



From Professional Deference to Patient-Centred Accountability: A Critical Analysis of Evolving Judicial Standards of Medical

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Abstract

Indian medical-negligence law has developed primarily through judicial decisions rather than a unified legislative code. Its doctrinal centre has historically been professional deference: courts ask whether a practitioner acted in accordance with a responsible body of medical opinion and caution against judging clinical decisions with hindsight. At the same time, constitutional jurisprudence, consumer protection, informed-consent doctrine and hospital liability increasingly frame the patient as a rights-bearing participant rather than a passive recipient of professional judgment. This article critically examines that transition. Using doctrinal and policy analysis, it studies leading decisions from *Indian Medical Association v. V. P. Shantha* to *Jacob Mathew*, *Samira Kohli*, *Kusum Sharma* and *V. Kishan Rao*, alongside the Consumer Protection Act, 2019, the National Medical Commission Act, 2019, section 106(1) of the *Bharatiya Nyaya Sanhita*, 2023, and the unsettled professional-conduct framework. It argues that Indian law has not abandoned the Bolam principle; instead, it has fragmented it across treatment choice, diagnosis, disclosure, institutional responsibility, criminal culpability and proof. This fragmentation protects legitimate clinical discretion but produces inconsistent thresholds, uneven access to expert evidence, uncertain compensation and weak coordination between courts, consumer commissions and medical regulators. The article proposes a patient-centred reasonableness model that preserves deference for responsible clinical judgment while subjecting professional opinion to logical scrutiny, requiring material-risk disclosure, recognising systems negligence and calibrating remedies to culpability and harm. The shift needed is not from expertise to judicial substitution, but from unreviewable professional custom to transparent, evidence-based and rights-sensitive accountability.

Keywords: medical negligence; standard of care; patient autonomy; informed consent; Bolam test; consumer protection; criminal negligence; hospital liability; National Medical Commission; India

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1. Introduction

Medical negligence lies at the intersection of scientific uncertainty, professional judgment and legal accountability. Courts must protect patients from avoidable harm without converting every adverse outcome into negligence. This balance is especially difficult in India, where uneven infrastructure, high patient loads, variable recordkeeping and unequal access to specialists coexist with rapid technological change and an expanding private healthcare sector. A standard designed only around an idealised doctor–patient encounter may overlook organisational failures; a standard driven only by outcomes may encourage defensive medicine and deny clinicians the latitude required for urgent care.

The traditional judicial response has been professional deference. The Bolam formulation asks whether conduct accorded with a practice accepted as proper by a responsible body of medical professionals. Indian courts adopted its protective logic, most prominently in *Jacob Mathew v. State of Punjab* (2005), while insisting that criminal prosecution requires gross negligence. Yet other decisions have strengthened patient autonomy, consumer remedies and institutional responsibility. *Samira Kohli v. Dr. Prabha Manchanda* (2008) made real consent central; *V. Kishan Rao v. Nikhil Super Speciality Hospital* (2010) rejected a mechanical insistence on expert evidence in every consumer case; and compensation jurisprudence increasingly acknowledges future care, dignity and loss of opportunity.

The resulting law is neither purely profession-centred nor fully patient-centred. It is a layered regime in which different forums apply different thresholds and remedial logics. This article argues that the central policy problem is not the existence of deference, but its object and limits. Courts should defer to reasonable clinical judgment within a range of medically defensible options; they should not defer automatically to professional custom on disclosure, recordkeeping, institutional safety or logically indefensible practice.

2. Research Problem, Questions and Original Contribution

Indian scholarship often describes medical negligence through a catalogue of cases or separates civil, criminal and consumer liability. That approach obscures a deeper doctrinal problem: the standard of care changes according to the nature of the alleged failure. A treatment-choice case raises scientific and professional questions; a consent case concerns autonomy and materiality; a hospital-infection or staffing case concerns organisational governance; and a criminal prosecution



concerns culpability beyond ordinary carelessness. Applying one undifferentiated Bolam formula to all four categories is conceptually unsound.

This article asks: (1) how have Indian courts moved from professional custom toward patient-centred accountability; (2) where does the Bolam principle remain legitimate and where should it be limited; (3) how do civil, consumer, criminal and disciplinary pathways interact; and (4) what reforms can produce consistency without promoting defensive medicine? Its original contribution is a domain-sensitive model that separates clinical judgment, informational autonomy, institutional safety and aggravated culpability, assigning each a distinct standard of review.

3. Methodology and Scope

The study uses qualitative doctrinal research. Primary sources include statutes, regulations and Supreme Court decisions governing duty, breach, causation, consent, expert evidence, hospital liability, compensation and criminal negligence. Comparative materials—the Bolam and Bolitho decisions and the United Kingdom Supreme Court’s patient-autonomy reasoning in *Montgomery*—are used as persuasive analytical benchmarks, not as substitutes for Indian law. Secondary sources include peer-reviewed medico-legal scholarship and World Health Organization patient-safety materials.

The article focuses on allopathic medical practice and hospital services. It does not attempt an empirical measurement of negligence claims or evaluate individual clinical protocols. Because the National Medical Commission’s Registered Medical Practitioner (Professional Conduct) Regulations, 2023 were placed in abeyance in August 2023, they are not treated as the operative ethical code. This regulatory uncertainty is itself analysed as a policy gap (National Medical Commission, 2023).

4. Conceptual Foundations of Medical Negligence

4.1 Duty, breach, causation and damage

Negligence ordinarily requires a duty of care, breach of the applicable standard, a causal connection and legally recognisable damage. In medicine, proof is complicated because disease itself creates risk and more than one reasonable treatment may exist. A poor result, diagnostic error or known complication does not by itself establish breach. The inquiry must reconstruct the information reasonably available at the time and avoid hindsight bias. Causation must then



distinguish harm attributable to the breach from harm likely to have occurred because of the underlying condition.

4.2 The Bolam principle and its legitimate domain

Bolam v. Friern Hospital Management Committee (1957) linked due care to a practice accepted by a responsible body of medical opinion. Its strength is epistemic humility: judges lack clinical expertise and should not choose between respectable schools of treatment. Its weakness is circularity if professional acceptance becomes conclusive. Bolitho v. City and Hackney Health Authority (1997) responded by allowing courts to reject an expert opinion that cannot withstand logical analysis. The combined principle supports bounded deference—professional evidence is necessary and weighty, but not immune from scrutiny.

4.3 Patient-centred accountability

Patient-centred accountability does not guarantee cure or allow courts to practise medicine retrospectively. It requires that clinical power be exercised transparently, that material information be communicated, that systems protect against preventable harm, and that injured patients can obtain reasons and remedies. It therefore shifts the focus from whether some doctors would have acted similarly to whether the decision was responsible, evidence-based, properly communicated and supported by safe institutional processes.

5. Judicial Evolution in India

5.1 Medical services as consumer services

Indian Medical Association v. V. P. Shantha (1995) brought medical services rendered for consideration within consumer law, subject to recognised exceptions for wholly free services and contracts of personal service. The decision transformed access to redress by providing a specialised and comparatively summary forum. It also framed negligence as deficiency in service, making hospitals and practitioners answerable to patients as consumers without reducing the relationship to an ordinary commercial transaction.

5.2 Civil standard and professional choice

Indian decisions repeatedly caution that a doctor is not negligent merely because another professional would have adopted a different course. In Kusum Sharma v. Batra Hospital & Medical Research Centre (2010), the Supreme Court consolidated protective principles: medicine is not an



exact science; courts must avoid hindsight; and liability follows where conduct falls below that of a reasonably competent practitioner. Properly read, these propositions protect reasonable choice rather than professional status. They do not excuse failure to obtain history, perform indicated tests, monitor deterioration or maintain records.

5.3 Criminal negligence after Jacob Mathew and the BNS

Jacob Mathew v. State of Punjab (2005) distinguished civil negligence from criminal negligence and required a much higher degree—gross or reckless conduct—before criminal liability could arise. It also sought to prevent indiscriminate prosecution by requiring credible medical opinion at the investigative stage. The rationale is sound: fear of arrest for an error of judgment can distort emergency care and promote defensive medicine. However, procedural protection must not become substantive immunity for recklessness, falsification or abandonment.

Section 106(1) of the Bharatiya Nyaya Sanhita, 2023 now provides that causing death by a rash or negligent act by a registered medical practitioner while performing a medical procedure may attract imprisonment up to two years and fine, compared with the general maximum of five years under that subsection. The explanation ties registration to qualifications and registers under the National Medical Commission Act, 2019. This differentiation recognises the special context of medical work, but the statutory text does not itself define the degree of negligence. Jacob Mathew's gross-negligence threshold therefore remains doctrinally important when interpreting criminal culpability consistently with principle.

5.4 Informed consent and autonomy

Samira Kohli v. Dr. Prabha Manchanda (2008) treated consent as real and specific rather than a blank authorisation. The Court required adequate information about the nature and purpose of treatment, alternatives, substantial risks and consequences of refusal, while preserving emergency exceptions. The decision marked a shift away from exclusive professional control, although its disclosure formulation remained more conservative than the material-risk standard later articulated in *Montgomery v. Lanarkshire Health Board* (2015). A patient-centred approach asks what risks a reasonable person in the patient's position would consider significant and what the particular doctor knows this patient would consider significant.

5.5 Expert evidence and access to justice

Martin F. D'Souza v. Mohd. Ishfaq (2009) advocated preliminary expert scrutiny, reflecting concern about frivolous claims. *V. Kishan Rao v. Nikhil Super Speciality Hospital* (2010),



however, clarified that expert evidence is not mandatory in every case and that consumer fora must decide based on complexity and facts. The latter approach is preferable. A universal expert requirement would be especially unfair where the alleged failure—wrong-site treatment, missing records, failure to respond to an obvious emergency or administration of a contraindicated drug—is understandable without specialised opinion. Complex causation and competing protocols, by contrast, ordinarily require independent expertise.

5.6 Institutional and vicarious liability

Spring Meadows Hospital v. Harjol Ahluwalia (1998) recognised hospital responsibility for negligent acts within organised care. Modern harm often results from systems rather than a single clinician: inadequate staffing, poor handover, equipment failure, infection control, delayed escalation, unsafe medication systems or fragmented records. A doctrine focused only on the individual doctor misses these organisational causes. Hospitals should bear a non-delegable responsibility for basic safety systems and vicarious liability for staff integrated into service delivery, subject to the facts of control and representation.

5.7 Compensation and corrective justice

Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka (2009) illustrates a more realistic approach to catastrophic injury, including future care and the long-term consequences of disability. Yet compensation across consumer fora remains inconsistent. Awards may understate unpaid caregiving, rehabilitation, assistive technology, inflation and loss of autonomy. Patient-centred accountability requires reasoned heads of damage and evidence-based calculation, while avoiding arbitrary punitive awards unrelated to statutory authority or culpability.

6. The Present Multi-Track Legal Framework

6.1 Consumer liability

The Consumer Protection Act, 2019 continues the deficiency-in-service framework established under the 1986 Act. Consumer commissions can provide compensation and other relief, but delay, pecuniary-jurisdiction disputes, uneven expert access and complex evidence can undermine the promise of summary redress. Digital filing improves access only if medical records, notices and expert processes are equally functional.



6.2 Tort and contractual liability

Civil courts retain jurisdiction over negligence and contractual claims. Tort principles permit a fuller evidentiary process and can address defendants outside consumer coverage, but ordinary litigation is costly and slow. India lacks a comprehensive statute codifying medical duty, limitation nuances, disclosure, apportionment and damages. The result is dependence on precedent and forum-specific practice.

6.3 Criminal liability

Criminal law is justified only for conduct displaying aggravated negligence. Section 106(1) BNS supplies the offence and differentiated maximum punishment, while judicial doctrine supplies caution against equating ordinary error with crime. Investigative safeguards should use independent, conflict-free experts and should be time-bound. They should not require approval from professional peers in a manner that makes investigation practically impossible.

6.4 Professional discipline

The National Medical Commission Act, 2019 distributes regulatory responsibilities among the NMC, autonomous boards, ethics structures and State Medical Councils. Disciplinary remedies protect professional standards but do not replace compensation or criminal adjudication. The abeyance of the 2023 conduct regulations leaves uncertainty about a modern, nationally coherent code addressing telemedicine, social media, records, conflicts and patient communication. Fragmented state-level processing also produces variability in timelines and reasons.

6.5 Constitutional and human-rights dimensions

Article 21 jurisprudence places preservation of life and emergency care within the constitutional order. *Parmanand Katara v. Union of India* (1989) rejected procedural delay in immediate treatment, while *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) connected failure of public emergency facilities with state responsibility. These cases demonstrate that patient safety is not solely a private dispute about individual fault; it also concerns public systems, equitable access and positive obligations.

7. Policy Gaps and Critical Findings

7.1 Doctrinal fragmentation

Courts invoke Bolam across disputes that require different reasoning. Clinical-choice cases warrant professional deference; disclosure cases require a patient-materiality inquiry; basic safety



failures can be judged against protocols and common reasoning; criminal cases require aggravated culpability. Failure to separate these domains produces both overprotection and overliability.

7.2 Unequal expert evidence

Experts are often drawn from the same professional networks as defendants, while patients may lack resources to obtain records or independent opinions. Courts need neutral panels, conflict disclosures, reasoned reports and the power to appoint experts without shifting prohibitive costs to claimants. Expert evidence should explain the range of acceptable practice and causal reasoning, not decide the ultimate legal question.

7.3 Medical records and informational asymmetry

The provider controls most evidence. Missing, illegible or retrospectively altered records weaken accountability and patient safety. The law should draw proportionate adverse inferences where records required by law or professional standards are unjustifiably unavailable, while allowing explanation for genuine emergency conditions. Interoperable records, audit trails and patient access are regulatory infrastructure, not mere administrative conveniences.

7.4 Systems negligence

Individualised litigation under-detects organisational causes. A hospital may blame a junior employee even where staffing, supervision or protocol design made error foreseeable. Accreditation and internal reporting are valuable but cannot substitute for enforceable minimum safety duties. Liability rules should incentivise root-cause analysis rather than concealment.

7.5 Delay and remedial inconsistency

A remedy delivered after prolonged litigation may not fund immediate rehabilitation or future care. Interim compensation, structured settlements and early neutral evaluation deserve consideration in catastrophic-injury cases. Consistency also requires guidance on non-pecuniary loss, attendant care, inflation and future medical costs.

7.6 The defensive-medicine objection

Defensive medicine is a genuine risk but is often asserted without evidence specific to the challenged rule. Clear safe harbours for documented adherence to validated guidelines can reduce uncertainty. At the same time, guidelines must not become rigid ceilings: justified departure may



be necessary for individual patients, and outdated or resource-insensitive protocols require judicial scrutiny.

8. A Patient-Centred Reasonableness Model

The following model would preserve clinical expertise while strengthening accountability:

- Clinical judgment: ask whether the decision fell within a responsible range supported by evidence available at the time; test the expert rationale for internal logic, risk–benefit coherence and relevance to the patient.
- Information and consent: assess disclosure through materiality to a reasonable patient in that position, supplemented by what the clinician knew or should have known about the particular patient’s priorities.
- Institutional safety: impose direct organisational duties concerning staffing, escalation, infection control, equipment, medication safety, record integrity and continuity of care.
- Proof: require expert evidence only where specialised scientific or causal issues genuinely demand it; establish independent panels with conflict safeguards and reasoned reports.
- Criminal culpability: reserve prosecution for gross negligence, recklessness, deliberate disregard of a serious risk, falsification or comparable aggravated conduct; retain time-bound pre-charge medical scrutiny.
- Remedies: adopt transparent compensation guidelines covering future care, disability, income, unpaid caregiving and non-pecuniary harm, with structured payments where appropriate.
- Learning system: protect good-faith internal incident reporting from inappropriate use while preserving discoverability of underlying clinical facts and preventing privilege from shielding concealment.
- Regulatory coordination: create referral and information-sharing protocols among consumer commissions, civil and criminal courts, State Medical Councils and the NMC, while preventing duplicative fact-finding and inconsistent outcomes.

9. Recommendations

Parliament and the responsible regulators should consider a Medical Injury and Patient Safety framework that codifies core duties without converting clinical guidelines into inflexible statutory commands. It should define the relationship among civil, consumer, disciplinary and criminal proceedings; secure prompt access to records; recognise institutional negligence; and establish principles for independent expertise and damages. A no-fault scheme could be piloted for narrowly



defined avoidable injuries—such as certain birth injuries or vaccine-related harm—without abolishing fault-based claims for serious misconduct.

The NMC should finalise a contemporary professional-conduct code through transparent consultation and clearly state the status of earlier ethical rules during transition. The code should include enforceable duties on material-risk communication, documentation, electronic records, conflicts of interest, referrals, telemedicine and disclosure of adverse events. State Medical Councils should publish anonymised, reasoned decisions and performance data.

Courts and consumer commissions should expressly identify which domain a case concerns—clinical choice, consent, basic safety, institutional systems or aggravated culpability—before selecting the standard and evidentiary burden. This simple discipline would reduce indiscriminate Bolam reasoning and make outcomes more predictable.

10. Discussion

The evolution of Indian medical-negligence law is best understood as a movement from status-based deference toward reason-giving. The patient-centred model does not deny expertise; it asks experts and institutions to explain why a course was reasonable, how risks were communicated and what systems existed to prevent predictable harm. Professional opinion remains central in technically complex cases, but its authority arises from evidence and logic rather than professional identity alone.

This model also clarifies the relationship between accountability and patient safety. Punishment after harm is insufficient. Record systems, disclosure, incident learning, staffing and coordinated regulation prevent injury before litigation begins. Conversely, a safety culture cannot depend on immunity. Trust requires visible consequences for recklessness, concealment and repeated system failure, alongside protection for reasonable clinical judgment made under uncertainty.

11. Conclusion

Indian law has travelled a considerable distance from near-exclusive professional deference. Consumer jurisdiction, informed-consent doctrine, hospital liability and constitutional duties have strengthened the patient's legal position. Nevertheless, the transition remains incomplete. Bolam continues to be invoked without sufficient attention to the type of duty in issue; expert evidence is inconsistently required; records and institutional causes remain underexamined; compensation lacks uniform methodology; and the professional-conduct framework is unsettled.



A patient-centred accountability framework should not invite judicial micromanagement of medicine. It should preserve a zone of reasonable clinical discretion while requiring logical expert justification, material-risk disclosure, reliable records, safe institutional systems and proportionate remedies. Criminal liability must remain exceptional and tied to aggravated culpability, including under section 106(1) of the Bharatiya Nyaya Sanhita. The mature legal position is therefore neither blind deference nor outcome-based liability. It is accountable expertise: medicine respected for its knowledge, and answerable for how that knowledge is exercised.

Declarations

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Relevance of these cases

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- *Achutrao Khodwa*—hospital and state liability for surgical negligence.
- *Poonam Verma*—treatment outside a practitioner's recognised system of medicine.
- *State of Haryana v. Santra*—negligence in sterilisation procedures.
- *Savita Garg*—burden of proof and hospital responsibility.
- *Suresh Gupta*—threshold for criminal medical negligence.
- *Malay Kumar Ganguly*—distinction between civil and criminal negligence.
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