International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Medical Negligence in India: A Policy Based Analysis to Meet Quality and Efficiency

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Abstract

Medical negligence has emerged as a major policy concern in India, some consider it as a legal issue but if we go deep, we will find that it is central health policy challenge in the Indian context. A recent report estimates that India's annual incidence rate of medical malpractices across various healthcares is around 5.2 million cases, with a sharp rise in both complaints and litigation over the last decade (Singh, 2024). This reflects a deeper structural weakness, gaps in regulatory framework implementation, weak accountability mechanism for patients' safety and limited access to timely redressal of complaints. This paper will examine ethical issues in Indian healthcare, mainly focusing on medical negligence in India through a public policy perspective. It first outlines the legal and regulatory framework governing negligence, including consumer law, criminal provisions under the Indian Penal Code, professional regulation via medical councils, and health sector policies such as the National Health Policy, 2017 (Rao, 2009). Then analysis trends will be followed in litigation and reported cases, drawing on recent reviews of National Consumer Dispute Redressal Commission (NCDRC) judgements and new empirical data from other medical journals (Sukumar, 2023). This will give us a clear highlight and recognizes key challenges existing in the current healthcare domain regarding fragmented redressal forums, procedural delays, inconclusive expert evidence, under-performing professional councils, and significant growth of defensive medicine (Shrivastava et al., 2023). In the last this paper proposes policies reforms, including specialized medical tribunals, stronger professional regulation, mandatory malpractices insurance, patient-safety oriented regulation, improved data systems and expanded public awareness program. These reforms aim to balance patient rights and provider protection, and to fix strong accountability mechanism for quality and universal healthcare coverage in India.

1. Introduction

In a country like India where doctors are perceived as incarnation of God had changed in last few years. Over the past three decades, India's healthcare system has undergone rapid transformation. The growth of the private sector with an increase in corporate hospitals, and the commercialization of healthcare providers have significantly changed the paradigms of the doctor-patient relationship. Due to this patient increasingly see themselves as consumer who pay for services and expect results, while on the other hand providers face pressure to be efficient, profitable, and competitive to sustain themselves in the healthcare industries. Given these circumstances, dispute over quality of care and allegations of medical negligence have become more visible, often amplified by media coverage and social media (Hadli, 2015).

Analyses drawing on National Library of medicine suggest an annual incidence of roughly 5.2 million cases related to medical malpractices across Indian healthcare settings, with litigation reportedly increasing by 400% over time and overall incidences rising by more than 100% (Rai, 2019). These figures may be inaccurate or not showing true picture due to under reporting but still indicative of gross medical negligence and malpractice in Indian healthcare service delivery system. Consumer courts are the main venues for resolving medical disputes. Several National Consumer Dispute Redressal Commission (NCDRC) decisions show a steady stream of cases involving specialitiessuch as obstetrics and gynaecology, surgery, orthopaedics, neurology and neurosurgery, with significant compensation awards in some instances (Sukumar, 2023).

Medical Negligence is typically understood as a breach of the duty of care owed by a healthcare provider to a patient, where the provider fails to exercise reasonable skill and care expected of an ordinary competent professional, and this failure causes harm (Rao, 2009). The logic of Bolam test (Annex. B) has been followed by the Indian courts to decide whether the medical practitioner acted in accordance with a practice accepted as proper by a responsible body of medical opinion, while adapting it to local circumstances (Medical Negligence - the Association of Surgeons of India, n.d.). The Supreme Court's jurisprudence, especially in Indian Medical Association v. V.P. Shantha (1995) and Jacob Mathew v. State of Punjab (2005), has played a fundamental role on in defining the acts done by medical practitioner amount to negligence and what thresholds apply for civil and criminal liabilities (Medical Negligence - the Association of Surgeons of India, n.d.). Later on, Bolitho Test (Annex. C) was taken into consideration due to the fact that Bolam test limits judges logical assessment, and left no options than to rely on expert opinion. Many times there are differences in the expert opinion provided by medical experts which is conflicting and limits the judgment delivery system. From health policy perspective - medical negligence firstly, affects patient safety and quality of care. Often put families into poverty through losing income and catastrophic health expenditure. Secondly, it erodes trust in healthcare system, undermining healthcare programmes and initiatives. Thirdly, increase in defensive medicine by healthcare providers to avoid litigations and compensations claims. This will lead to overuse of diagnostic tests, unnecessary procedures, subsequent referrals which will increase the costs and distort care (Rao, 2009).

Problem statement - Multiple legal and regulatory mechanisms exist to resolve medical negligence related cases in India with an elaborate mix of consumer, civil, criminal and professional regulatory bodies. Despite of all there is a widespread dissatisfaction with how medical negligence is addressed. Patients face complex pathways, high evidentiary burdens, and long delays in dispute resolution. While doctors argue that consumer law is being misused and the media trial often damages the reputations even when negligence is not proven at later stage. Thus, India's current healthcare framework shows a fragmented, slow, and weakly linked to patient's safety, resulting dissatisfaction among both patients and healthcare providers. The objective of this paper is to firstly, map the contemporary legal and policy framework governing medical negligence in India. Secondly, analyzing empirical evidence and trends concerning to negligence claims and litigation. Thirdly, identifying key gaps and challenges in the functioning of existing redressal mechanisms and lastly, proposing policy reforms that could strengthen accountability while supporting a safe and sustainable healthcare system. The analysis is based on secondary sources like laws, landmark judgements, policy instruments and empirical study of Cases related to medical negligence for health system strengthening.

2. Problem Analysis

a) Legal and Policy Framework

India's regulations on medical negligence are built on multiple overlapping and complex legal regimes. There are consumer courts for the protection of the consumer of any good and services which includes healthcare, there are civil law through which a patient can file suit for compensation, criminal law for the prosecutions of healthcare providers, professional regulatory bodies and sectoral health regulation. This multi-layered and complex structure offer numerous options for dispute redressal mechanism but often created confusion and inconsistency among affected patient as where to go and whom to approach.

Consumer Protection law has become most visible forum for medical negligence claims. The Consumer Protection Act (CPA), 1986 and its successor, the CPA, 2019 recognizes patients as "consumer" of medical services and allow them to seek compensation for deficiency in services before District, State, and National Consumer Commission (Rao, 2009). Also, in Indian Medical Association v. V.P. Shantha (1995), the Supreme Court of India confirmed that most medical services fall within the CPA, except those provided free of charge in purely charitable settings (Medical Negligence - the Association of Surgeons of India, n.d.). This judgement opened the door for large numbers of patients to pursue negligence claims via Consumer Forum Courts which is relatively accessible and inexpensive mechanism compared to ordinary civil courts. Alongside consumer law, civil liability through tort claims in civil courts remain possible particularly for high value cases but the complexity, high cost, and duration of civil suits make it less likely to be opted by ordinary patients (Shrivastava et al., 2023).

Criminal Law comes into play when negligence is alleged to be gross that it amounts to crime. Previous to the the Bharatiya Nyaya Sanhita (BNS), Sections 304A, 337 and 338 of the Indian Penal Code (IPC) addresses causing death or injury by a rash or negligent act (Goyal & Goyal, 2024). In Jacob Mathew v. State of Punjab (2005), the Supreme Court cautioned against routine criminal prosecution of doctors for negligence, holding that criminal liability requires a higher degree of culpability than civil negligence and that expert medical opinion should normally be obtained before proceeding **(**Jacob Mathew vs State Of Punjab & Anr, 2005).

Professional self-regulation is regulated by the National Medical Commission (NMC) and State Medical Councils (SMCs). These bodies are responsible for licensing doctors, enforcing the Code of Medical Ethics, and imposing disciplinary measures such as warnings, suspension, or removal from the register (Shrivastava et al., 2023). However, some reports have criticized medical councils for not taking issues related to medical negligence into their cognizance and their actions taken are not transparent. There is a limitation while deciding a case, as they only can impose professional sanctions and cannot award monetary compensation to harmed patients.

Additionally, sectoral health laws such as the Clinical Establishments (Registration and Regulation) Act, 2010 is adopted by some Indian states. A minimum standard for hospitals and clinics is set up by this in those regions. While public health insurance schemes like Ayushman Bharat Pradhan Mantri Jan Arogya Yojana have their own empanelment and grievance mechanisms. Apart from this, the National Health Policy 2017 explicitly acknowledges concerns about overcharging and negligence and proposed the creation of its own separate Tribunal for deciding disputes related to medical treatment, billing and malpractice (Sarda, 2017). So, in short there is a confusion and dilemma among patients because of a comprehensive framework and different institutions with varying mandates, procedures. This divided scope of regulation produce a different but equally important problem without a single agency leading

regulation, no-one has a comprehensive view of performance and problems can result, especially if regulatory agencies do not communicate and share their findings.

b) Burden and Trends in Medical Negligence

Reliable national data on medical negligence in India are scarce and doubtful but according to an analysis indicates that an annual incidence of up to 5.2 million medical practice related events too place in the country (Rao, 2009). This includes not only litigated cases but broad range of medical errors and adverse events but somehow suggests that unsafe medical is a major public healthcare issue. A recent paper on legal regimes for negligence compiled data shows that only 46% of healthcare providers in certain studies reported adherence to formal ethical guidelines and highlighted surgical errors and emergency-room mismanagement as leading cause of reported medical error deaths (Goyal & Goyal, 2024). Also, a five-year retrospective review of 253 NCDRC cases (2015-2019) found that a substantial portion of claims involved high-risk specialties, and that outcomes varied widely depending on the quality of documentation, expert opinions, and the nature of alleged error (Sukumar, 2023). But it's very hard for the victim (patients) to proof his case before the court because of the existing complexity. Majority of adverse events never reach any formal forum or court. patients and families may lack awareness of their rights, struggle to obtain medical records, or many times deterred by the enormous legal expenses and perceived notions of delays in getting justice by the existing overburden Indian judiciary (eitherview, 2024).

c) Gaps and Challenges

Fragmentation of accountability forums and tribunals is a central problem. In theory, a patient can choose between consumer courts, civil courts, criminal prosecution or complaints to medical councils but in practiceit may leads to parallel proceedings, forum-shopping and inconsistent outcomes (Shrivastava et al., 2023). For e.g. a doctor might be acquitted by medical council yet found negligent by consumer commission or vice-versa. This may be happening because of limited coordination or information sharing among institutions, and no single body responsible for synthesizing lessons for patient safety. Well-functioning health information systems (HIS) are essential for informed decision making and have four key functions: data generation, compilation, analysis and synthesis, and dissemination and use (Mokdad, 2022). Another challenge is procedural delays and massive pendency of cases which often take years or sometime more than a decade to conclude (Goel et al., 2024). For patient and victim families seeking compensation, such delays are devastating. For providers, the prolonged uncertainity, reputational damage, and legal expenses is a big problem. The slow pace of professional disciplinary proceedings in many State Medical Councils compounds the problem (Shrivastava et al., 2023). The quality and use of evidence based on expert opinion is another weak spot. Due to technical and uniqueness of questions raised by the forums and courts, it's very tough to find qualified experts who are willing to testify the evidence with limited access to documents provided to them. In the absence of robust expert opinion, cases are dismissed (Goel et al., 2024). Additionally, professional regulation by SMCs and the NMC has also been criticized. Lack of transparency, minimal patient participation, and possible conflicts of interest are of great of great concern, especially when doctors themselves adjudicate complaints against their peers (Shrivastava et al., 2023). Surveys suggest that a climate of fear and "defensive medicine," with doctors ordering more diagnostic tests than medically necessary and referring high-risk patients to avoid liability (Rai & Devaiah, 2019). This contributes to rising costs and exposes patients to unnecessary interventions. At the same time, violence against healthcare workers following adverse events has been reported in various states, which further polarizing

patient-provider relations (Goel et al., 2024). We need robust regulation. By "regulation" we mean the use of the coercive power of the state to change the behavior of individuals and organizations in the health sector ((Roberts et al., 2008). This will help to achieve two intermediate objectives in the healthcare system reform in India. First one is the quality of healthcare and secondly, is efficient institution for better healthcare delivery.

3. Reforms recommended

Addressing medical negligence in India requires a coherent policy packages that balances compensation, deterrence, and learning. These four proposed reforms below would be beneficial to achieve the targeted policy reforms.

a) Institutional design towards specialized and coherent forums (Organizational structure)

The National Health Policy 2017, proposed the creation of specialized health or medical tribunals. These bodies would combine legal and medical expertise, adjudicating disputes about negligence, overcharging, and denial of services more efficiently than general courts. Such tribunals could standardize the use of independent expert panel, shorten the case timeline and provide a single window for disputes that currently scattered across forums. However, tribunals may not be a magic bulletunless until a strong governance mechanism be attached with it. The success would depend on its independence, transparency, adequate resources and appeal mechanisms. It would be prudent to implement it on pilot basis in few states before nationwide rollout. In parallel, well designed grievance redressal cells within the hospital premises must be strengthened. This could resolve many disputes at an early stage, preventing escalation to litigation.

b) Legal and Regulatory reforms

Clarity and consistency in the legal framework are essential for fairness and delivery of timely justice. Otherwise, justice delayed is justice denied would prevail. For this firstly, need to clarify standards for negligence and expert evidence. Parliament or the Supreme Court (through guidelines) could clarify when expert opinion is mandatory in negligence cases, how experts should be chosen, and how their independence be determined. This would reduce arbitrary reliance on expert testimony and provide clearer expectations for litigants. Secondly, defining a clear interface between criminal, civil and consumer law. Thirdly, strengthening regulations of medical councils and healthcare facilities. There is need to reform in State Medical Councils. They should address transparency, timeliness, conflict of interest, and representation of public voices by setting statutory time limits for disposing complaints and creating independent mechanisms. Facility regulation through the Clinical Establishment Act and state laws should be expanded and enforced to achieve patient safety, staffing norms, emergency case standards.

c) Building a patient-safety and learning system

The most transformative set lies in shifting from a blame culture to a learning culture by setting up patient-safety and learning system. International experience from UK's National Health Service, shows that endless increases in negligence liabilities are unsustainable and that preventing harm is more effective than paying after the fact. India could take concrete steps towards a national patient-safety strategy. Firstly, by establishing a national incident reporting system for adverse events and near misses, with legal protection for good faith reporting and a focus on systems failures rather than playing individual blame game. Secondly, developing and disseminating standard treatment guidelines (STGs), it would provide reference point for both clinicians and courts when assessing whether care was

reasonable. Thirdly, by institutionalizing the clinical audit as a part of hospital accreditation and regulatory regimes with a regular review of adverse events like mortality and high-risk procedures. These interventions are not substitute for legal accountability but complementary strategies that would reduce the frequency of negligence incidents in the first place.

d) Setting up data, research and awareness (HIC's)

Finally, setting-up **Health Information Centres** (HIC's). A robust policy response can be possible only through creation of national database that collates anonymized information on negligence complaints, forum chosen, timelines, outcomes etc. This would allow more systematic analysis by region, specialty, and facility type, and help evaluate the impact of reforms from time to time. Additionally, patients often lack clarity on their rights, realistic expectation of treatment, and the appropriate forums for grievances. Through public campaigns and guides could reduce misinformation and conflict.

5. Conclusion

Medical negligence in India is not only merely a legal dispute which is supposed to be resolved in courtrooms and forums, but it is a systematic healthcare policy challenge. It touches on quality, equity, trust, efficiency and financial sustainability. Evidence suggests that high number of adverse events and malpractice related incidents, with millions of people are associated with litigation. At the same time, there is a widespread dissatisfaction among both patients, who struggle to obtain timely and effective redressal, and healthcare providers, who feel overexposed to liability and public criticism. The existing framework and structure based on a patchwork of consumer court, civil court, criminal court and professional regulatory mechanisms which provides multiple institutions to approach. At the same time suffers from fragmentation, delays, inconsistent standard of expert evidence, and underperforming medical councils. These all together weaken public trust, limit deterrence, and do little to promote systematic learning. The above four policy recommendations argued for a more coherent policy response and none of them are easy to implement. They require coordination across ministries, courts, councils, and professional bodies, as well as sustained political will. As India have the goals to achieve Universal Health Coverage and the Sustainable Development goals, it must ensure that expanding access does not be achieved at the expense of quality and efficiency of providing safe healthcare services. A balance patient centric and learning oriented approach to medical negligence can be achievable through above recommended policy reforms. This will not only protect patient's rights but also support healthcare providers to deliver safe, evidence-based care in order to build a resilient and trustworthy healthcare institution in India.

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Annexures-

Annex:-A

Instrument	Forum	Type of Liability	Who Can File	Remedies Available	Key Challenges
Consumer Protection Act (CPA) 1986 & 2019	Consumer Courts	Civil (Compensation)	Patients (consumers)	Compensation, Apology, Service Redressal	Delays, inconsistent standards of evidence, forum-shopping
Indian Penal Code – Sections 304A, 337, 338	Criminal Courts	Criminal (Rash/Negligent Act)	State, Public Prosecutors	Punishment (Imprisonment/Fine)	High threshold for liability, reliance on expert opinions
National Medical Commission (NMC)	Medical Councils	Professional (Ethical Violations)	State Medical Councils, NMC	Disciplinary action (Suspension, Expulsion)	Limited powers, inefficiency, bias, conflict of interest
Clinical Establishments Act, 2010	State-level authorities	Regulatory (Standards of Care)	Healthcare providers	Facility Registration, Minimum Standards	Limited implementation across states, weak enforcement
National Health Policy 2017	Government (Policy Level)	Policy Regulation	Government, Providers	Empowered Medical Tribunals, Health-Safety Framework	Slow adoption of proposals, underfunded health systems

Annex:-B

Bolam v. Friern Hospital Management Committee (1957) 1 WLR 582

Facts: A patient who suffered a fractured hip during electro-convulsive therapy (ECT). Patient sued for negligence, arguing they should have been warned of the risks and given a muscle relaxant.

Issue concerned: Whether the hospital was negligent for injuries sustained by a patient, Mr. Bolam, during electro-convulsive therapy (ECT)?

Principle Established: It was ruled by the UK court that the hospital was not negligent and not liable because the doctors had followed a procedure that was accepted as proper by a responsible body of medical opinion at the time.

Annex:-C

Bolitho v City and Hackney Health Authority [1998] AC 232

Facts: A two year child was admitted to hospital with croup and later died after his condition worsened. The hospital admitted a breach of duty for failing to attend him but the doctor that even if she had admitted, she would not have intubated him because the procedure might be risky for the child. The child's parents argued that intubation would have saved his life.

Issue concerned: Whether a doctor's actions, supported by a body of medical opinion, could be considered non-negligent even if it appeared illogical to the court? Also, the standard of care for medical negligence was raised as an issue?

Principle Established: It was ruled by the court that court is not bound to accept a medical practice as reasonable just because a body of medical opinion supports it. The court must be satisfied that expert opinion must be logical and also said that court must apply a logical analysis to the medical opinions presented, ensuring the opinion is sound and not just supported by a group of experts. This judgment of the court given the power to courts to reject an expert opinion if they find it to be illogical, even if it is supported by a body of medical professionals

Annex:-D

Indian Medical Association v. V.P. Shantha (1995) 6 SCC 650

Facts: After the Consumer Protection Act, 1986 was passed, many medical negligence cases were filed in High Courts and consumer forums, but there was significant legal ambiguity and conflicting interpretations among courts. This lack of a uniform approach led the Indian Medical Association to file a writ petition to seek a definitive ruling from the Supreme Court on the applicability of the Act to the medical profession.

Issue concerned: Whether medical services fall under the Consumer Protection Act, 1986?

Principle Established: The Court said that medical services are consumer services, under the Consumer Protection Act, 1986 and the Supreme Court gave patients the rights to sue the healthcare providers for negligence in consumer courts. Thus, it was held that patients are consumers. The principle expanded the reach of consumer law. The principle gave patients a path to legal recourse and allowed for more accessible legal recourse for patients to seek compensation for negligence, in consumer courts.

Annex:-E

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

Facts: Dr. Jacob Mathew was accused of medical negligence after a patient died because of a misdiagnosis. The case clarified the standards for criminal liability in medical negligence cases.

Issue concerned: Whether a doctor can be held criminally liable for negligence under Section 304A (causing death by negligence) of the Indian Penal Code?

Principle Established: It was held by the Supreme Court that criminal liability in medical negligence requires a higher threshold. Emphasis was given to the fact that gross negligence to establish criminal liability. Also, the Supreme Court ruled that expert opinion given by medical expert should be sought before filing the criminal charges against healthcare providers.