

REVIEW ARTICLE

Injury, an Actionable Wrong, is Defined as Harm Illegally Caused Versus act of a Licensed Medical Practitioner

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ABSTRACT

Background: The Bharatiya Nyaya Sanhita (BNS) redefines “injury” and “illegal” acts, creating ambiguity in medical negligence jurisprudence. This article examines whether harm caused by licensed physicians during treatment constitutes “illegally caused injury” under BNS.

Methods: Doctrinal analysis of BNS Sections 2(14), 2(15), and 26; comparative review of IPC provisions, common law, and landmark case laws.

Results: Liability hinges on breach of statutory duty (BNS 2(15), not mere harm. Deficient consent invalidates treatment legality but requires causal harm for negligence claims. Consumer law frames consent as contractual autonomy.

Conclusion: BNS prioritizes *legality of conduct over outcome*. Harmonizing statutory “good faith” (Sec 26) with material risk disclosure prevents liability. *The article underscores the classic legal dilemma between wrongful harm and privileged action under statutory license.*

KEYWORDS

• Medical Negligence • Bharatiya Nyaya Sanhita • Informed Consent • Duty of Care • Consumer Protection Act • *Illegally Caused Injury* • Good Faith

INTRODUCTION

Injury, as traditionally conceived in law, is an actionable wrong arising from the unlawful invasion of a legally protected interest. But what happens when harm results not from an unlawful act, but from a procedure performed under statutory license by a medical professional acting with purported “beneficial intent”? Section 26 of the Bharatiya Nyaya

Sanhita introduces precisely this conundrum: it accords legitimacy to acts done in “good faith” for a person’s benefit, potentially shielding the actor from criminal liability.

Q. BNS 2(14) “injury” means any harm whatever illegally caused to any person, in body, mind, reputation or property,¹

BNS 2(15) “illegal” and “legally bound to do”. The word “illegal” is applicable

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*to everything which is an offence, or which is prohibited by law, or which furnishes ground for a civil action; and a person is said to be "legally bound to do" whatever it is illegal in him to omit;*²

Let's break down the analysis of these provisions and their implications for a licensed doctor accused of medical negligence.

I. Definitions and Their Implications

BNS 2(14) - "Injury": This provision defines "injury" very broadly as any harm whether to the body, mind, reputation, or property that is illegally caused. The crucial point here is that for harm to qualify as "injury" under this definition, its cause must have an element of illegality.

BNS 2(15) - "Illegal" and "Legally Bound to Do": Here, the term "illegal" encompasses any act or omission that violates a law or, put differently, that a person is legally obligated to perform (or refrain from omitting). This is key because it implies that a failure to act where one is "legally bound to do" something that is, where there is a duty imposed by law can be considered illegal.

II. The Duty of Care and Its Legal Consequences

Under the common law doctrine of duty of care, a licensed medical practitioner has a legal obligation to render treatment when approached by a patient. This duty is foundational to medical practice. In practical terms, this means:

- **Duty to Act:** A registered doctor must at least provide care, especially when the patient's condition warrants prompt intervention.
- **Omission as a Violation:** If a doctor fails to provide treatment despite being approached by a patient (and where treatment is indicated), such an omission can be read as "illegal" under BNS 2(15) because the doctor is legally bound to act.

In this light, if harm occurs because the doctor neglects this duty whether intentionally or inadvertently it may well be considered "injury" under BNS 2(14) because the underlying cause is an illegal omission (or a commission if the act deviated grossly from accepted care standards).

III. When Is the Doctor's Act Considered "Illegal"?

Legal Acts vs. Illegal Acts in Medical Practice:

- **Legal, Standard Practice:** When a doctor duly performs a procedure or treatment using accepted methods, even if complications arise, the act itself remains "legal." The harm, in this case, is an accepted risk of treatment. Even though the outcome may be unfortunate, there is no breach of the legal duty. Thus, any harm that arises as an inherent risk from a properly performed treatment does not fulfill the "illegal" element required by BNS 2(14) for injury.
- **Deviation from Duty (Negligence):** On the other hand, if a doctor breaches the duty of care say, by failing to act when urgently required or by performing a procedure with gross incompetence and that breach directly causes harm, the act (or omission) becomes "illegal" in the sense elaborated under BNS 2(15). Here, even if the harm was not intended, its foreseeability and direct association with the breach render it compensable as an "injury."

Thus, whether a doctor's act is "illegal" depends entirely on whether it deviates from the legally required standard of care.

IV. Injury from a "Legal" Act: When Does It Become Liable?

Under BNS 2(14), "injury" is predicated on the harm being illegally caused. This raises two possibilities for a licensed physician:

- **Acceptable, Lawful Acts with Known Risks:** If a doctor performs a legally sanctioned and careful treatment, complications or adverse outcomes even if severe are generally viewed as inherent risks. These outcomes are not "illegally caused" because there's no breach in the duty of care. Thus, although harm has occurred, it does not meet the injury threshold for liability as per BNS if the standard treatment protocol was followed.
- **Negligent Acts or Omissions Causing Harm:** Conversely, if the doctor's actions fall short of the required standard be it through omission or an erroneous procedure then the harm suffered by the

patient is a direct result of an illegal act (a failure to fulfill a legal duty). Such harm qualifies as “injury” under BNS 2(14) and can give rise to liability, irrespective of the absence of malicious intent.

In effect, liability arises not merely from the presence of harm but from the demonstration that the harm occurred because of a breach of a legally imposed duty (Table 1).

Table 1: Tabular Analysis: Negligence Liability Framework

Element	IPC Era	BNS Era	Medical Implication
Injury Definition	Physical harm (Sec 319 IPC) ³	Harm + Illegal cause (BNS 2(14))	Standard treatment complications ≠ injury
Legality of Medical Act	Bolam test competence	Good faith + Benefit + Consent (Sec 26) ⁴	Non-consensual act = illegal origin
Consent Deficiency	Battery (assault)	Invalidates Sec 26 protection	Standalone tort; negligence if harm causal

V. Synthesis and Broader Considerations

To answer your questions directly:

- **Can the act of such a doctor be considered illegal?** A licensed doctor’s act is not inherently illegal simply because they intervene in treatment. It becomes subject to legal liability if and only if the doctor either:
 - ♦ Omits to provide treatment when legally bound to do so (an omission meeting the “illegal” criterion).
 - ♦ Takes an action that deviates significantly from accepted medical practice, thereby breaching the duty of care, which makes the act “illegal” in its consequences.
- Can the harm, intentional or unintentional, caused by a ‘legal’ act of the physician be considered injury for liability?

- ♦ If the doctor’s actions are within the ambit of accepted legal practice (the standard of care), then any harm even if unintentional generally does not attract liability because it lacks the element of illegality defined in BNS 2(14). However, if the legal act is performed negligently and that deviation leads to harm, then even if the harm was not intended the result may be deemed “injury” because it originates from an act that violated the doctor’s legal duty of care.

These distinctions underscore the delicate balance in medico-legal jurisprudence between holding medical professionals accountable for negligent deviations and recognizing the inherent risks associated with complex treatments (figure 1).

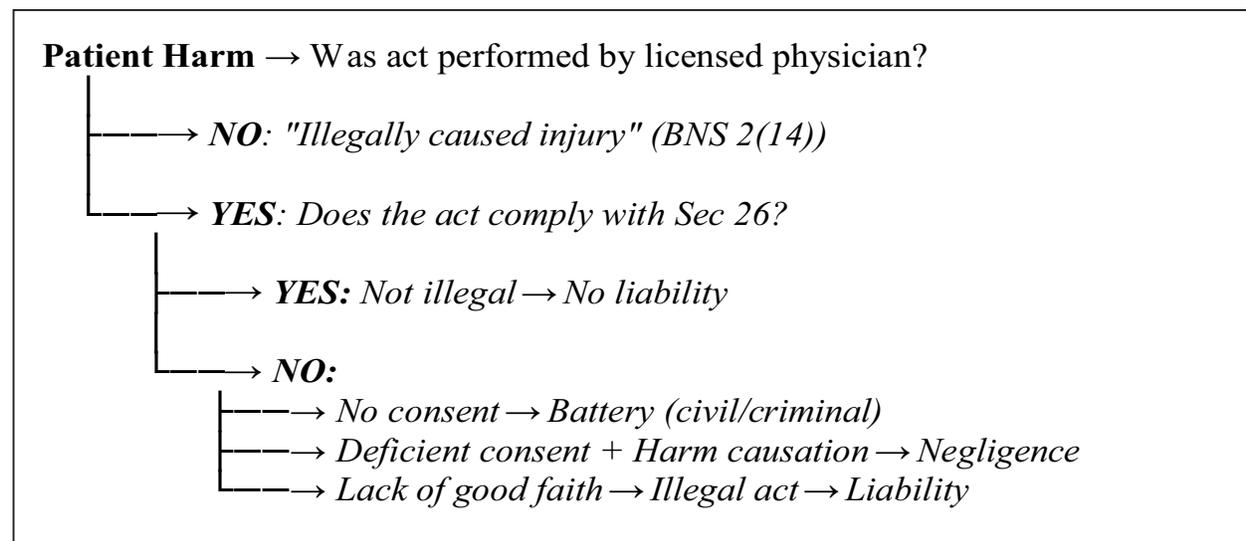


Figure 1: Flowchart for patient harm vs negligence

VI. Further Thoughts

The interplay between statutory definitions (like in the BNS provisions) and the common law duty of care has been shaped by seminal cases (such as *Jacob Mathew v. State of Punjab* and *Bolam v. Friern Hospital Management Committee*). The courts have long stressed that not every negative outcome qualifies as negligence; rather, there must be a clear breach of a legally imposed duty resulting in harm that is not merely a risk inherent in medical treatment. This delicate distinction

is crucial in balancing patient rights with professional autonomy and ensuring that medical professionals can operate without the undue fear of liability when complications arise within the accepted realm of practice.

Moreover, discussions on “beneficial intent” and how it interacts with the legal definitions in BNS further nuance these issues. While the intent to help does not nullify liability if the duty of care is breached, courts often take into consideration the context assessing if adherence to medical protocols was maintained (Table 2).

Table 2: Comparative Chart: Landmark Cases on Consent & Negligence

Case	Holding	BNS Alignment
<i>Samira Kohli v. Dr. Prabha Manchanda</i> (2008) ⁵	Consent must be “real”; material risks disclosed	Sec 26 “consent” requires disclosure
<i>Jacob Mathew v. State of Punjab</i> (2005) ⁶	Gross deviation = negligence	Aligns with BNS 2(15) “illegal” act
<i>Montgomery v. Lanarkshire</i> (2015, UK) ⁷	Patient-centered risk disclosure	Informs “benefit” under Sec 26

DISCUSSION

In summary, liability under BNS for medical negligence hinges on whether a breach of duty results in harm that can be legally characterized as “injury.” The fact that a doctor is duty bound to assist does not automatically render every outcome illegal; it is the deviation from accepted care that crosses the threshold into illegality and, consequently, liability.

Q. This means that a licensed physician’s act of treatment (care), to be legally valid, the definition of a legal act, must be read with Sec 26 of BNS, that provides legal framework and parameters for the act of a physician to be legal. The parameters prescribed are to conform to the three doctrines of Good Faith, Benefit and Consent as per their wide interpretations and fine nuances. Harm resulting from contravention of this provision, the physician shall be held accountable. However, this legal provision is governed by the overriding provisions of the exception clauses. An act of a medical profession that conforms to these exceptions, will render the offence a non-offence, that is an act illegal would be considered legal for protection from liability. Please discuss the legality of a medical act of negligence in its wider context of liability.

AI: > Let’s explore this in depth by considering how Section 26 of the Bharatiya Nyaya Sanhita (BNS) interacts with the general legal framework of medical negligence. The core idea is that for a licensed physician’s act

of treatment to be legally valid and thereby protected from liability it must not only be performed within the ambit of professional duty but must also conform to the parameters set out in Section 26. This section essentially guides us through the three principles of **Good Faith, Benefit, and Consent**. Each of these elements must be present, as understood in their wide and nuanced interpretations, for the medical act to be considered not only legally valid but also shielded against claims of negligence. Any harm resulting from a contravention of these principles would bring the physician within the grasp of liability under the statutory definitions, unless the harm falls within broadly drafted exceptions provided under BNS.

The Role of Section 26 in Defining Legality

1. Good Faith: Performing in good faith means that the physician acts honestly and diligently, aiming at the welfare of the patient. It is not enough to simply follow standard procedures; the underlying motive must be to improve the patient’s condition. If a doctor undertakes any procedure without the requisite honesty or with ulterior motives, the lack of good faith can convert an otherwise acceptable act into one that is legally culpable. This doctrinal safeguard ensures that even if a medical intervention carries some inherent risk, as long as the intent is pure and patient focused, the act retains its legal validity.

2. Benefit: The doctrine of benefit extends beyond achieving a tangible medical gain it encapsulates the entire concept of beneficial intent. A procedure carried out for the benefit of the patient implies that the action is taken with the anticipation of a positive outcome, even amid uncertainties inherent in medical treatment. When a physician acts with the intent to benefit the patient, the adverse outcome, however unfortunate, can be understood as an adjoined risk rather than as a negligent deviation. Thus, harm resulting from an act done with genuine intended benefit would not typically be deemed “injury” for the purposes of liability under BNS, provided no deviation from accepted protocols occurs.

3. Consent: Consent whether express or implied is a critical element of a legally valid medical act. The requirement of consent ensures that the patient, having been informed about the risks and benefits, voluntarily agrees to the procedure. Consent serves to protect the physician by evidencing that the patient understood the potential risks involved. Without proper consent, even a well-intentioned act could be deemed unauthorized, thereby exposing the physician to liability. However, when the process of obtaining consent is thorough and informed, it aligns the medical act within the legal parameters set out under Section 26, lending it a protective shield against subsequent negligence claims.

Exception Clauses and the Wider Context of Liability

Crucially, Section 26 of BNS, 2023 is not an absolute shield. It is subject to overriding exception clauses that recognize the complexity and inherent uncertainty in medical practice. These exception clauses provide that even if an act falls under a potential breach of statutory norms, the act may be rendered legal and hence non-offensive if it conforms to certain conditions. For instance, in emergency situations or in cases where the standard of care ambiguities exist, a medical act that might otherwise be classified as negligent is permitted under these exceptions. This means that if a physician’s action is performed in line with the accepted norms and falls within one of these protective exception clauses, the potential “illegal” character of the act (even if harm occurs) is nullified for the purpose of liability.

On the other hand, when the act of negligence deviates from the three core tenets highlighted in Section 26 by, say, acting without proper benefit or consent or without good faith the protective umbrella of the legal provision is lost (Equation 1). Thus, the harm caused by such a deviation becomes “illegally” ascribed to the act, leading directly to liability. The wider context of liability here mirrors the principles enshrined in the common law doctrine of duty of care, wherein a breach of duty (with a clear nexus to the injury) triggers the liability of the professional.

Equation 1: Statutory Legality of Medical Acts

<p>Equation: Statutory Legality of Medical Acts</p> <p>Legality of Medical Acts under BNS requires that Doctors Act Legally (DAL)</p> $Doctors\ Act\ Legally = [Good\ Faith\ (G)] \times [Benefit\ Intent\ (B)] \times [Valid\ Consent\ (C)]$ <p>Where:</p> <ul style="list-style-type: none"> •→*G, B, C = 1* (present) or *0* (absent). •→*DAL = 1*: Full immunity (Sec 26). •→*DAL = 0*: Act = “illegal” → Potential liability.

The Legality of a Medical Act of Negligence

Balancing Act: Legally, a medical act must first satisfy the statutory thresholds of Section 26 to be deemed valid and protected. When a physician’s actions adhere to the doctrines of Good Faith, Benefit, and Consent, even if a poor outcome or harm results, the incident is typically viewed as an inherent risk rather than a breach of duty. Liability in such cases

is mitigated by the fact that the act itself is executed legally, within the framework of accepted medical practice.

When Negligence is Established: In contrast, if the execution of the medical act deviates from these established principles for instance, failing to obtain proper consent, neglecting the benefit element, or acting without good faith then even if the underlying intention was to help,

the act may be branded negligent. The key factor is whether the deviation led directly to harm. In such scenarios, the infringement on the statutory parameters would render the harm “illegal” in its origin, thereby exposing the physician to liability.

This legal analysis reflects the broader jurisprudence that seeks to balance accountability with the recognition of inherent medical risk. Judicial precedents have consistently underscored that not every adverse outcome translates into legal liability; rather, there must be a demonstrable breach of the statutory and professional duty of care.

Further Reflections

The shift towards a framework that integrates statutory parameters (as seen in Section 26 of BNS) with an understanding of exception clauses signals an evolving legal landscape. It underscores that while medical professionals are not expected to deliver perfect outcomes, they are required to adhere to defined legal and ethical standards. Accountability arises only when a deviation from these standards directly leads to harm particularly when that deviation negates the protective factors of good faith, benefit, or consent (Figure 2).

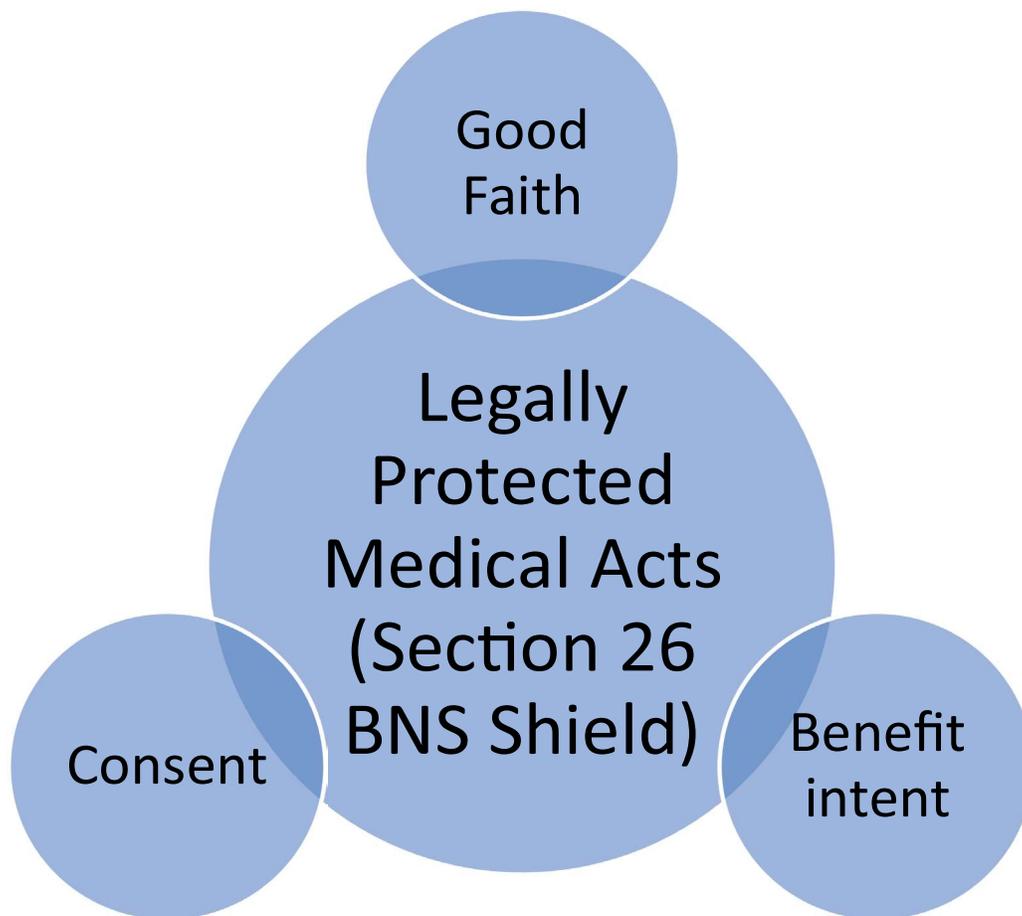


Figure 2: BNS Section 26's Triad pillar shield for Legally Protected Medical Acts

Key Elements Explained

1. Good Faith (Left Pillar)

- *Definition:* Honest intention + Due diligence
- *Legal Test:* "Would a reasonable physician consider this action justified?"
- *Failure Consequence:* Loss of statutory immunity

2. Benefit Intent (Center Pillar)

- *Definition:* Anticipated therapeutic gain > Inherent risks
- *Legal Test:* Bolam/Bolitho standards for medical justification
- *Example:* High-risk surgery for life-threatening condition

3. Consent (Right Pillar)

- **Definition:** Voluntary agreement after material risk disclosure
- **Legal Threshold:**
 - ◆ **Routine care:** Implied consent (e.g., blood test)
 - ◆ **High-risk procedures:** Written informed consent

- **Failure Consequence:** Criminal battery (BNS §124) + Civil liability

4. Mechanics of Protection

- **Intact Triad:** Full immunity under BNS §26 even if harm occurs
- **One Pillar Missing:**
 - ◆ Liability as “illegal act” under BNS §2(15)
 - ◆ Loss of “good faith” defense (Table 3)

Table 3: Judicial Precedents violating the Triad of BNS 26 shield for doctors

Pillars of BNS 26 shield	Violation Case	Outcome	Key points from judgement
Good Faith	<i>Dr. Harish Kumar v. State</i> (2022) ⁸	Fined ₹50L for unnecessary surgery	Landmark ruling on “good faith” under medical negligence law. The court fined Dr. Kumar 50 lakhs for performing unnecessary spinal surgery without clinical justification.
Benefit	<i>Martin F. D’Souza v. Mohd. Ishfaq</i> (2009) ⁹	Liability for non-beneficial chemotherapy	The Supreme Court ruled that doctors must justify the benefit-risk ratio of prescribed treatments. Advising unnecessary or disproportionately risky interventions without clinical indication constitutes negligence under the Consumer Protection Act, 1986.
Consent	<i>Samira Kohli v. Dr. Manchanda</i> (2008) ¹⁰	25L damages for undisclosed risks	Unauthorized hysterectomy without explicit consent violated autonomy. SC mandated procedure-specific, informed consent, banning blanket permissions.

Additionally, this discussion opens up deeper questions about how courts will interpret nuanced concepts like “benefit” and “good faith” in rapidly evolving medical contexts, especially given emerging technologies and treatments. Future legal debates may well further refine these doctrines, balancing the need for patient protection with safeguarding the practical realities of medical innovation.

In essence, the legality of a medical act of negligence is not black and white it is a layered inquiry into whether the act met the legal norms prescribed by Section 26 (along with its cant of exception clauses) and whether any deviation directly caused harm subject to liability.

QUESTION AND ANSWERS: AI DEBATE ON INJURY & ACTIONABLE WRONG

Q. While lack of good faith or lack beneficial intent would render the act illegal ‘in its origin’ the same is only partially true for the informed consent. Intervening on human body without a consent is an independent offence and not a necessary constituent of medical negligence. Since there is no direct nexus (causal) between a deficient consent and the alleged bodily harm, it cannot be a basis of medical negligence. This is not a contributory cause either.

AI: > You’re absolutely right that “**no consent**” isn’t by itself medical negligence it’s a standalone wrong (think battery or assault) and, often, a criminal offence when you operate without consent. Negligence, by contrast, requires three limbs:

1. A duty of care
2. A breach of that duty
3. Causation of harm flowing from the breach

When a surgeon proceeds without any consent at all, there is a tort (and possibly a crime) of non-consensual touching. But if that same surgeon does operate, follows all accepted standards of medical practice, and the patient comes through unharmed, you’ve got a battery case, not negligence. There is no element (3) because there’s no harmful outcome to link back to a sub-standard professional performance.

By the same token, a “**defective consent**” claim only triggers negligence liability when the lack of proper disclosure or explanation actually causes you harm. For example:

- If you sign a consent form that doesn’t warn you the procedure carries a 5 percent risk of nerve injury, and you end up with nerve damage you never would’ve agreed to, you can say: The doctor owed

me a duty to explain material risks. He breached that duty by under-informing me. I suffered the precise harm he hid. Voila negligence.

- But if no risk materializes, there's no bodily harm traceable to the informational gap and so no negligence claim. You'd still have a battery or deficiency-of-service claim for lack of real consent, but not negligence.

Key takeaway: lack of consent is its own civil (and criminal) wrong; negligence demands that the breach of duty actually injure you.

Where to go from here?

- Want to unpack how courts balance patient autonomy against emergencies where consent can't be had?
- Curious how contributory negligence plays when patients decline recommended treatments?
- Interested in the ethical and regulatory codes (IMC Regulations, Consumer Protection Act) that thread through India's take on consent?

Let me know which angle you'd like to dive into next.

Q> This is a contractual liability and not medical negligence liability. Had the surgeon disclosed the percentage of inherent adverse consequences, as covenant in consent, this would have amounted to the patient assuming the risk and specifically consenting for it. This would have protected the surgeon from liability. The surgical procedure consented, in this case spinal decompression, was a duly recognized procedure performed without a deviation to cause harm. The surgery having been performed with due competence, care and caution, was a legal act. The surgeon can be penalized for breach of contract; to label it as medical negligence is tortuous.

AI: You're right that the surgeon-patient relationship wears a contractual hat (you sign a consent form, pay fees, etc.), but it never sheds its tort-law skin. In India, "informed consent" sits at the crossroads of contract and negligence:

1. Contract side: by agreeing to a procedure you're undertaking treatment on agreed terms risks disclosed become "assumed" risks and, in theory, the doctor can't be sued for those specific, disclosed complications.

2. Tort side: the law also imposes on every doctor an independent duty to disclose "material" risks those a reasonable patient would want to know. If the surgeon omits a risk that later materializes, you've got more than a bare breach of contract; you've got a breach of the duty of care in line up in court?

Q. The breach of duty under tort alluded to did not directly cause the bodily harm to the patient. Penalty is attracted as the surgeon breached personal right of the patient, not because the surgery was negligently performed.

AI: > You've hit on a crucial distinction: the moment a surgeon operates without valid consent, you're in battery/assault territory an infringement of the patient's personal autonomy that doesn't depend on any physical injury. Negligence, by contrast, is all about **breach + causation + damage**.

Here's how they sit side-by-side:

1. Battery/Assault (no consent):

- Wrong "in its origin," period civil battery and often a crime under IPC sections 319-324.
- Liability attaches the instant you invade the patient's body without lawful permission.
- No need to show that the lack of consent caused medical harm.

2. Negligence (informed-consent failure):

- Duty to disclose material risks, breach of that duty, causation and actual harm must all line up.
- If an undisclosed risk materializes and injures the patient, you can sue in tort.
- If no harm happens, you've got breach of contract and battery but not negligence.

Because battery protects a "personal right" (your bodily integrity), it stands alone.

Negligence only kicks in when a procedural slip (like failing to warn of a 1 in 20 chance of nerve damage) actually manifests in nerve damage you wouldn't have accepted.

Next steps to explore:

- The criminal side how IPC sections on "voluntarily causing hurt" map onto medical battery.
- Consumer Protection Act and whether "lack of consent" alone counts as a

“deficiency in service.”

- Ethical codes vs. legal codes: should disciplinary panels, not courts, handle pure battery-by-bioethics?

Which thread should we pull on next?

Q. A deficient consent harms the surgeon not the patient. Deficient consent is not no consent. Will you please conclude for the benefit of an honest regularly performing surgeon?

AI: > Here’s the bottom line for a straight-shooting surgeon who always wants to stay out of trouble:

1. Treat consent as your first line of defense.

- Sit down, explain the diagnosis, the nature of the procedure, all “material” risks (even those under 5 percent), reasonable alternatives and what happens if you do nothing.
- Make sure the patient actually understands use plain language, ask them to repeat back, note it in your chart.

2. Get it in writing (and, if you like, on video).

- A signed, procedure-specific consent form that lists the key risks presumptively “assumes” those risks.
- But it’s not bulletproof against every claim courts will still ask: “Did you really warn of what mattered to this patient?”

3. Remember what each legal claim demands:

- Battery/contract breach = you performed without valid consent at all. No harm needed.

Equation 2 on necessary things for taking a Consent

$\text{Valid Consent} = \text{Material Risk Disclosure} + \text{Voluntary Agreement} + \text{Competence Assessment}$
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Q. Consumer protection law renders even medical consent into a contract. The patient is a client- a contracting party. The physician is the service provider for agreed consideration. Is there a concept of client autonomy here?

AI: Under consumer-law, the doctor patient relationship is formally “booked” as a service contract: the patient is a “consumer,” the doctor a “service-provider,” and the fee paid is the “consideration.” Yet the very idea of contracting in medicine sits uneasily alongside the long-standing principle of patient autonomy. Here’s how the two fit together:

- Negligence = you failed to disclose a material risk AND that undisclosed risk actually injured the patient.
- If a risk you warned about occurs, you’re generally safe even if the patient sues.

4. Document relentlessly.

- Quick note after your consent discussion time, place, who was there, how long you spoke, what concerns the patient raised.
- That note is gold in any court or complaint-panel.

5. Run your practice under ethical and statutory guardrails.

- Follow IMC Regulations on disclosure.
- Treat consent as a dynamic process refresh it if the plan changes.

By nailing every step of informed consent, you convert “deficient consent” from a lurking liability into a legal fortress (Equation 2). An honest surgeon who errs only in paperwork but never in care will face a contract or battery claim at worst, not a negligence suit for a perfectly performed operation.

Practical Implications

- **Emergencies:** Benefit intent overrides consent (Implied consent doctrine)
- **Documentation:** Audio visually recorded consents on record alongwith written consent reduce negligence claims
- **Consumer Law:** CPA 2019 treats deficient consent as "deficiency in service"

1. Contractual framing vs. ethical autonomy

- Under the Consumer Protection Act, 2019, “medical services” supplied for a fee fall within the Act’s definition of “service,” so poor outcomes or deficient care can be challenged as breach of contract/deficiency of service in consumer forums.
- But unlike a straightforward commercial transaction, medicine carries a duty of care grounded in professional ethics. A patient can’t be “sold” an operation the way one sells a toaster there must first be valid consent.

2. What autonomy means in medicine

- Autonomy is the right of a competent individual to make free, informed choices about their own body and treatment what to accept, what to refuse, and on what basis.
- Ethically and legally, autonomy is protected by: Tort law (assault/battery for treatment without consent) Constitutional guarantees (life and personal liberty under Art. 21) Contract law (consent as meeting of minds) Medical regulations (duty to disclose material risks and alternatives)

3. Informed consent as the nexus of contract and autonomy

- The “**consumer**” buys a medical service, but the contract is conditional on valid, informed consent i.e., the patient must understand the nature, purpose, risks, benefits and alternatives before agreeing.
- In India’s landmark Samira Kohli case, the Supreme Court held that consent must be “**real or valid**,” not a mere signature. Doctors must disclose risks per a doctor-centered standard (the Bolam test), but courts signaled the need to revisit this towards a more patient centered standard over time.

4. Does consumer law enhance or erode autonomy? Pro-autonomy effects: Patients gain contractual rights to transparency, redress and choice of provider. Consumer forums can force disclosure of hospital practices and consent-form contents (e.g., NCDRC striking down pre-printed “**blanket**” consent clauses as unfair trade practice). Possible downsides: Contractual mindset may reduce medicine to “**buyer beware**,” ignoring the fiduciary doctor patient bond. Power asymmetry and information gaps may mean consent remains nominal unless robustly enforced.

Bottom line Yes “**client autonomy**” remains a core concept. Even within a consumer-contract framework, the law insists that consent be informed, voluntary and revocable. Consumer protection law simply adds a layer of contractual right to existing tort, constitutional and ethical protections of autonomy it doesn’t replace them.

Next up, would you like to explore how

courts balance the Bolam doctor-standard against a more modern “**reasonable patient**” disclosure test? Or perhaps discuss practical steps hospitals can take to strengthen genuine informed consent?

Q. Isn't it True: A client patient has all the rights to seek all details about the medical service he is contracting. He has a right to know everything. In medical consent he certifies that he has asked all the questions he wanted to be answered about the service. He should not sign the consent otherwise. Wouldn't Law for waiver operate if he fails to exercise his right?

AI. Your observation raises a significant point about informed consent and waiver in medical practice. Legally, every patient does indeed have the right to receive complete, accurate, and comprehensible information about the service they are about to receive. Informed consent is conceived not merely as a signed piece of paper, but as a process grounded in patient autonomy where the patient is expected to be an active participant in understanding the risks, benefits, and alternatives of the proposed treatment.

However, the notion that a patient’s failure to question or request further detail constitutes a full waiver of rights is far from straightforward. In principle, if a patient signs a consent form that includes a declaration stating he or she has asked all desired questions and received answers to those inquiries, it might be argued that the patient has, on the surface, waived further claims arising from any subsequent dissatisfaction or claim of incomplete disclosure. This is often termed an “**express waiver**” within the consent document. Still, courts tend to scrutinize such waivers very closely.

Legally, the onus to ensure that the patient is truly informed doesn’t rest solely on the patient’s initiative to ask questions it is also the physician’s responsibility to proactively disclose all material information. If it later emerges that the healthcare provider omitted crucial details or failed to explain the procedure in a manner that met the standard expected by the “**prudent patient**” test, the signed consent form may not serve as an effective shield against liability. In such cases, the waiver might be deemed invalid because the patient’s consent was not fully informed despite the form’s declarations.

In summary, while there is a legal mechanism whereby a patient's signature on a detailed consent form could imply a waiver of further questioning; this does not automatically and unconditionally protect the provider. The waiver only holds if the entire process of informed consent is properly conducted. A lapse by the patient in exercising their right to ask questions cannot retroactively validate insufficient disclosure. Thus, the "law for waiver" does not operate in a vacuum it must be supported by a robust, clear, and comprehensive disclosure by the healthcare provider.

This delicate balance ensures that while patients are empowered to seek clarification and information, healthcare providers remain bound by professional duties to ensure that consent is genuinely informed. If you'd like to dive deeper into how judicial precedents have handled disputes over the adequacy of informed consent or explore related statutory nuances, we can discuss landmark cases and statutory interpretations further.

Q. Unilateral obligation to fully disclose every detail in a risky surgery is understandable. But medical consent is taken for every procedure, diagnostic and therapeutic, to be performed, including medicines prescribed. If he is legally obliged to disclose every possible risk of adverse consequences of every consented act of treatment, that he is aware of, he will have no time to treat. The law has to be rational and pragmatic. The physician and patient are not adversaries.

AI: > Your observation brings us to a central tension in medical law and ethics. While full disclosure is critical in high-risk surgical procedures, requiring an exhaustive inventory of every conceivable adverse consequence for every act of treatment would be both impractical and counterproductive. The law is designed to be both rational and pragmatic, and it recognizes that the informed consent process must strike a balance between ensuring patient autonomy and maintaining the efficiency of patient care.

In practice, the concept of "material risk" is key. Physicians are generally required to disclose risks that a reasonable patient would consider significant to their decision-making process. For routine diagnostic tests, therapeutic procedures, or even medications, it is neither necessary nor feasible to enumerate every

theoretical risk if those risks are exceptionally rare or clinically insignificant. Instead, what is expected is a clear communication of the common, serious, and potentially life-altering risks, along with an invitation for the patient to ask questions. In this way, the physician ensures that the patient understands the critical points without getting overwhelmed by minutiae that might only serve to delay treatment or create undue anxiety.

Moreover, the consent process is fundamentally a dialogue, not a one-sided declaration. The responsibility to ask questions or seek further clarification is shared. While patients are encouraged and indeed have the right to ask for more details, the physician is professionally obligated to deliver information in a manner that is comprehensible and relevant. This cooperative dynamic underscores that the physician and patient are partners in the decision-making process rather than adversaries. Such an approach protects patient autonomy while allowing healthcare providers to focus on delivering care effectively.

Thus, the legal framework does not impose an unrealistic, unilateral burden on physicians to disclose every possible risk. Instead, it demands a balanced disclosure of material risks, guided by what a reasonable patient would consider important. In doing so, it respects both the need for informed consent and the practical realities of medical practice. This pragmatic approach helps avoid information overload and ensures that the physician can continue providing timely and effective treatment without being bogged down by an unworkable standard of comprehensive disclosure.

CONCLUSION

BNS decouples "harm" from "injury," centering liability on **illegality of conduct**. Physicians acting in good faith with valid consent retain statutory immunity (Sec 26). Deficient consent remains a contractual breach but requires causal harm for negligence. Pragmatic disclosure of material risks not theoretical minutiae balances autonomy with clinical efficiency.

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