

Informed Consent and Medical Negligence in Indian Law

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Abstract

Medical practice in India is shaped by court decisions, consumer legislation, criminal law and professional regulations, yet no single statute states what a patient must be told before treatment or when a failure to tell amounts to negligence. This paper examines how Indian courts have handled medical negligence and informed consent, using the leading decisions of the Supreme Court of India and a short comparison with the United Kingdom, the United States and Australia. It is observed that the quality of treatment is still measured mainly by the Bolam test, while the adequacy of disclosure is judged, at least in principle, from the patient's point of view. The two standards sit uneasily together, and the resulting uncertainty affects doctors and patients alike. The paper argues that consent in hospital practice risks being reduced to paperwork, that language and literacy barriers receive little legal attention, and that the law on emergencies and on patients who cannot decide for themselves remains incomplete. Suggestions are made on codification, the process of consent, protection for doctors and oversight.

Keywords: Informed Consent, Medical Negligence, Standard of Care, Bolam Test, Patient Autonomy, Indian Law

1. Introduction

For a long time the relationship between doctor and patient rested on trust and deference. The doctor decided, the patient complied, and questions were rarely asked. That picture has changed. Patients now arrive with information from the internet, relatives with opinions and, increasingly, lawyers. Courts in many countries have accepted that a competent adult has the right to decide what is done to his or her body, a principle put with unusual clarity by Benjamin Cardozo, then a judge of the New York Court of Appeals, in *Schloendorff v. Society of New York Hospital* [1].

India has absorbed this principle without ever legislating on it. There is no general statute that tells a surgeon what must be disclosed before an operation, in what form consent must be recorded, or what follows when it is not. The rules have instead gathered in judgments, in professional regulations, and in a few statutes that deal with particular groups of patients. Negligence law has grown in much the same way. The Supreme Court has laid down the standard of care, the test for criminal liability and the reach of consumer law, yet the rules on disclosure and the rules on negligence have been developed separately and are seldom discussed together.

That separation matters because, in practice, the two questions are tied. A patient who suffers a complication will usually ask two things: was the procedure done properly, and was he or she told that this could happen? A claim may succeed on the second even where the first is answered in the doctor's

favour. How courts treat each question therefore decides how much protection patients receive and how much exposure doctors face.

Four questions are addressed in this paper. First, what standard of care does Indian law apply in cases of medical negligence, and through which forums is it enforced? Second, what must a doctor disclose before treatment, and how has the Supreme Court dealt with consent? Third, do the standards applied to treatment and to disclosure fit together coherently? Fourth, what reforms would make the law clearer for doctors and fairer to patients?

The study is doctrinal. It relies on primary sources, namely the decisions of the Supreme Court of India, relevant statutes and professional regulations, supplemented by leading decisions from the United Kingdom, the United States and Australia for comparison. No empirical data has been collected. Observations about hospital practice are therefore offered as points for further testing and not as established findings.

2. Medical Negligence in Indian Law

2.1 Duty and Standard of Care

The starting point is the duty a doctor takes on when a patient is accepted for treatment. In *Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Babu Godbole*, the Supreme Court described this as a duty of care in deciding whether to take up the case, a duty of care in deciding what treatment to give, and a duty of care in administering that treatment [2]. A breach of any of these, causing harm, is negligence.

How is breach measured? Indian courts have followed the test laid down by *McNair J. in Bolam v. Friern Hospital Management Committee*, under which a doctor is not negligent if he or she acted in accordance with a practice accepted as proper by a responsible body of medical opinion [3]. The House of Lords later added a safeguard in *Bolitho v. City and Hackney Health Authority*: the body of opinion relied upon must itself be able to withstand logical analysis [4]. The Supreme Court adopted the *Bolam* approach in *Jacob Mathew v. State of Punjab*, and it has since been applied in civil, consumer and criminal proceedings alike [5].

Two consequences follow. A doctor is not liable merely because treatment failed or because another practitioner would have chosen differently, a point the Supreme Court restated when it summarised the governing principles in *Kusum Sharma v. Batra Hospital and Medical Research Centre* [6]. And an error of judgment is not the same thing as negligence. Medicine involves choices made on incomplete information, often under pressure of time, and the law accepts that a reasonable doctor can be wrong. What it does not accept is carelessness of a kind that no competent practitioner would show.

2.2 Routes of Liability

A patient who believes that treatment fell below standard can move in four directions, and the threshold differs in each. These are summarised in Table 1.

Table 1: Routes of Liability for Medical Negligence in India

Route	Forum	Threshold	Usual Outcome
Civil	Civil courts	Breach of the duty of care that causes harm	Damages
Consumer	Consumer commissions	Deficiency in service	Compensation

Route	Forum	Threshold	Usual Outcome
Criminal	Criminal courts	Gross negligence or recklessness	Fine or imprisonment
Disciplinary	Medical councils and the National Medical Commission	Professional misconduct	Warning, suspension or removal from the register

The consumer route is attractive to patients because its procedure is simpler than that of a civil suit. In *Indian Medical Association v. V.P. Shantha*, the Supreme Court held that medical services rendered for a fee fall within consumer protection law, while services provided entirely free of charge, and services under a contract of personal service, were left outside it [7]. The Consumer Protection Act, 2019 now governs the field [8]. The procedure for such complaints has itself been contested. In *Martin F. D'Souza v. Mohd. Ishfaq*, the Court directed that a complaint against a doctor should ordinarily be referred to an expert opinion before notice is issued [9]. Soon afterwards, in *V. Kishan Rao v. Nikhil Super Speciality Hospital*, the Court held that this direction was not correct as a general rule, that expert evidence is not needed in every case, and that the doctrine of *res ipsa loquitur* may apply where the facts speak for themselves [10]. The criminal route is narrower. Prosecution for causing death by a negligent act was long brought under section 304A of the Indian Penal Code, 1860. The offence now appears in section 106(1) of the *Bharatiya Nyaya Sanhita, 2023 (BNS)*, which provides a lower maximum punishment for a registered medical practitioner performing a medical procedure than for others [11]. The Supreme Court has insisted that criminal liability requires gross negligence or recklessness and not mere want of due care, as it held in *Dr. Suresh Gupta v. Government of NCT of Delhi* and discussed again in *Jacob Mathew* [12, 5]. *Jacob Mathew* also set out safeguards: a private complaint should ordinarily not be entertained unless it is supported by the credible opinion of another competent doctor, and a doctor should not be arrested as a matter of routine. Disciplinary proceedings form the fourth route. They are conducted under the *National Medical Commission Act, 2019* and the professional conduct regulations, and they are concerned with professional misconduct and not with compensation [13, 14]. The National Medical Commission (NMC) is the regulator under that Act.

3. Informed Consent in Indian Law

3.1 Meaning and Sources

Informed consent has four working elements. The patient must have the capacity to decide; the decision must be voluntary; the patient must have received enough information about the nature of the procedure, its risks and the alternatives; and the patient must have understood that information. Take away any one of these and the consent becomes weak, and for a major procedure it may fail altogether.

The legal basis for the requirement in India is a mixture. Constitutional doctrine supplies the foundation, since the right to life and personal liberty under Article 21 has been read to include bodily integrity and, as the Constitution Bench recognised in *Common Cause v. Union of India*, dignity and autonomy in decisions about one's own treatment [15, 16].

Statute addresses consent only for particular groups. The *Mental Healthcare Act, 2017* provides for advance directives and for decisions by a nominated representative [17]. The professional conduct regulations of 2002 require a physician to obtain written consent before an operation [14]. Outside these,

the position is governed by case law. In emergencies, the Supreme Court held in *Parmanand Katara v. Union of India* that every doctor, in a government or a private setting, has a duty to give immediate aid to an injured person without waiting for formalities [18].

3.2 Samira Kohli v. Dr. Prabha Manchanda

The leading decision on consent is *Samira Kohli v. Dr. Prabha Manchanda*. An adult woman had consulted a gynaecologist about a menstrual complaint and agreed to a diagnostic hysteroscopy and laparoscopy. While she was under anaesthesia, the doctor decided on the spot to remove the uterus and ovaries, and did so without her consent. The Supreme Court held that consent given for a diagnostic procedure cannot be treated as consent to a more serious therapeutic one, and that a doctor who goes beyond the consent given is liable unless the case falls within a narrow exception [19]. That exception covers an unforeseen condition discovered during the procedure, where waiting to obtain consent would endanger the patient's life or health. The Court found that nothing of the kind arose here: the doctor could have stopped, let the patient recover and discussed the findings with her. Compensation was awarded, though in a modest sum. The judgment is also the main Indian authority on what a patient must be told. The Court said that before treatment the patient should be given the nature of the procedure, its material risks and the alternatives, so that the decision is genuinely his or her own, without any need to list every conceivable risk [19]. Importantly, the Court separated disclosure from treatment. A doctor's decisions on diagnosis and treatment are judged by the standard of a reasonably competent practitioner, but what a patient ought to have been told is a different question, approached from the position of the person who has to decide [19].

3.3 The Comparative Position

The Indian approach can be placed against developments elsewhere. For many years English courts applied the Bolam test to disclosure as well as to treatment, so that a doctor was safe if a responsible body of colleagues would have said the same. That position was abandoned in *Montgomery v. Lanarkshire Health Board*, where the United Kingdom Supreme Court held that a doctor must take reasonable care to ensure that the patient knows of any material risks and of reasonable alternatives. A risk is material if a reasonable person in the patient's position would be likely to attach significance to it, or if the doctor knows or should know that this particular patient would [20]. The same direction had been taken earlier in the United States in *Canterbury v. Spence*, although state law there varies and some states still use a professional standard [21], and in Australia in *Rogers v. Whitaker* [22]. The main features are set out in Table 2.

Table 2: Disclosure Standards in Four Jurisdictions

Jurisdiction	Leading Decision	Test for Disclosure
India	<i>Samira Kohli v. Dr. Prabha Manchanda</i> (2008)	Material information the patient needs in order to decide, assessed apart from the Bolam test used for treatment
United Kingdom	<i>Montgomery v. Lanarkshire Health Board</i> (2015)	Material risks and reasonable alternatives, from the viewpoint of a reasonable patient and of the particular patient
United States	<i>Canterbury v. Spence</i> (1972)	Risks material to a reasonable patient's decision, with variation between states

Jurisdiction	Leading Decision	Test for Disclosure
Australia	Rogers v. Whitaker (1992)	Material risk, judged by a reasonable patient and by the known concerns of the particular patient

Seen in this light, Samira Kohli looks forward-looking, since it moved away from a purely professional standard seven years before Montgomery. Its weakness lies not in the principle but in the limited guidance on how the principle is to be applied in a busy clinic or operating theatre.

4. Discussion

4.1 Two Standards, One Consultation

The Indian position can be summed up in a line: Bolam for treatment, a patient-centred approach for disclosure. In theory this is coherent, and it matches the direction taken in other common law systems. In practice it creates a difficulty for the doctor, who is judged by the opinion of colleagues on the operation and by a different yardstick on the conversation that came before it. A doctor who can produce expert witnesses in support of the choice of operation may still be held liable because the patient was not warned of a recognised risk. That is not unfair, but it is easily missed by practitioners trained to think of legal risk as a matter of technical competence alone.

A further difficulty is that the disclosure standard has been stated in judicial terms without legislative backing. Its application therefore depends on how each forum reads it, and nothing guarantees uniformity between consumer commissions, High Courts and criminal courts.

4.2 Consent as a Form and Consent as a Conversation

A common criticism is that consent in hospital practice has become a matter of paperwork. A printed form is signed at admission, often in English, covering any procedure the hospital may consider necessary. The signature is later produced as proof that the patient agreed. The complaint is not that forms are wrong, since a written record is useful to both sides, but that a signature records agreement and says nothing about understanding. The reasoning in Samira Kohli points the same way: consent must be real, and a form couched in general terms cannot replace a discussion about this patient and this procedure [19]. Because this study has not gathered data on hospital practice, the criticism is stated here as a concern that deserves empirical testing.

4.3 Language, Literacy and Time

Patients in India speak many languages and have very different levels of schooling. A consent form in a language the patient cannot read, or an explanation of risk in medical vocabulary, satisfies the formality and defeats the purpose. Public hospitals face an added problem, since the time available for each patient may be short and a full discussion of risk can feel like a luxury. These are not arguments for lowering the standard. They are reasons why the standard cannot be met by documentation alone, and why the law should say something about how disclosure is to be made, including the use of the patient's own language and, where necessary, an interpreter.

4.4 Emergencies, Minors and Patients Who Cannot Decide

Where a patient cannot consent, the law becomes thin. The emergency exception recognised in Samira Kohli and the duty described in Parmanand Katara are sound, but they are stated in general terms, and the line between a genuine emergency and a convenient one is left to be drawn after the event [19, 18]. For adults who lack capacity, statutory machinery exists only for mental illness, under the 2017 Act [17]. For

decisions at the end of life, the Supreme Court has filled the gap by recognising passive euthanasia in *Aruna Ramchandra Shanbaug v. Union of India* and advance directives in *Common Cause*, with the procedure later modified in January 2023 [23, 16, 24]. For other patients, such as an unconscious adult who needs a non-emergency procedure, or a minor whose parents disagree, there is no statutory answer.

4.5 Protecting Doctors without Shielding Non-Disclosure

The case law on criminal liability reflects an understandable concern that doctors should not be prosecuted for honest mistakes. The safeguards in *Jacob Mathew* and the lower penalty in the BNS express that concern [5, 11]. It is a legitimate one. Fear of litigation can push practitioners towards defensive medicine, with unnecessary tests, needless referrals or a refusal to treat high-risk patients. But a failure to disclose is a different kind of fault from a clinical error, and safeguards built for the second should not be stretched to cover the first. A doctor who operates without valid consent has not made a mistake of judgment; the decision has been taken out of the patient's hands. That is why *Samira Kohli* treated the matter as one of rights and not of skill [19].

4.6 Proof and Evidence

Disputes about consent usually come down to what was said, and doctor and patient will often remember it differently. The doctor holds the records, knows the risks and has an interest in showing that disclosure took place. The patient holds only a recollection. A rule that leaves the patient to prove non-disclosure puts the burden on the party with less information. The decision in *V. Kishan Rao*, which declined to make expert evidence compulsory and accepted that the facts may speak for themselves in some cases, shows that the Court is alive to this imbalance in negligence claims [10]. A similar approach could be taken to disclosure, with the hospital expected to show, through contemporaneous records, that the discussion took place.

5. Suggestions

5.1 A Statutory Statement of the Law of Consent

The first step is legislation or, at the least, binding rules made by the central government in consultation with the NMC. A short statute could state the elements of valid consent, adopt a material-risk standard of disclosure, define the emergency exception narrowly, deal with consent for minors and for adults who lack capacity, and require a record of the discussion. It need not displace the case law. Its purpose would be to take the basic rules out of judgments, where only a lawyer is likely to find them, and place them where a practitioner or a patient can read them.

5.2 The Standard of Disclosure

The statement of the disclosure standard should follow the reasoning of *Samira Kohli*, which is closer to *Montgomery* than to *Bolam*. It should recognise a limited therapeutic exception, allowing information to be withheld where disclosure would cause serious harm to the patient's health, and it should make clear that the exception cannot be used merely because a patient might decide against treatment.

5.3 Making the Process Meaningful

Standard forms should be specific to the procedure, available in regional languages and written in plain terms. A form should record that a discussion took place, who conducted it and what was explained. For major elective surgery, a short interval between the discussion and the operation would give patients time to reflect and ask questions. Communication and consent should also receive more weight in medical training and in continuing medical education.

5.4 Balanced Protection for Doctors

Reform should not tilt the law against practitioners. The safeguards in Jacob Mathew against casual prosecution should be preserved, and an independent expert screening mechanism for negligence complaints deserves consideration, designed so that it supports the courts without delaying cases in which the facts are plain. Early mediation of disputes over consent and communication, which may often grow out of a breakdown of trust and not out of clinical failure, could reduce the cost of litigation for both sides.

5.5 Implementation and Oversight

Some statutes that could support better practice already exist but are unevenly applied. The Clinical Establishments (Registration and Regulation) Act, 2010, which applies only in those States that have adopted it, besides the Union Territories, requires registered establishments to meet prescribed minimum standards [25]. Wider adoption, and a clear link between registration and consent practice, would help give the law practical effect.

6. Conclusion

Medical law in India has developed in the way that is usual where Parliament has said little: through a handful of important judgments, each answering the question placed before it. The result is a body of law that works well enough for the cases that reach the Supreme Court and less well for the doctor or patient who needs to know the rules in advance. The standard of care in treatment is settled in broad terms. The standard for disclosure is stated in principle but with little operational detail. The position of patients who cannot consent for themselves is covered only in pieces.

It would be a mistake to treat this as a contest between patients and doctors. A clear law of consent protects practitioners as much as patients, because a doctor who follows a known procedure and records it is better placed to answer a complaint than one who relies on a signature obtained at admission. Equally, safeguards against unfair prosecution serve patients, who gain when doctors are willing to take on difficult cases. The suggestions in this paper aim at that shared interest. Further work should test the concerns raised here against real data, in particular on how consent is obtained in public and private hospitals and on how consumer commissions have treated disclosure claims in recent years.

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