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The Jurisprudence of Medical Negligence under the Consumer Protection Act, 2019: Trends, Challenges, and Reform

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Abstract

For the past three decades or so, there have been two themes that have underpinned Indian consumer law: the first is that anyone who paid for care was a consumer, and the second is that a failure to provide someone with the level of care expected was a service deficit. The Supreme Court had upheld this stance in "Indian Medical Association v. V.P. Shantha" (1995) and it had held tough when "healthcare" was quietly omitted from the definition of "service" in the Bill during Parliament. This study attempts to explore the "Operation of the Medical-negligence liability under (new) "Consumer Protection Act, 2019". It outlines the fundamental components of an area the imitation for the standard of care, the role of notice, the status of non-conforming conduct, which is held accountable for the conduct of others and how courts value a loss as well as the elements of the 2019 statute that changed, including the IOLTA chapter and the mediation process. Next, it shifts to the most painful present hazard, the Court's judgment in the case "Bar of Indian Lawyers v. D.K. Gandhi" in 2024, after which the young woman came out of the consumer domain and the Court seemed to entertain suspicions about V.P. Shantha's continuation. A review petition filed in 2025 was rejected, and the case went to a three-judge Bench in November 2024, without that Bench disturbing the status quo of V.P. Shantha, this paper argues, a whole category of liability yet remains under the shadow of this unnecessary dispute. The final piece suggests changes in the areas of doctrine, use of experts, compensation, and avoiding defensive medicine.

Keywords: medical negligence; Consumer Protection Act, 2019; deficiency in service; standard of care; V.P. Shantha; D.K. Gandhi; informed consent; product liability.

I. Introduction

Few dealings in law carry the weight of trust, imbalance, and stakes that mark the bond between a patient and a doctor. A patient usually comes without knowledge and frequently in fear, while the doctor commands technical expertise the patient cannot independently test. When treatment produces a bad result, the law must sort out whether the injury was a matter of bad luck, a lapse of judgment, or blameworthy carelessness and it must do so without turning every unsatisfactory clinical result into a verdict of fault. India tackles this through several overlapping routes: tort law, the criminal law governing rash and negligent conduct, professional-disciplinary oversight, and most readily of all the consumer-protection regime.

The consumer pathway has led medical-negligence litigation in this country since the mid-1990s, and the reasons are not hard to see. Compared with the ordinary civil courts, consumer fora cost less, sit outside the stiff procedure of the Code of Civil Procedure, grant compensation through an abbreviated process, and operate at three levels reaching every part of the country. After the Supreme Court ruled in "Indian Medical Association v. V.P. Shantha"[1] that medical services supplied for payment fall inside the statutory idea of "service," the consumer forum became the ordinary

[1] Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651.

place for injured patients to seek redress. That settlement now continues under the "Consumer Protection Act, 2019",[2] which took the place of the repealed "Consumer Protection Act, 1986".

This study pursues three aims. The first is to lay out how medical-negligence liability is structured as the consumer jurisdiction has shaped it the applicable standard of care, the handling of expert testimony, the requirement of informed consent, a hospital's responsibility for its staff, and the calculation of damages. The second is to examine what the 2019 statute introduced and left unclear, among them the heavily debated dropping of "healthcare" from the statutory meaning of service and the fresh product-liability scheme that now extends to medical devices and implants. The third is to weigh the unsettling consequences of the Supreme Court's 2024 judgment in "Bar of Indian Lawyers v. D.K. Gandhi"[3] before setting out proposals for reform.

II. Conceptual and Historical Foundations

A. Negligence and the Reasonable Standard of Care

Medical negligence falls under the umbrella of negligence and the three causes of action remain the same: a duty of care owed to the injured party, a breach of that duty and damage arising from the breach of duty. What sets the clinical setting apart is the yardstick used to judge breach. A physician promises no guaranteed recovery, and a poor result alone does not establish negligence. India's controlling test is still the one laid down in "Bolam v. Friern Hospital Management Committee"[4], under which "a medical professional is not negligent if they have acted in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art, even if a different body of opinion would have taken a contrary view".

Indian courts took the Bolam test on board and developed it through a series of rulings. In "Jacob Mathew v. State of Punjab"[5], a three-judge Bench treated the measure as the competence and skill an ordinarily capable practitioner would bring to the field, and held that liability arises in only two situations where the practitioner lacked the skill the task demanded, or where, possessing it, the practitioner failed to deploy it with reasonable care adding that a simple error of judgment does not amount to negligence. In "Kusum Sharma v. Batra Hospital & Medical Research Centre"[6], the Court drew together a set of governing principles: a doctor is to be assessed against the standards in force when the treatment was given, no exceptional or above-average level of skill is required, and a court should hesitate to label conduct negligent simply because the outcome was unfortunate.

B. From the 1986 Act to the Watershed of V.P. Shantha

There was no mention of the term, medical services in the "Consumer Protection Act, 1986". Only one point was left out to be decided in V.P. Shantha: does Section 2(1)(o) of the 1986 Act include "services" rendered by doctors in the exercise of their medical profession, including consultation, diagnosis and treatment medical or surgical as would allow a patient to drag a doctor before a consumer forum at all? The Bench took the notion of consideration for its path, as in a practitioner or hospital where no charge is being made, no charge is paid, and the recipient is not a consumer, and, where a fee is being paid for the services rendered to a patient by a practitioner or hospital, the patient is a consumer, and where in a hospital trading is done on both fee and consideration basis the non-paying patient is also a consumer entitled to a no-fee service, which is a service provided on a consideration basis.

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[2] The Consumer Protection Act, 2019 (Act No. 35 of 2019).

[3] Bar of Indian Lawyers v. D.K. Gandhi PS National Institute of Communicable Diseases, 2024 INSC.

[4] Bolam v. Friern Hospital Management Committee, [1957] 1 WLR 582 (QB).

[5] Jacob Mathew v. State of Punjab, (2005) 6 SCC 1.

[6] Kusum Sharma v. Batra Hospital & Medical Research Centre, (2010) 3 SCC 480.

Two clarifications came soon afterward. In "Spring Meadows Hospital v. Harjol Ahluwalia",[7] the Court treated both the child who is treated and the parent who foots the bill as consumers, allowing recovery for the child's injury as well as for the mental suffering of the parents. In "Poonam Verma v. Ashwin Patel"[8], it held that a practitioner trained in one stream of medicine who prescribes treatment from another stream is negligent as a matter of course. Taken together, these rulings made the consumer forum not just one option but the leading battleground for medical-negligence disputes in India.

The dividing line that proved central in V.P. Shantha between a contract of service, meaning the master–servant tie the statute leaves out, and a contract for services, meaning the supply of professional skill the statute brings in would much later sit at the heart of the 2024 dispute taken up in Part V. For thirty years, though, the question seemed closed.

III. The Architecture of the Consumer Protection Act, 2019

Rather than a surface revision, the 2019 statute amounted to a full re-enactment answering to how much the market had changed since 1986, above all the growth of online commerce. A number of its provisions touch medical-negligence claims directly.

A. The Redrawn Definitions: Service, Deficiency, and Consumer

Section 2(42) of the 2019 Act keeps the broad, open-ended shape of the earlier definition of "service," listing fields such as banking, insurance, transport, housing construction, and entertainment by way of illustration, and it carries over the same pair of carve-outs: services given free and services performed under a contract of personal service.[9] Section 2(11)'s definition of "deficiency" has been widened in a meaningful way, now reaching in terms "any act of negligence or omission or commission by such person which causes loss or injury to the consumer,"[10] language that maps onto medical negligence with striking exactness. The meaning of "consumer" in Section 2(7) still turns on consideration, holding on to the paid-versus-free line that V.P. Shantha drew.

B. The "Healthcare" Omission and the Interpretive Controversy

Where medical liability is concerned, the 2019 Act's most talked-about feature is an omission. The version the Lok Sabha passed "The Consumer Protection Bill, 2018" had named "healthcare" outright in the illustrative list under service, but the term was struck out before the measure was brought back and enacted in 2019. Doctors and hospitals read that removal as a conscious action by Parliament to drive medical services beyond the arms length of consumer fora.

That reading has been consistently denied by courts. As far as the text is concerned, Section 2(42) is expressed as a list that cannot be exhaustive and therefore with the deletion of one example, the definition is not curtailed and the words on which V.P. Shantha interpreted it remain the same. Thereupon, the Kerala High Court took an adversarial stance to the argument, holding that a paring aid like a deleted draft clause was relevant in construing a statute only when the language provisionally used was 'unmistakable', which in its opinion was not the case in the definition used here as a service was inclusive. A structural point makes the same point: The legislature is to be read to have adopted a reading of the definition after having enacted it knowing exactly how V.P. Shantha had read it in 2019. The settled view, then, is that medical services stay inside the Act despite the missing word.

C. Restructured Pecuniary Jurisdiction

[7] Spring Meadows Hospital v. Harjol Ahluwalia, (1998) 4 SCC 39.
[8] Poonam Verma v. Ashwin Patel, (1996) 4 SCC 332.
[9] Consumer Protection Act, 2019, s. 2(42).
[10] Consumer Protection Act, 2019, s. 2(11).

The 2019 Act keeps the familiar three layers District, State, and National Commissions yet alters how their pecuniary reach is worked out. The 1986 scheme measured jurisdiction by the worth of the goods or services together with the compensation demanded; the 2019 scheme fixes it on the value of the consideration actually paid, no longer tied to the amount of compensation claimed.[11] Those money limits were later reset by the "Consumer Protection (Jurisdiction of the District Commission, the State Commission and the National Commission) Rules, 2021": a District Commission now takes matters where the consideration is no more than ₹50 lakh, a State Commission those from ₹50 lakh up to ₹2 crore, and the National Commission those over ₹2 crore. This creates an odd result for medical-negligence cases since jurisdiction tracks the small fee paid rather than the frequently large damages sought for devastating injury, even enormous claims can end up lodged at the District Commission.

D. Product Liability and Medical Devices

Chapter VI of the 2019 Act sets up a statutory product-liability scheme a wholly fresh addition with nothing matching it in the 1986 Act.[12] It places responsibility on those who make, sell, or provide a product when a defective one causes harm. For healthcare this matters a great deal: a hospital or clinic that fits implants, prosthetics, stents, or similar devices—and the manufacturers and distributors behind them can now be answerable not on the footing of a shortfall in clinical service but for a defective product.

E. Mediation, the Central Authority, and Telemedicine

There are three other changes to mention. The first is a formal mediation process; commissions can refer themselves to mediation cells which can be helpful in a medical dispute, because a swift and confidential resolution may be preferable to a prolonged court battle.[13] The second is the newly established Central Consumer Protection Authority which is tasked with safeguarding consumer rights, consumer unfair trade practices and false or misleading advertisements, including those being made by hospitals, diagnostic chains and drug marketers. Third, the Act explicitly covers electronic and online dealings, as such, telemedicine (a rapidly growing specialty) is included within the scope of the Act, meaning the same duty of care and informed consent requirements would apply to electronic or online consultation as with face-to-face consultation.

IV. Judicial Trends in Medical-Negligence Jurisprudence

The cases mostly referred to the Supreme Court and National Commission and its working principles are predominantly of the consumer jurisdiction which continues to guide cases in the 2019 Act. Some of the authority's lines should be noted.

A. The Standard of Care and the Bolam–Bolitho Question

Indian forum continues to use Bolam in the above shade and flavor. One issue which has persisted is whether Bolitho v City and Hackney Health Authority has added a gloss to the concept of reasonable body of professional opinion in England, and whether it was or whether it should have been incorporated into the Indian rules. There has been a nod toward Bolitho in Indian judgments but never has the practice been embraced. Consequently, the test of when to accept professional opinion has and when to challenge the opinion before the court is not entirely clear.

B. Res Ipsa Loquitur

If the accident in its very nature shows carelessness say where a surgical instrument or sponge is left inside a person the res ipsa loquitur doctrine allows a court to draw the inference that negligence occurred without having to identify

[11] Consumer Protection Act, 2019, ss. 34, 47 and 58.

[12] Consumer Protection Act, 2019, ss. 82–87.

[13] Consumer Protection Act, 2019, ss. 37 and 74–81.

a specific negligent act. In Achutrao Haribhau Khodwa v. State of Maharashtra,[14] the Supreme Court used the maxim where a mop abandoned in the abdomen during an operation led to fatal peritonitis. In practice the doctrine moves the burden onto the practitioner, who must then account for how such a result could have happened in the absence of negligence.

C. The Role of Expert Evidence

Whether independent expert testimony is required in medical-negligence matters has drawn inconsistent rulings. In "Martin F. D'Souza v. Mohd. Ishfaq"[15], the Supreme Court indicated that a consumer forum should as a rule secure an expert opinion before sending notice to a doctor. Barely a year on, that view was questioned in "V. Kishan Rao v. Nikhil Super Speciality Hospital"[16], where the Court ruled that expert evidence is not required in every matter, and that when negligence is plain or res ipsa loquitur is in play a forum may decide on the record already before it. The working position today is that expert evidence, while highly desirable, is not always essential, its necessity turning on how complex the clinical issue is.

D. Informed Consent

Patient autonomy finds its protection in the doctrine of informed consent, which received its leading treatment in "Samira Kohli v. Dr. Prabha Manchanda"[17]. The Court ruled that consent must be both genuine and freely given, and it must reflect the specific procedure that was actually performed; a consent for a diagnostic procedure would not authorize a surgeon to proceed to major surgery that is considered necessary during the diagnostic procedure, unless life is at stake. For the time being, it appears that the "reasonable medical professional" disclosure test would be closer to the disclosure required in India, while the "prudent patient" disclosure test would be closer to a more patient-centric disclosure, but in practice, there's not much difference between them.

E. Vicarious and Institutional Liability of Hospitals

A hospital is responsible for the negligence of doctors and support staff it is contractually or permanently engaged, whether through another hospital or directly, and for the negligence of its own institutional faults weak infrastructure, weak protocols, failure to refer. Administrative breakdown, a late referral to a higher centre, poor communication and a lack of monitoring have all become hallmarks of the National Commission finding of deficiency as well as a specific clinical error, as Spring Meadows is the leading expert in breaches of institutional liability.

F. The Quantification of Compensation

The way damages are assessed has grown a good deal more sophisticated. Its peak is the litigation that followed Anuradha Saha's death, which ended in "Balram Prasad v. Kunal Saha"[18], where the Supreme Court raised the award to about ₹6.08 crore at the time the highest ever in an Indian medical-negligence case. The Court worked through lost earnings on a structured, multiplier-guided basis and refused to impose any fixed statutory ceiling, making clear that an award should track the real extent of the loss. More recently, in "Najrul Seikh v. Dr. Sumit Banerjee" (2024)[19], the Court stressed that a doctor's duty reaches past the operating table to cover assessment before surgery and care afterward a holding that sits firmly in the V.P. Shantha tradition.

G. The Civil–Criminal Boundary

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[14] Achutrao Haribhau Khodwa v. State of Maharashtra, (1996) 2 SCC 634.

[15] Martin F. D'Souza v. Mohd. Ishfaq, (2009) 3 SCC 1.

[16] V. Kishan Rao v. Nikhil Super Speciality Hospital, (2010) 5 SCC 513.

[17] Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 SCC 1.

[18] Balram Prasad v. Kunal Saha, (2014) 1 SCC 384.

[19] Najrul Seikh v. Dr. Sumit Banerjee (2024).

Lastly, the consumer jurisdiction needs to be kept apart from criminal liability for negligence. Jacob Mathew set the bar for criminal liability at negligence that is "gross" or of a very high order a far stricter test than the civil measure of a want of reasonable care that decides a consumer claim. A patient can therefore win before a consumer forum on facts that would never support a prosecution, the two routes running on their own.

V. The D.K. Gandhi Disruption: An Existential Question

The most important recent turn is also the most unsettling. In "Bar of Indian Lawyers v. D.K. Gandhi" (14 May 2024) a two-judge Bench of the Supreme Court ruled that advocates cannot be sued before consumer fora for deficiency in service. Legal practice, the Bench reasoned, is a thing apart: an advocate's duties run not only to the client but to the court, the advocate acts as the client's agent subject to a high degree of the client's control, and the profession answers to its own disciplinary machinery under the Advocates Act, 1961. On that reasoning an advocate's services belong to the excluded class of a "contract of personal service."

Had the Bench gone no further, none of this would necessarily have touched medical negligence. It did go further, remarking that neither the professions nor professionals had ever been meant to come within the Consumer Protection Act, be it the 1986 or the 2019 version, and that the three-judge ruling in V.P. Shantha "deserves to be revisited" by a larger Bench—so it sent the question to the Chief Justice of India.[20] The remark set off immediate worry across the medical and legal worlds and drew pointed academic criticism about judicial discipline: a two-judge Bench had effectively voiced disagreement with a binding three-judge precedent even as it disposed of the case on the footing that the precedent was right, and had claimed to refer only a portion of the issue upward.

VI. Conclusion

At bottom, the law of medical negligence under the Consumer Protection Act, 2019 is a developed body of doctrine that leans toward protecting patients. It stands on a connected set of ideas a reasonable standard of care, an informed-consent doctrine rooted in autonomy, the drawing of an inference of negligence where the facts speak for themselves, the institutional responsibility of hospitals, and an ever more principled approach to damages built up over three decades and carried, largely whole, into the 2019 framework. If anything, the statute's structural amendments, including the expanded definition of deficiency and the Chapter on product liability strengthen a plaintiff's text-based argument.

Despite this, the region is at a juncture. It was an interpretive snag that could be resolved, that any reference to "healthcare" could be removed from the statutory definition of "service"; the comments in D.K. Gandhi were something else an open question which the Supreme Court had allowed to hang over something much more than merely a narrow branch of liability itself. What is now evident is that V.P. Shantha is standing and that she is standing without any new decision, without any affirmation of her position on the merit which is an unnecessary uncertainty. What the courts and the legislature would need to address is not the rebuilding of a viable system, but a process to cement the financial foundations and improve efficiency of that system standardizing benefit coverage, improving the standard of care, incorporating expertise, putting compensation on a rational basis, while easing the litigation pressures that lead to defensive medicine. Together such changes would bring a regime that would be fair to patients, but fair also to practitioners, whose practice depends on patient trust.

[20] Bar of Indian Lawyers v. D.K. Gandhi (n 3).