostic and lab reports, referral notes, treatment details, and discharge summaries.
2. The Investigating Officer should immediately inform the competent authority of the complaint and request the convening of an Expert Panel without delay.

²⁰ CRL.MC NO. 3414 OF 2025, also available at :

<https://www.verdictum.in/court-updates/high-courts/kerala-high-court/dr-mohamed-rizwan-t-v-state-of-kerala-medical-negligence-cases-guidelines-1589959> (last visited on 29 September 2025)

3. Each district should maintain a list of medical practitioners categorized by specialty, ensuring they are briefed on handling negligence complaints. The Expert Panel must include a doctor from the relevant specialty.
4. The Expert Panel is required to complete its review within 30 days of being formed.
5. Both the medical practitioner involved and the complainant must be notified and given an opportunity to submit written representations to the Panel.
6. If the Panel finds prima facie evidence of gross negligence, the concerned doctor should be asked to appear personally and explain the treatment or procedure followed.
7. The Panel's report should record the individual views of each expert, while the final conclusion must reflect a consensus decision.
8. The report should directly addresses whether gross negligence or recklessness, resulting in loss of life, can be attributed to the doctor, identify the individuals responsible, and provide reasons for the finding.
9. A uniform standard, such as the Bolam test, should be applied by the Panel in determining criminal negligence. The reasoning must be clearly reflected in the report, ideally using a structured reporting template.
10. Copies of the Panel's report must be provided to the affected medical practitioners. If no negligence is established, the complainant should also receive a copy of the report.
11. Both the medical practitioner and the complainant should have a right to appeal against the findings of the Expert Panel.
12. Clear timelines should be prescribed for filing an appeal and for its disposal by the State-level Apex Expert Committee. If an appeal is filed within the prescribed time, the Investigating Officer may submit the final report only after the appeal has been decided.

The Court directed the ADGP to present the draft guidelines to the Government for prompt action. Consequently, the High Court suspended further proceedings for three months and scheduled the matter for hearing on 30 September 2025.

Landmark and Recent Decisions: Evolving Standards

In the years since *Jacob Mathew*, the Supreme Court and High Courts have mostly hewed to the path it charted, reinforcing the threshold and procedural safeguards. Notable developments include:

- **Emphasis on Expert Evidence:** Courts have consistently held that absence of an independent medical expert opinion is fatal to the prosecution at the threshold. A 2024 analysis of 90 Indian judgments found that in a majority of cases, proceedings were quashed because the investigative authorities failed to obtain the requisite unbiased medical opinion as mandated. For instance, if the only supporting opinion comes from a doctor who was part of the treating team (hence not “independent”), or from someone not qualified in the relevant branch, courts have refused to let the case proceed. This insistence has operationalized *Jacob Mathew*'s intent: separating genuine cases of prima facie criminal negligence from situations of medical misfortune.
- **Few Convictions, Many Quashings:** Empirical data underscore how high the bar has been set. Legal reports indicate that cases of medical negligence have increased nearly fourfold in recent years. States such as Punjab (24%), West Bengal (17%), Maharashtra (16%), and Tamil Nadu (11%)²¹ account for the majority of such litigations. NCRB data further shows that from 2017 to 2022, over 1,000 criminal cases²² were filed against doctors for alleged deaths caused by negligence. This escalation is largely linked to greater public awareness of patient rights and the Consumer Protection Act (CPA), encouraging patients to pursue legal action for perceived harm. While this trend has intensified the legal challenges faced by healthcare professionals, many of these complaints appear to be frivolous or intended to harass.²³ Most such cases, as one study noted, ended with the

²¹ Khatri S,” Stats on Medical negligence cases in India in comparison to other countries”, available at : <https://www.delhimedicalnegligence.com/post/stats-on-medical-negligence-cases-in-india-in-comparison-to-other-countries#:~:text=As%20per%20the%20National%20Library,110%25%20jump%20in%20annual%20numbers> (last accessed on 29 September 2025)

²² Ministry of Home affairs, Government of India .National Crimes Records Bureau .ncrb.gov.in, available at : <https://ncrb.gov.in/crime-in-india.html> (last visited on 29 September 2025)

²³ Ravi Kirthika, Devnath Gerard P and James Ranjit I, ‘Medical Negligence in India: Urgent Call for Comprehensive Data, Tort Reforms, and Cultural Transformation to Revitalize Healthcare System’ (2024) 17(2) Medical Journal of Dr DY Patil Vidyapeeth 259, doi:10.4103/mjdrdypu.mjdrdypu.601.23.

criminal case being quashed, often due to non-fulfilment of the *Jacob Mathew* preconditions. This trend has been interpreted as a sign that the judiciary is successfully preventing unjust prosecutions. It also suggests that truly egregious cases (which would warrant conviction) are fortunately rare.

- **Clarifying Gross Negligence vs. Medical Disagreement:** The courts have drawn a line between genuine negligence and mere differences in medical opinion. In the *Dr. P.B. Desai*²⁴ case, the Supreme Court clarified that if one doctor's approach differs from others that alone don't amount to negligence – provided the chosen treatment was in line with standard care of that time. In other words, an error of judgment, or choosing one of multiple accepted courses of action, is not negligence. Only when the chosen course is one that no reasonable contemporary medical professional would support can it be termed grossly negligent. This principle prevents hindsight bias or second-guessing from labelling doctors criminally culpable for bad outcomes despite adhering to accepted practice.

- **Cross-System Practice (Quackery):** One category where courts have been willing to infer gross negligence is what is sometimes called “mixopathy” or crosspathy – unqualified practice of medicine. For example, in *Dr. Ashish Khare v. State of M.P.*²⁵, a practitioner of Ayurveda was treating a patient with allopathic medicines and the patient died. The Madhya Pradesh High Court held the doctor prima facie negligent per se, since he lacked training in the system he employed. It was noted he could also be liable under the Medical Council Act for unauthorized practice. Such cases fit into the notion of *gross ignorance* leading to the harm – something the Supreme Court in *Suresh Gupta* had flagged as an instance of criminal negligence (when a practitioner is “totally apathetic” or exhibits “gross ignorance” of essential precautions). So, while a mere mistaken judgment by a qualified doctor isn't criminal, the deliberate undertaking of a treatment without requisite qualification or using plainly hazardous methods can cross into criminality.

- **Duty to Refer or Take Precautions:** Another scenario attracting criminal liability is where a doctor knowingly undertakes a high-risk situation without necessary facilities or expertise, and disaster ensues. In *Dr. Subas Chandra Dash v. State of Orissa* (decided by Orissa High Court)²⁶, the doctor handled a complicated pregnancy case (with antepartum hemorrhage) in a center lacking blood transfusion or surgical facilities, and the mother died. The Court refused to quash the case, finding that not referring the patient to a properly equipped facility “*implies a gross disregard of the life of the patient and hence might amount to criminal negligence.*” This illustrates that conscious disregard of known limitations (treating a case one is unequipped to handle) can be deemed reckless. The expectation is that a prudent doctor would either refer the patient or take additional precautions; failing that, if the outcome is tragic, a case of gross negligence can be made.

- **Protection for Government Doctors:** The courts have also pointed out that when prosecuting a government doctor, an additional legal safeguard may apply: Section 197 of the CrPC²⁷, which requires government sanction to prosecute public servants for acts done in the course of duty. In *Dr. Manorama Tiwari v. Surendra Rai*²⁸, it was held that an on-duty government doctor has a protective shield – unless the alleged negligent act was wholly outside the scope of duty – and prosecution without sanction would be barred. This adds another layer ensuring that doctors in public service aren't dragged into court for bona fide treatment decisions without oversight by higher authorities.

In sum, the Indian Supreme Court through *Jacob Mathew* and subsequent decisions has established a robust protective doctrine for medical professionals: only conduct that no reasonable doctor would endorse, reflecting gross deviation from standard care with indifference to consequences, can lead to criminal guilt. Lesser lapses belong to civil law or professional disciplinary realms. The practical effect is that the criminal justice system very rarely convicts doctors for negligence – a fact borne out by statistics. While this approach has been occasionally criticized by victim advocates as being too lenient, the courts view it as necessary to prevent defensive medicine and ensure doctors are not deterred from taking necessary risks in treatment. The next Part compares how this balance is struck in other countries, shedding light on alternative approaches and convergent principles.

²⁴ 2013 (15) SCC 481

²⁵ MANU/MP/0348

²⁶ SCC Online Ori 132. 2017

²⁷ The Civil Procedure Code, 1973 (Act No. 2 of 1974)

²⁸ (2016) 1 SCC 594

Comparative Jurisprudence: UK, US, and Canada

The question of criminal liability for medical negligence is not unique to India. Jurisdictions like the United Kingdom, United States, and Canada which rooted in common law traditions have grappled with similar issues, albeit with different legal frameworks and outcomes. A comparative look reveals a common recognition that only egregious negligence should be criminal, but each countries legal system operationalizes that recognition in its own way.

United Kingdom: Gross Negligence Manslaughter

In UK law, there is no special statute for “medical negligence crimes”; instead, doctors (and anyone else) can be prosecuted for manslaughter by gross negligence (a common law offence) if a patient dies as a result of their extremely negligent act or omission. The seminal definition dates back to *R. v. Bateman*²⁹ and has been consistently affirmed. In *Bateman*, The defendant, a medical practitioner, while delivering a stillborn child, inadvertently removed a portion of the mother’s uterus along with the placenta and caused rupture to several internal organs. Although her health began to deteriorate, he delayed transferring her to the hospital, which ultimately resulted in her death. A conviction for gross negligence manslaughter was entered against the defendant. The Court of Appeal explained that to establish manslaughter, the negligence “must go beyond a mere matter of compensation between subjects and show such disregard for the life and safety of others as to amount to a crime.” This standard was later endorsed by the House of Lords in *R. v. Adomako*³⁰— a case involving an anaesthetist who failed to notice a disconnected oxygen tube, leading to a patient’s death. The Law Lords in *Adomako* held that the jury must consider whether the breach of duty was grossly negligent and consequently criminal, and they quoted the very formulation of *Bateman* (disregard for life and safety amounting to a crime). Thus, English law aligns closely with the principles articulated in *Suresh Gupta* and *Jacob Mathew*: not every medical error causing death is manslaughter – it must be a gross error, one that evokes outrage in its deviation from the expected standard.

To convict a doctor of gross negligence manslaughter in the UK, the prosecution must prove: (1) The doctor owed the patient a duty of care;

(2) The doctor breached that duty by act or omission;

(3) The breach caused the patient’s death;

(4) The breach was grossly negligent, meaning, as one court put it, “truly, exceptionally bad” in all the circumstances. The assessment of “grossness” is typically left to the jury’s judgment, guided by the judge’s instructions.

In *R. v. Misra and Srivastava*³¹, The two appellant doctors were found guilty of gross negligence manslaughter after a post-operative patient in their care died. The patient had developed a wound infection that went unrecognized and untreated despite clear signs, ultimately leading to death from toxic shock. On appeal, they argued the test for gross negligence was circular and breached legal certainty. The Court of Appeal dismissed the argument, affirming that the *Adomako* test was sufficient and not incompatible with human rights; it also made clear that the risk of death from the doctor’s conduct must be “foreseeable” and obvious. Thus, in the UK there is an additional nuance that the gross breach of duty must involve a risk of death (not merely injury). This focuses criminal law on the most devastating outcomes.

In practice, the UK has seen a number of prosecutions of health professionals for gross negligence manslaughter. Some notable cases illustrate the circumstances and controversies:

²⁹ (1925) 19 Cr App R 8

³⁰ *Supra* at. 6

³¹ [2005] 1 Cr App R 328

- **Dr. John Bodkin Adams (1957)³²** – One of the first high-profile cases, though he was acquitted. A physician accused of hastening the deaths of elderly patients with morphine, raising questions of intent versus negligence.
- **Dr. Leonard Arthur (1981)³³** – A Paediatrician tried (and acquitted) for the death of a Down's syndrome infant to whom he had ordered only palliative care. This case touched on complex ethical issues beyond straightforward negligence.
- **R. v. Prentice & Sullman³⁴** : A group of appeals including Adomako where the House of Lords clarified the law, as discussed. Convictions in some of those cases (junior doctors administering wrong drugs) were quashed on technical grounds, but the *gross negligence* test was cemented.
- **Dr. Jagdish Misra & Dr. Rajeev Srivastava (2003)³⁵** – As noted, convicted for gross negligence manslaughter after failing to act on clear signs of a fatal infection. Their case confirmed that the test was not too vague.
- **The Bawa-Garba Case³⁶** – Perhaps the most debated recent case. Dr. Hadiza Bawa-Garba, a junior doctor, was convicted of manslaughter in 2015 after a hospitalized child died from sepsis under her care. The case drew huge attention because multiple systemic failings contributed (staff shortages, IT failures), yet an individual doctor was criminally blamed. She received a suspended sentence, but the Medical Practitioners Tribunal initially struck her off the register, prompting outrage among doctors who felt scapegoated. Ultimately, on appeal in 2018, Dr. Bawa-Garba was reinstated to the medical register. The case spurred an independent review (the "Hamilton Review" in 2019) into gross negligence manslaughter in healthcare, and led the General Medical Council and Crown Prosecution Service (CPS) to reconsider guidelines. The CPS issued guidance emphasizing that truly systemic errors or "honest mistakes" should not ordinarily lead to prosecution; only cases meeting the high grossness threshold and serving public interest should proceed.

Statistically, prosecutions of doctors in the UK are still uncommon, but possibly more frequent than in India. The usual trend is that a doctor should not be prosecuted for a "slip" that is bound to happen on occasion in human affairs. Only a lapse that is extraordinary in its wrongness should face criminal sanction, effectively the same standard as the Indian courts use (no reasonable doctor in that situation would have done it). The British Medical Association and other professional bodies have advocated for clearer definitions and even a specialist tribunal for such cases, arguing that fear of manslaughter charges can discourage incident reporting and learning in hospitals. This is part of a broader debate between a "no blame" culture aimed at improving patient safety versus a "retributive" desire to punish severe medical misconduct.

In conclusion, UK law on criminal medical negligence converges on the idea of gross deviation from standard care being required. The *terminology* differs (manslaughter rather than "negligence causing death"), but functionally it mirrors the Indian position post-*Jacob Mathew*. However, UK prosecutions have occasionally drawn fire for inconsistency, leading to ongoing discussions about reforming how these cases are handled (for instance, better guidance on when to prosecute, and possibly involving medical experts in the decision-making process before charging an approach India mandated by judicial fiat through *Jacob Mathew*).

United States: Diverse Approaches to Criminal Malpractice

The United States lacks a single unified doctrine for criminal medical negligence; instead, each state defines crimes like "involuntary manslaughter" or "criminally negligent homicide" in its own penal code. Generally, American law distinguishes between recklessness and criminal negligence as levels of culpable mental state. A common formulation (from the Model Penal Code, adopted in many states) is that criminal negligence means the defendant should have been

³² [1957] Crim LR 365

³³ [1985] Crim LR 705

³⁴ R v Prentice [1993] 4 All ER 935 CA, R v Sullman [1994] QB 302

³⁵ Supra at. 31

³⁶ [2018] EWCA Civ 1879; also available at P Case and G Sharma, 'Promoting Public Confidence in the Medical Profession: Learning from the Case of Dr. Bawa-Garba' (2020) 20(1) *Medical Law International* 58, available at <https://doi.org/10.1177/0968533220933788> (last visited on 29 September 2025).

aware of a substantial and unjustifiable risk while recklessness means the defendant consciously disregarded such a risk. In the context of medical practice, most prosecutions arise under laws penalizing conduct that causes death through gross negligence or recklessness. The precise threshold varies by jurisdiction, but it is higher than ordinary civil malpractice. U.S. courts and scholars often cite the maxim that mere medical malpractice is for civil courts, and criminal charges are reserved for “gross departures” from the standard of care.

Historically, criminal prosecutions of doctors in the U.S. have been rare, and usually confined to particularly egregious facts or when the doctor’s actions go beyond negligence into wilful wrongdoing (like performing illegal procedures). However, recent years have seen a slight uptick in such cases, often driven by public outcry in high-profile incidents:

- **Dr. Conrad Murray (California, 2011)³⁷:** The personal physician of pop star Michael Jackson was charged with involuntary manslaughter after Jackson died from a concoction of sedatives and the anesthetic propofol administered by Dr. Murray. The prosecution argued Murray exhibited a gross deviation from the standard of care using a powerful anesthetic at home without proper monitoring equipment, and then leaving the sedated patient unattended. A Los Angeles jury found Dr. Murray guilty; the trial judge underscored that this was not a mere error in judgment but “*reckless conduct*” demonstrating serious disregard for life. Dr. Murray was sentenced to four years (serving about two). This case is emblematic: it took extraordinary facts – a doctor essentially providing dangerous drugs on demand to a celebrity – to result in criminal conviction. The judge’s remark, “*This is not a crime involving a mistake in judgment... the offense... is a homicide*”, highlights that Murray’s behavior was deemed so far below any acceptable standard (indeed described as “unconscionable” in media reports) that it merited punishment.
- **Opioid Overprescription Cases:** A handful of doctors have been prosecuted for deaths caused by reckless prescribing of controlled substances. In a landmark case, Dr. Hsiu-Ying “Lisa” Tseng³⁸, a California physician, was convicted in 2015 of *second-degree murder* (a more serious charge than manslaughter) for the overdose deaths of three patients to whom she had recklessly prescribed painkillers. This was reportedly the first time a U.S. doctor was found guilty of murder for prescription practices. Evidence showed Dr. Tseng ignored clear signs of addiction and overdoses, essentially operating a “pill mill.” The conviction required a finding of implied malice (subjective awareness of the danger to life) – effectively that she knew her actions risked killing patients and did it anyway, which is beyond negligence and into recklessness. Similar prosecutions have occurred in other states (e.g., cases in Florida and Oklahoma where doctors faced murder or manslaughter charges for egregious over prescription leading to patient deaths).
- **Surgical and Anesthesia Mishaps:** On occasion, particularly extreme negligence during surgery or perioperative care has led to criminal charges. For example, a jury in Texas in the 2000s convicted a neurosurgeon (Dr. Christopher Duntsch, infamously nicknamed “Dr. Death”)³⁹ of gross aggravated assault after multiple patients were maimed or killed by his surgeries – this was not a classic manslaughter prosecution (since one patient survived severely injured, the charge was for injury), but it reflected a criminal justice response to a doctor who egregiously breached standards (in that case, allegedly due to incompetence and possible impairment).
- **Nursing Case (RaDonda Vaught, Tennessee 2022)⁴⁰:** Although a nurse rather than a doctor, this recent case gained national attention and is relevant in principle. RaDonda Vaught was convicted of criminally negligent homicide after a patient died from being given the wrong medication (a neuromuscular blocker instead of a sedative). The error was catastrophic, but many nurses argued it was a systemic failure (labelling and computer override issues) and that criminalizing such mistakes would hinder reporting of errors. Vaught

³⁷ Lyons B, ‘Medical Manslaughter’ (2013) 106(1) Irish Medical Journal 26. Available at : <https://pubmed.ncbi.nlm.nih.gov/23472376/>

³⁸ M McCarthy, ‘California Doctor Convicted of Murder over Deaths of Three Patients by Overdose’ (2015) 351 *BMJ* h5913, available at <https://doi.org/10.1136/bmj.h5913>

³⁹ A Mullock, ‘Surgical Harm, Consent, and English Criminal Law: When Should “Bad-Apple” Surgeons Be Prosecuted?’ (2021) 21(4) *Medical Law International* 343, available at :

<https://researchrepository.wvu.edu/cgi/viewcontent.cgi?article=6415&context=wwlr>

⁴⁰ C Lusk et al., ‘Reconsidering the Application of Systems Thinking in Healthcare: The RaDonda Vaught Case’ (2022) 129(3) *British Journal of Anaesthesia* e61–e62, available at <https://doi.org/10.1016/j.bja.2022.05.023>

received a lenient sentence (probation) amid widespread support from the nursing community, but the very fact of conviction sparked debate about the line between human error and culpable negligence in healthcare. The prosecutors contended Vaught's actions were grossly negligent (overriding safety warnings, not monitoring the patient). Critics feared the case sets a precedent for punishing individual practitioners when system safeguards fail.

The American experience thus shows a reluctance to prosecute medical negligence except in cases of compellingly wrongful conduct. To convict, U.S. prosecutors often must prove not just carelessness but a gross deviation that often verges on recklessness. The legal standards used – “criminal negligence” or “recklessness” – require showing a substantial departure from what a careful person (or reasonable doctor) would do, and in many states the jury must find the conduct to be morally blameworthy. As one legal commentator noted after Dr. Murray's conviction, the verdict left many wondering about the line between malpractice and manslaughter, and emphasized that the law looks for a level of negligence “approaching indifference to life” before branding a doctor a criminal.

The policy concerns echo those in India and the UK. On one hand, there is societal outrage when a patient dies due to what appears to be a doctor's gross negligence, especially if driven by greed or other improper motives (as suspected in some opioid cases). On the other hand, medical organizations caution that fear of criminal liability could impede honest disclosure of errors and deter practitioners from high-risk fields. Most U.S. states have not adopted any special statutory protections akin to *Jacob Mathew's* guidelines, but as a de facto practice, district attorneys rarely pursue charges unless aggravating factors exist: fraud, intoxication, abandonment of patient, or repeated warnings ignored. The American approach is thus fragmented but aligns with the principle that only truly egregious misconduct (or a series of negligent acts beyond the pale) will cross into criminal territory.

Canada: Criminal Negligence Causing Death and the “Marked Departure” Test

Canada's legal framework for medical negligence resulting in death is codified in its Criminal Code, which contains the offenses of “criminal negligence causing death” (Section 220) and manslaughter. Under Section 219 of the Canadian Criminal Code, a person is *criminally negligent* who in doing anything, or omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons. This definition essentially captures gross negligence in statutory words – *wanton or reckless disregard*. It applies to anyone owing a legal duty to another (which doctors unquestionably do to their patients). If such negligence causes death, Section 220 prescribes a penalty (up to life imprisonment, although that is rarely invoked to the maximum for medical cases).

Canadian courts have interpreted this to require a marked and substantial departure from the standard of a reasonable person in the circumstances. In the context of medical professionals, the question becomes: did the doctor's conduct represent a marked and substantial departure from what a reasonably prudent doctor would have done, showing a reckless disregard for patient safety? If yes, it could amount to criminal negligence. If the departure is merely *marked* (significant, but not a huge deviation) it might suffice for lesser offenses like dangerous driving causing death (in driving cases) but for criminal negligence causing death, jurisprudence has required “*marked and substantial*” departure – a higher bar. In short, Canadian law, like others, does not criminalize every medical mistake, only those that are gross aberrations from expected standards.

A very pertinent recent case is *R. v. Javanmardi*⁴¹ (Supreme Court of Canada, 2019). Mitra Javanmardi was a Quebec naturopath who gave an IV injection of nutrients to a patient; tragically, the injection was contaminated and the patient died of septic shock. Importantly, Quebec law prohibits naturopaths from administering injections (only licensed medical doctors can), so at first glance Javanmardi's act was unlawful and potentially negligent. She was charged with both unlawful act manslaughter and criminal negligence causing death. The trial judge acquitted her, finding that she had followed the standard practices of naturopathy (she was well-trained, and many jurisdictions allow naturopaths to give such injections) and did not exhibit a marked departure from what a reasonable professional in her position would do. The Quebec Court of Appeal reversed, convicting her, essentially taking the stance that because giving injections was

⁴¹ 2019 SCC 54(CanLII)

illegal for her and the act was dangerous, that alone established gross negligence. The Supreme Court of Canada, in a 5-2 decision, reinstated the acquittal. The majority held that the Court of Appeal erred by not accounting for Javanmardi's *training and experience* in assessing the reasonableness of her conduct. Justice Abella, writing for the majority, said there is indeed a standard of "*the reasonably prudent naturopath*" – meaning the reasonable person standard in a criminal negligence case should consider the specific skills of the accused. Because evidence showed Javanmardi had adhered to the highest standards of her field (using sterile technique, etc.), the majority concluded her conduct did not represent a marked and substantial departure from what a reasonable (albeit unauthorized) practitioner would do. The mere fact that her act was legally unauthorized did not automatically make it criminally negligent – context mattered. The dissent, by contrast, would have held that giving an injection when not authorized was per se objectively dangerous and a marked departure, warranting conviction.

The *Javanmardi* case underscores a few key points in Canadian law: (1) Contextual Reasonableness: The standard of care is tailored to the accused's role – akin to how in India and the UK a specialist is judged by the standards of that specialty, not a layperson. (2) High Threshold: Even performing a treatment one is not legally allowed to do did not automatically equal criminal negligence; the court looked for gross deficiency in how it was done, not just the fact it was done. (3) Role of Risk: The majority found that the risk of death from an IV of vitamins was extremely low (the death was due to an unforeseen contamination), whereas the dissent stressed the inherent risk of any invasive procedure by an unlicensed person. This reflects how perceptions of risk influence the "wanton disregard" analysis.

Other Canadian cases of note include prosecutions for deaths in non-hospital settings or due to outrageous conduct. For example, there have been cases involving midwives or traditional healers charged when a patient died under their care – again turning on whether their conduct was a marked and substantial departure from what a reasonable person would do in those circumstances. In one older case, *R. v. Tutton*⁴², the Supreme Court dealt with parents withholding insulin from a diabetic child due to religious belief, not a doctor case, but it split the Court on how to judge criminal negligence (subjectively or objectively). The law now uses an objective test (what a reasonable person would foresee/do), but allows some consideration of the accused's circumstances (short of full subjective intent).

In general, Canada sees few criminal prosecutions of physicians for malpractice. The cases that do occur often involve additional wrongdoing (for instance, a doctor sexually assaulting patients under anaesthesia leading to injury could face criminal charges beyond negligence, or a street cosmetic procedure by someone impersonating a doctor). The medically licensed professionals in hospitals are seldom prosecuted unless there is clear evidence of recklessness (e.g., a surgeon operating while intoxicated – which has happened and did lead to criminal charges in at least one instance).

To sum up, Canada's standard for criminal medical negligence is *wanton or reckless disregard* which is conceptually the same as gross negligence or recklessness in other jurisdictions. The Canadian courts articulate it as a "marked and substantial departure" from the norm, and require proof beyond a reasonable doubt of that level of fault. Acquittals like *Javanmardi*'s demonstrate a judicial reluctance to punish providers who earnestly try to help patients within their sphere of training, even if something goes horribly wrong, absent truly gross failings. The emphasis is on moral blameworthiness, consistent with the idea that criminal law is reserved for conduct deserving of societal condemnation, not mere human error.

Convergence and Divergence

Across the surveyed jurisdictions, a common theme emerges: Criminal liability in the medical context is an exception, not the rule. It is intended to address only those cases where the practitioner's conduct is so deplorable that it warrants punishment beyond civil damages. All systems struggle with defining the exact threshold, but all employ concepts of grossness, recklessness, or wanton disregard. English and Indian law use the terminology of "gross negligence" explicitly; Canadian law uses "wanton or reckless disregard"; American law uses a spectrum but in practice requires gross deviation. In effect, they are different ways to describe a similar culpability line.

⁴² [1989] 1 S.C.R. 1392

One interesting divergence is procedural: India, through *Jacob Mathew*, has imposed a pre-screening mechanism (expert opinion and no-arrest rule) to protect doctors at the threshold. The UK has no formal requirement of an independent medical opinion before charging, though in practice police often consult experts and the Crown Prosecution Service has internal guidelines that echo the need for strong evidence of gross negligence. Canada similarly does not mandate a prior medical review by law; however, given that charges are typically brought after inquests or professional inquiries, some vetting happens indirectly. The US approach depends on grand juries or preliminary hearings, but again no special rule for doctors – yet American prosecutors typically consult medical experts to testify that the conduct was a gross deviation if they pursue charges.

Another subtle difference is jury versus judge: In the UK, Canada, and most US states, these cases can go before juries, which decide if the negligence is “gross” or if the accused showed reckless disregard. In India, there is no jury system; judges make these determinations. Indian judges, perhaps more sensitized to the policy implications, have set a clearer legal filter at the inception of cases, whereas Western systems often leave it to the trial stage to filter out borderline cases (with the risk and stress of trial for the accused).

What about outcomes? In India, convictions of doctors for 304A IPC are exceedingly rare. In the UK, while rare, convictions have occurred and in US also, convictions are also rare and usually in extreme scenarios like Dr. Murray or Dr. Tseng. Canadian records show very few convictions of licensed doctors in recent times (most cases of criminal negligence causing death involve other contexts like car accidents).

One might conclude that the law around the world is converging on a high threshold plus caution in prosecution. Indeed, legal experts internationally often cite the *Jacob Mathew* guidelines approvingly for how they reinforce the need for medical input and careful scrutiny before labelling a doctor a criminal. Conversely, patient rights advocates might point out that some grossly negligent doctors still slip through with only civil consequences. The systems attempt to address that by having the criminal law as an available tool for the worst offenders is not met with impunity.

Theoretical Frameworks and Policy Considerations

From a jurisprudential perspective, the question of criminalizing negligence engages several theories of justice and policy concerns:

Retributive vs. Utilitarian Views: Retributivism would argue that if a patient dies due to a doctor’s gross negligence, punishment is deserved proportionate to the harm and the blameworthiness. Utilitarian or consequentialist views, however, worry about deterrence and social cost – will prosecuting a doctor for an “honest mistake” improve or worsen overall patient safety? As Ferner and McDowell noted in the JRSME, society faces a trade-off “*whether to exact retribution, or to minimize harm. All those involved need to realize that the two goals are inconsistent.*”. Punishing a doctor might satisfy a retributive urge and perhaps specifically deter that doctor, but it could also drive errors underground and instil fear in other practitioners, thereby undermining candid reporting and systemic learning from mistakes. The modern trend in healthcare safety is towards a “no blame” culture for errors (except in cases of wilful or reckless conduct), focusing on systemic improvement. This aligns with keeping the criminal law narrow only for *culpable* negligence and using civil and disciplinary avenues for the rest. The Indian Supreme Court explicitly echoed these utilitarian concerns, warning that overly expansive criminal liability would lead doctors to become overly defensive and detract from patient care.

Mens Rea and Moral Blame: Philosophically, criminal law typically punishes conscious wrongdoing. Negligence blurs that line since by definition the actor did not consciously choose the harmful outcome. Penal negligence is justifiable as it on the basis that a grossly negligent person *ought* to have been aware of the risk and their failure to perceive it is culpable in itself. The *Common-law systems have traditionally only made negligence the subject of criminal sanction when the level of negligence has been high and standard traditionally described as gross negligence.* This reflects a widely held view that there is a gradation of fault, and only at the high end does negligence start to approximate the culpability of intentional crime. The jurisprudence across countries concurs: the law inserts a qualitative threshold

(“gross”, “wanton”) to essentially bridge the gap to mens rea. In effect, gross negligence serves as a proxy for the kind of moral blame that justifies criminal punishment.

Professional Autonomy vs. Accountability: Doctors historically enjoyed a high degree of autonomy and trust. As medicine became more consumer-focused, accountability mechanisms grew (malpractice suits, medical councils, etc.). Criminal law is the bluntest instrument of accountability. The jurisprudence shows an effort to calibrate it finely – to intervene only when there is a grave transgression of duty. The *Bolam* test and its variants ensure deference to professional judgment: if a doctor’s decision had any reasonable basis in medical practice, it should not be condemned as negligence. This protects professional autonomy. Yet, when a decision or lack thereof is so far outside the bounds (e.g., a surgeon abandoning a patient mid-surgery, as occurred in one infamous case, or a doctor failing to attend at all to a critical patient), then accountability demands a response, potentially criminal. The law tries to assure the medical community that good faith errors won’t be criminalized, but also assures the public that egregious misconduct won’t be ignored. It’s a difficult balance, and courts often rely on expert testimony to navigate it.

Preventive and Deterrent Effect: There is debate whether the spectrum of criminal prosecution actually deters substandard care or merely causes defensive medicine. Defensive practices (like avoiding high risk cases or over-prescribing tests to avoid missing anything) can increase healthcare costs and sometimes harm patients. The Supreme Court of India in *Jacob Mathew* noted that doctors might “*be more worried about their own safety than giving the best treatment to patients*” if they fear criminal action for every adverse outcome. On the other hand, a certain minimal level of deterrence can be positive knowing that gross neglect could lead to jail might discourage reckless shortcuts or practicing outside one’s competence. For example, prosecutions of fake doctors or those indulging in dangerous quack remedies likely have a deterrent effect on others considering such behaviour. It is arguably appropriate that those who are grossly irresponsible face not just license revocation but also criminal sanction, both to punish and to signal societal condemnation.

Victim’s Perspective: Families of patients who die due to medical mistakes often seek a sense of justice. Civil damages, especially if insurance pays them, may not provide that emotional closure. Some turn to criminal complaints out of grief or anger, especially if they suspect callousness or cover-up. The legal standards, however, often disappoint them because most errors, even fatal ones, do not meet the grossness threshold. This can lead to perceptions of injustice or that doctors are “above the law.” Transparency and communication are key in such scenarios. One policy recommendation is to strengthen the medical grievance redressal mechanisms – such as hospital based inquiry committees or fast-track medical tribunals – which can investigate and explain what, happened. If patient’s families see accountability in those forums, they may be less likely to resort immediately to police and courts. Indeed, *Jacob Mathew* had suggested that the Government frame guidelines in consultation with the Medical Council of India. To date, apart from some states adopting standard operating procedures for police in such cases, there hasn’t been comprehensive legislation. A possible reform could be a *statute requiring an expert panel review* before any medico-negligence criminal case proceeds and *effectively codifying the Court’s guidelines* so they have binding force on investigators.

Role of Medical Councils: Professional disciplinary bodies can take action (suspension, cancellation of license) in cases of severe negligence. These sanctions, though non-penal, uphold accountability. A strong medical council response to gross negligence might reduce the perceived need for criminal law intervention. One issue raised in the UK after Bawa-Garba was the relationship between criminal findings and professional discipline: initially the medical tribunal removed her license because she was convicted of manslaughter, but that was overturned considering mitigating factors. In India, state medical councils have sometimes been slow or reluctant to act unless prompted by court judgments. Strengthening these bodies processes ensuring that they thoroughly investigate and appropriately sanction malpractice could bolster public confidence that bad doctors are not practicing with impunity, thereby indirectly reducing demands for criminal prosecution.

Insurance and Civil Remedy: From a policy lens, providing adequate compensation to victims through civil channels is crucial. The *Jacob Mathew* Court itself noted that the hospital might be civilly liable for the oxygen cylinder lapse,

even though the doctor was not criminally liable. In the infamous *Kunal Saha* case⁴³ in India (where a patient died due to grossly inappropriate treatment, though the doctors were not criminally prosecuted, the consumer court awarded an unprecedented amount in damages), the significant civil award perhaps fulfilled some sense of justice. If civil remedies are robust and timely, victims might feel less need to push for criminal charges. Therefore, legal reform could also aim at fast-track medical negligence civil courts or better patient compensation schemes (even no-fault compensation in certain cases, as implemented for vaccine injuries or other specific areas). New Zealand's no-fault compensation system for medical injury is an extreme model that virtually eliminates malpractice litigation (and any thought of criminal proceedings) by compensating injured patients without assigning blame, though that system has its own trade-offs.

Public Communication: Often, criminal cases against doctors stir public emotions where the medical bodies decry them as witch-hunts and patient advocates champion them as setting examples. It's essential for the jurisprudence to be clearly communicated so that the public understands why a certain case did not result in criminal charges. For example, when courts quash a case because no independent expert supported the allegations, this is a safeguard to ensure innocent doctors aren't dragged to court. Explaining that "*every death is not a crime and every doctor's error is not a felony*" is important. Conversely, when a doctor is convicted (like Dr. Murray or Dr. Tseng in the US), it should be communicated that their conduct was extraordinarily bad and not a mere slip, but a reckless breach of duty – to reassure the medical community that only the truly wayward are targeted. Judicial opinions, like those from *Suresh Gupta* and *Jacob Mathew*, often serve this educative function by explicitly discussing the rationale behind protecting doctors from routine criminal prosecution.

Recommendations for Clarity and Reform

Considering the analysis above, several recommendations emerge to improve doctrinal clarity and policy balance in the area of medical negligence and criminal liability:

1. Codify the Gross Negligence Standard: It would be beneficial for the Indian Parliament to amend the law to expressly incorporate the "gross negligence" threshold for criminal liability in healthcare. For instance, an explanation could be added to Section 304A IPC stating that liability for medical professionals arises only in cases of gross negligence, as defined by conduct showing a heedless disregard for patient life. This would cement the *Jacob Mathew* rule into statutory form, leaving no doubt or room for inconsistent application. It could also define "gross negligence" illustratively (e.g., performing duties under the influence of alcohol, treating patients in areas beyond one's qualification, abandoning a patient in critical stage, etc., are likely grossly negligent). A legislative definition can guide lower courts and investigators more clearly.

2. Statutory Pre-screening Mechanism: The *Jacob Mathew* guidelines on obtaining independent medical opinion before prosecution and avoiding routine arrests should be formalized via legislation or at least binding rules. One proposal is to have a medical review board in each state (comprising senior doctors of relevant specialties, perhaps under the aegis of the state medical council) to review any allegations of criminal medical negligence before an FIR can lead to charges. Police could be required to get a certificate from such a board that the case is *prima facie* one of gross negligence. This would institutionalize what the Supreme Court has directed and ensure uniform compliance. As noted in a 2024 study, many trial courts still proceeded without independent opinions until quashed by High Courts a formal mechanism could prevent the initiation of such cases in the first place.

3. Improve Error Reporting and Compensation Systems: To reduce the punitive instinct, the healthcare system should encourage internal reporting of adverse events and ensure patients (or their kin) receive explanations and, where appropriate, apologies and compensation promptly. Instituting protocols like root cause analyses for every hospital death and sharing findings (in a protected way) with the patient's family might alleviate suspicions of foul play. If compensation is due, hospitals/doctors (through insurance) should offer it rather than forcing protracted litigation. Some jurisdictions use **mediation** or "candour" regulations (the UK has a statutory duty of candour for healthcare

⁴³ 2014 (1) SCC 384

organizations to admit serious lapses). Such transparency and recompense can reduce the perception that criminal law is the only avenue to get justice.

4. Strengthen Medical Regulatory Action: Medical councils should be proactive in addressing negligence. Swift suspension or retraining orders in cases of serious negligence (even if not criminal) demonstrate accountability. For example, if a surgeon operates on the wrong limb (a serious error but usually not criminally prosecuted absent gross recklessness), the medical council should intervene with disciplinary measures. Publicizing these actions can reassure the public that the profession is self-policing effectively. In turn, if the public and prosecutors see that “bad doctors” face consequences (losing license etc.), they may feel less need for criminal punishment unless truly warranted.

5. Guidance for Prosecutors: Just as the CPS in the UK has issued guidance on gross negligence manslaughter, Indian authorities (perhaps the Ministry of Home Affairs in coordination with Medical Council of India/NMC) could issue standard guidelines to police and prosecutors on handling medical negligence allegations. These could echo the need for expert consultation, the high threshold required, and instruct that charges should be filed only if evidence shows a high degree of culpability. This would ensure consistency across regions. In the US context, professional associations like the American Medical Association could work with legal authorities to develop best-practice guidelines on when prosecutorial action in medical cases is appropriate.

6. Public and Professional Education: Doctors should be educated about their legal responsibilities and limits. Incorporating medico-legal training in medical curricula and continuing education can help doctors understand the thin lines (for instance, knowing that stepping out of one’s field of competence or ignoring basic safety can land them in trouble). On the flip side, patients and public should be educated that not every bad outcome is due to negligence, and not every negligence is a crime. Media often play up “doctor booked for death of patient” but rarely follow up when cases are quashed or doctors acquitted. A more balanced reporting perhaps aided by input from medico legal experts would help set realistic expectations.

7. Fostering a Safety Culture: Borrowing from the patient safety movement, healthcare institutions should strive to create systems where errors are minimized and caught before causing harm (through checklists, team communication, etc.). When errors do occur, separating “blameworthy” from “blameless” error is crucial. James Reason’s famous framework distinguishes human errors (slips, lapses) from negligence or violations. Hospitals could implement confidential reporting systems for near-misses or errors without fear, using them to improve practices. This reduces actual negligence incidents over time. If fewer truly negligent events occur, naturally the intersection with criminal law remains rare. Moreover, if a culture of accountability exists within the profession (learning from mistakes, sanctioning willful neglect internally), external punitive intervention is less frequently needed.

8. Case Law Compilation and Judicial Training: The judiciary itself benefits from consolidation of principles. A compilation of leading cases (domestic and international) on medical criminal negligence could be prepared under the auspices of judicial academies. Workshops can be held for magistrates and judges to sensitize them: on one hand to doctors’ constraints (e.g., sometimes outcomes are poor despite no fault), and on the other hand to patients’ rights (e.g., not to dismiss genuine gross negligence if it appears). This would promote uniform application of the high threshold and prevent outlier decisions that either over-criminalize or under-enforce. Given that *Jacob Mathew* is from 2005, refresher through newer cases (like highlighting the 2024 data of low conviction rates, or foreign cases) can update perspectives.

In implementing these recommendations, it is crucial to involve all stakeholders – medical professionals, legal experts, patient advocacy groups, and law enforcement. Such co- llaborative framing ensures that reforms are balanced. The end goal is a legal regime where truly culpable medical wrongdoing is addressed firmly, but everyday medical risks and errors are managed through improvement and compensation, not handcuffs. The Supreme Court of India’s message in *Jacob Mathew* was to trust the medical community’s judgment except in the clearest cases of abuse of that trust. Also the Kerala High Court’s guidelines in the case of Md. Rizwan are also remarkable and its proper practice helps to prevent frivolous medical negligence claims and facilitate the trial of genuine cases.

Conclusion

Criminal liability in cases of medical negligence represents one of the most sensitive interfaces between law and medicine. The jurisprudence, both in India and comparatively, reveals a deliberate effort to set a high bar for such liability and a reflection of the understanding that while doctors are not above the law, the law's harshest sanctions should be reserved for conduct that truly shocks the conscience by its deviation from accepted standards. The Supreme Court of India, through landmark rulings like *Jacob Mathew*, has crystallized the principle that gross negligence (akin to recklessness) is the sine qua non for criminal guilt in medical cases. This principle is consistent with English law's gross negligence manslaughter, American jurisprudence on criminal negligence, and Canada's requirement of wanton or reckless disregard all converging on the idea that only a gross failure warrants penal intervention.

Our analysis highlighted that Indian courts have largely achieved a workable balance. They shield well-intentioned practitioners from the trauma of criminal proceedings when outcomes go wrong despite adherence to standard care, yet leave open the door to punish those few whose conduct betrays a profound neglect of their duties (for example, a surgeon performing operations while drunk or an unqualified charlatan administering dangerous treatments). The issuance of practical guidelines in *Jacob Mathew* mandating prior expert review and discouraging hasty arrests has influenced how such cases are handled on the ground, leading to many unwarranted prosecutions being aborted at early stages.

Comparative insights reinforce these findings. In the UK, despite a stricter-sounding system, the actual number of doctors convicted of manslaughter remains very low, and recent moves aim to further ensure that only truly culpable cases proceed. In the US, high-profile prosecutions have been limited to egregious instances of recklessness or abuse (such as Dr. Conrad Murray's case), and there too the legal threshold is high and juries are cautious to convict physicians unless evidence of gross deviation is compelling. Canadian courts, as seen in *Javanmardi*, guard against criminalizing practitioners who follow their training in good faith, even if the outcome is tragic.

From a jurisprudential viewpoint, the underpinning theory is that criminal law's moral condemnation should align with the practitioner's mental state. Only when a practitioner's failure bespeaks something approaching callousness or indifference essentially a culpable state of mind is criminal punishment. Ordinary negligence, errors, and misjudgments, which are often part of the human condition, lie outside the province of criminal law, to be dealt with through tort remedies, professional discipline, or systemic improvements. This demarcation serves the utilitarian goal of not discouraging medical innovation and decision making out of fear, while satisfying the retributive demand that truly heinous lapses are not given a free pass.

The practical implications of maintaining this balance are significant. For healthcare professionals, it provides reassurance that genuine efforts to heal will not lightly land them in the dock and encouraging them to act in the patient's best interest without an omnipresent fear of prosecution for every unfortunate result. For patients and society, it ensures that gross malpractice is the kind that betrays the fundamental trust we place in medical caregivers, therefore can be met with appropriate punitive responses to reinforce the trust in the system. The key, as always, is meticulous implementation: police investigators must be discerning and guided by medical expertise; prosecutors must exercise sound judgment in the public interest; and judges must continue to uphold the high standards of proof and fault that these cases demand.

In conclusion, the law on medical negligence and criminal liability, as it stands and as it is evolving, strives to deliver just outcomes in tragic situations. The Supreme Court's jurisprudence has laid a strong doctrinal foundation that is in line with global best practices, emphasizing *mens rea*, proportionality, and the unique context of medical decision making. The ongoing reforms through the judicial innovation or legislative action should therefore build on this foundation to enhance clarity and consistency. By implementing measures such as those recommended in this article (expert review procedures, statutory clarity, better communication, and robust civil alternatives), India can further reduce the friction between the medical and legal systems. The ultimate aim is a healthcare environment where doctors conscientiously uphold high standards of care, knowing that the law will protect them when they act in good faith and conversely, where patients are secure in the knowledge that egregious wrongdoing will not be excused under the guise of "medical error." Achieving this equilibrium is an ongoing process of jurisprudential refinement, but the trajectory set by the courts thus far is a heartening one that accords with both justice and medical welfare.
