CASE COMMENT ON

Dr. C.P. SREEKUMAR V. S.RAMANUJAN

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INTRODUCTION

This landmark verdict by the Supreme Court of India goes into the nitty-gritty of medical negligence in the context of tort law and the Consumer Protection Act,1986.

ORIGIN OF THE CASE:

1. The case stemmed from a complaint made by Mr. S.Ramanujan against De. C.P. Sreekumar and his hospital, Surya hospital.
2. The row was over the handling of a hip fracture caused to Mr. Ramanujan in a road accident. A minor hairline fracture received initially allegedly developed into a more complicated fracture during the patient, stay in the hospital. The patient was then operated upon with a surgery called hemiarthroplasty. The complainant claimed negligence on three main fronts, which is mishandling by hospital staff, which resulted in the fractured to aggravate, a wrong selection of surgical intervention, and infection post operation.

It may be noted that litigation of this kind proliferated rapidly in the years following the extension of consumer protection remedies to medical services, with commentators observing a marked rise in patient awareness and a corresponding increase in negligence complaints before consumer fora. This expansion in litigation heightened the need for the judiciary to articulate a workable threshold capable of distinguishing a genuine lapse in care from an unavoidable clinical complication.[1]

[1] S V Joga Rao, 'Medical Negligence Liability under the Consumer Protection Act: A Review of Judicial Perspective' (2009) 25(3) Indian Journal of Urology 361.

3. The case examines the standard of care that can be expected from a medical practitioner, The pivotal position of evidence, and establishing negligence, and the application of well-settled regal principles, such as the Bolam test in the Indian legal framework.

STAGES OF THE CASE:

1. In May 1993, Mr Ramanujan filed the initial complaint at State Consumer Disputes, Redressal Commission. After the trial, which included the examination of Dr SreeKumar, the state commission by its order dated 29 January, 1999, dismissed the complaint. It found no evidence of negligence or deficiency in service, noting specifically that complainant had had failed to produce any witnesses or even appear as a witness himself to substantiate his claims.
2. Aggrieved by the dismissal, Mr Ramanujan appealed to the National Commission, via its order on November 15, 2006 allowed the appeal. It held the Dr. liable for negligence, concluding that the fracture had worsened to mishandling by hospital and that the chosen surgical procedure was inappropriate for a patient of the respondent age which was 42 years. It awarded a total compensation of ₹5.5 lakh.
3. The final stage saw two crossing appeals in Supreme Court. Dr. SreeKumar appealed seeking the dismissal of complaint and the setting aside of National Commissions order. Mr. Ramanujan also appealed seeking an enhancement of the compensation to ₹12 lakh. The Supreme Court heard both appeals together and delivered the final judgement, allowing the doctors appeal and dismissing the patient's complaint.

LEGAL PROVISIONS INVOLVED

- Section 21 of Consumer Protection Act,1986[2] - jurisdiction of National Consumer Disputes Redressal Commission.
- Section 23 of Consumer Protection Act,1986[3]- any person aggrieved by order from NCDRC to file an appeal to Supreme Court within 30 days of order.
- The case does not rely on specific statutory provisions, but on legal principles established through case law. While adjudicating under the consumer protection act, 1986, it is legal foundation is built on common law, precedents.

[2] Consumer Protection Act, 1986, No. 68 of 1986, § 21 (India).

[3] Consumer Protection Act, 1986, No. 68 of 1986, § 23 (India).

• Medical ethics principles-

1. The duty to possess requisite skill and knowledge.
2. The duty of reasonable care and diligence.
3. The standard of care in treatment.
4. The primacy of patient welfare.

• ICMR's ethical guidelines-

1. Principle of professional competence
2. Principle of adherence to scientific standards
3. Principle of professional Judgement

It is worth noting that the ethical framework governing medical practice in India remains institutionally unsettled: the National Medical Commission's 2023 Professional Conduct Regulations, intended to update the earlier Code of Ethics, were placed in abeyance within three weeks of notification, with the result that the 2002 Regulations framed by the since-superseded Medical Council of India continue to apply. This regulatory flux illustrates that judicially articulated standards of care, such as those applied in the present case, have often had to operate independently of a settled statutory or regulatory code of conduct.[4]

• The judgement heavily cited the Bolam Test.

• Applies the principles laid down in Jacob Mathew V. State of Punjab,

FACTS

First. On 31 December 1991, 42year old Mr S Ramanujan was struck by a motorcycle and injured in his right leg. He was admitted to the care of Dr C.P. Sreekumar at Surya hospital. An x-ray disclosed a Garden type 1 hairline fracture of the neck of the right femur, Dr. Sreekumar chose to treat the leg, conservatively, mobilising it in a plaster cast. Under the widely used Garden classification for femoral neck fractures, Type I and II injuries are considered undisplaced and are generally amenable to conservative management or internal fixation, whereas Type III and IV fractures are displaced and

[4] Shouryendu Ray and Vatsala Poddar, 'National Medical Commission Professional Conduct Guidelines: A Knee-Jerk Approach to Medical Regulation' (Bar and Bench, 17 September 2023) <https://www.barandbench.com/columns/nmc-professional-conduct-guidelines-a-knee-jerk-approach-to-medical-regulation> accessed 19 August 2026.

more often call for arthroplasty. This clinical distinction is significant, since it was the later reclassification of the fracture from Type I to Type III that formed the basis of the decision to operate.[5]
Second on January 8, 1992, during preparation for discharge of the patient in x-ray was performed to the surprise, it showed that the simple fracture had displaced and deteriorated to Garden type 3 fracture.

Third because of this complication, Dr. Sreekumar decided that surgery had to be performed. After discussing the alternatives, he did a hemiarthroplasty on January 10, 1992, with consent of the patient. This is a procedure where in half of the hip joint, (the femoral head) is replaced.

Fourth, the patient after the surgery developed a superficial infection and was discharged on February 5, 1992. Mr Ramanujan complained that the fracture was aggravated by rough handling of award boy and labourers while he was being shifted for x-ray. He also argued that hemiarthroplasty was an inappropriate procedure for a person of his age for whom internal fixation would have been the better option.

The development of a superficial infection following hemiarthroplasty is not, by itself, unusual. Epidemiological reviews of hip fracture surgery report surgical site infection rates of approximately three percent after hemiarthroplasty, a complication associated more closely with patient frailty, wound care and length of hospital stay than with any particular lapse by the operating surgeon. This clinical background is relevant to assessing whether the infection reported in the present case could, without more, be treated as evidence of negligence.[6]

Fifth the physician said that the patient was becoming a nuisance in the hospital, and so he paid him an ex gratia of ₹50,000 to calm him down. The patient, however, insisted that this was an advance payment towards the settlement of ₹3 lakh.

Sixth on account of recurring pain, Mr Ramanujan saw other physicians. Eventually, on April 24, 1995, more Than three years. After the first surgery, he had a total hip replacement by Dr Mohandas in another hospital. Subsequently, he modified his complaint with the State Commission, raising his complaint for compensation to ₹12 lakh from ₹3 lakh.

ISSUES

1. Whether Dr SreeKumar was qualified to undertake a hemiarthroplasty and whether he opted for his operation because he did not have the skill for the alternative (internal fixation).

[5] Jon Olansen, Zainab Ibrahim and Roy K Aaron, 'Management of Garden-I and II Femoral Neck Fractures: Perspectives on Primary Arthroplasty' (2024) 16 Orthopedic Research and Reviews 1.
[6] J Masters, D Metcalfe, J S Ha, A Judge and M L Costa, 'Surgical Site Infection after Hip Fracture Surgery: A Systematic Review and Meta-Analysis of Studies Published in the UK' (2020) 9(9) Bone & Joint Research 554.

2. Whether the hospital staff's negligence resulted in the aggravation of the fracture from Garden type 1 to Garden type 3.
3. Whether hemiarthroplasty was the correct surgical intervention for a 42 year old patient in such circumstance.

ARGUMENTS OF THE PARTIES

Arguments of the appellant (Dr. C.P. SreeKumar):

1. The main ground of appeal was that the National commission had erroneously accorded the respondent's allegations in his complaint the status of established facts. No ocular or expert evidence in support of his allegations of misconduct or improper handling of the case was forthcoming from the respondent. The respondent did not even appear in the witness box himself.
2. The physician contended that the fracture displacement was not caused by mishandling but resulted from a natural and involuntary muscular spasm, which is a recognised complication. His statement on this issue was not contradicted by any evidence to the contrary adduced by the respondent.
3. It was contended that the selection of hemiarthroplasty was a professional decision in the best interest of the patient. The objective was to provide faster recovery as well as ambulation. The decision was taken after noting during the surgery that the health of the bone had weakened.
4. The lawyers argued that there was no hard and fast rule hemiarthroplasty was absolutely excluded for individuals below 60. While internal fixation may be the preferred method, hemiarthroplasty was an accepted alternative in medical practice, and the option is based on numerous factors unique to the patient.
5. The payment of ₹50,000 was not an admission of culpability but was done solely to "mollify the respondent was making a nuisance"

Arguments of the respondent (S. Ramanujan):

1. The respondent, presenting in person, strongly asserted that the fracture was displaced because of the forceful mishandling by an unqualified ward boy and workers when he was shifted for the X-ray.
2. He theorised that the standard medical literature explicitly says that for a patient who is 42 years old, every attempt at all costs must be done to retain the natural femoral head with internal

fixation. Hemiarthroplasty, he believed was a procedure for old sedentary patients. This reflects a genuine and continuing divide in orthopaedic practice. Comparative reviews note that while internal fixation is conventionally preferred for younger patients with undisplaced fractures, arthroplasty is increasingly favoured once a fracture becomes displaced, since the risk of the fixation failing or of the femoral head losing its blood supply rises sharply. The persistence of this clinical disagreement lent some credibility to the respondent's argument, even though, without expert evidence, it did not establish that the appellant's specific choice was unreasonable.[7]

3. He claimed that the physician selected hemiarthroplasty as he did not have the required expertise to do the more complicated procedure of internal fixation.
4. The respondent kept asking for the case to be remanded to the State Commission so that he could produce evidence, alleging that his earlier lawyer had conspired with the doctor and intentionally discouraged him from doing that. This was denied by Supreme Court, citing the inordinate delay (18 years after the incident).

DECISION

The Supreme Court, after a careful reading of facts, evidence and legal principles, admitted Dr. SreeKumar's appeal and rejected Mr. Ramanujan's grievance. As a result, the respondent's cross appeal seeking enhancement of compensation was rejected and the National Commission's order granting ₹5.50 lakh was revoked.

OBITER DICTUM

The bench of Justice Harjit Singh Bedi and Justice Dalveer Bhandari, drawing support from earlier judgements made salient observations-

The court reaffirmed that unwarranted suspicion about the negligence of doctors and undue interference by courts would be a highly perilous idea, it would deter doctors from making crucial decisions in complicated scenarios, which would ultimately harm the patient who would be the ultimate victim.

It was seen that if the medical field is always at the risk of civil and criminal proceedings, physicians would be discouraged from taking reasonable risks to salvage patients with complex illnesses or

[7] Olansen, Ibrahim and Aaron (n 10).

unforeseen complications in surgery. This would create a culture of "defensive medicine" that is not good for society.

RATIO DECIDENDI

The high court ruled that the burden of establishment of medical negligence rests squarely on the complainant and this has to be proved by adducing cogent evidence. A complaint by one party, denied by the opposite party, cannot be considered as evidence. The inability of the complainant to come up with any expert or factual evidence in substantiation of his allegations of mishandling by hospital personnel was a fatal flaw in his case.

Adopting the principles of Jacob Mathew V. State of Punjab[8], which embraces Bolam test, the court held that a doctor will not be held liable for negligence provided they adhere to an accepted practice among the medical profession at that time. The decision to undertake a hemiarthroplasty even for a young patient constituted a school of thought among doctors. The physician was not negligent just because a better-trained physician would have selected a different procedure (internal fixation).

The court had accepted the unchallenged expert evidence of the doctor that the fracture must have deteriorated as a result of natural muscular spasm, rather than rough handling. The complainant had offered no evidence to counter this clinical explanation, negligence could not be established beyond doubt. The doctor's choice was a one of professional judgement formed on his clinical evaluation and there was no evidence to establish that it was palpably wrong.

CRITICAL ANALYSIS

Following the Supreme Court is ruling in Indian medical Association v. V.P. Shantha[9] in 1995, medical services came under consumer protection act,1986 and consumer forums received a flood of complaints against physicians. There was a pressing need to establish the parameters of " deficiency in service" in a medical setting. Empirical accounts of this litigation surge note that compensation awards for medical negligence in India have, in the years since, occasionally reached extraordinary sums, including an award of approximately eleven crore rupees by the Supreme Court in 2013 and an award of one crore rupees by the National Consumer Disputes Redressal Commission in 2022. Such figures illustrate why appellate courts came under increasing pressure to draw a clear and workable

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

[9] Indian Medical Ass'n v. V.P. Shantha, (1995) 6 SCC 651

line between compensable negligence and an unfortunate clinical outcome.[10] The prime challenge was to separate legitimate, malpractice and unfortunate results that are part and parcel of medical practice. Courts required a clear standard in order to avoid doctors being held responsible for any lapse of judgement or for choosing between two acceptable mode of treatment. It was in such a backdrop that the 2009 judgement in Dr. C.P. Sreekumar V. S.Ramanujan[11] came as a landmark, precedent decisively clarifying the high threshold, a complainant is required to clear in order to establish a doctor civil liability.

How the standard of care in Consumer Law evolved?

The building block of doctor's duty of care was laid out in Dr. Laxman Balakrishna Joshi V. Dr.Trimbak Bapu Godbole[12]. Yet to apply this to the consumer law model needed a more refined standard. The quotes increasingly picked up on the Bolam test under English law. , Which compares the doctors action to the practices of an approachable body of medical opinion. This test was ratified by the Supreme Court in Jacob Matthew V. state of Punjab. While a criminal judgement, its elaborate explanation of the test of care became the guiding precedent for civil matters as well. The Sreekumar case is the purest use of the Jacob Matthew guidelines to a urely consumer grievance, establishing the test for all future civil negligence cases.

The SreeKumar judgement gave an accurate definition of "deficiency and service" for medical doctors. The Supreme Court held that deficiency cannot be inferred just from an unsuccessful treatment. To establish deficiency, a complainant would have to show that the doctors conduct was a departure from a standard of care accepted as proper by other competent members of the profession in that field. The court specifically defined that selecting one accepted course of medical treatment over another though not as frequently practised is not a deficiency.

The reasoning of the court rested on two pillars-

1. The primacy of Bolam test- The court considered the decision between internal fixation and hemiarthroplasty. It discovered that although one was favoured for a younger patient, the other was also an accepted School of thought. Thus, the decision by the doctor according to his clinical judgement was not negligent.
2. The inviolable onus of proof- In a critical manner, the court stated that cogent evidence must be provided by the claimant. It believed the doctor's clinical account of a muscular spasm since the

[10] Suresh K Pandey and Vidushi Sharma, 'Alarming Rise in Consumer Cases/Medical Malpractice Claims with Huge Compensation: How to Safeguard Medical Professionals?' (2023) 71(3) Indian Journal of Ophthalmology 1041.
[11] Dr. C.P. Sreekumar, M.S. (Ortho) v. S. Ramanujam, (2009) 7 SCC 130.
[12] Laxman Balkrishna Joshi v. Trimbak Bapu Godbole, A.I.R. 1969 S.C. 128

patient provided no expert evidence to rebut it. The judgement founded the rule that a doctor's reasonable explanation will succeed over a patient complaint unless disproven by credible evidence.

Criticism of the Precedent:

Although the judgement safeguards doctors against spurious lawsuits, it is severely criticised for generating an unbalanced process. The main criticism is that it overlooks the huge information asymmetry between a patient and a doctor. A doctor may provide an intricate clinical explanation that an ordinary person is not able to rebut. By making the entire onus of refutation fall on the patient the court exacerbates this handicap. In addition the need for expert opinion collides with the practical obstacle of the "conspiracy of silence", under which physicians are reluctant to testify against other physicians. This structural difficulty is compounded by the limited effectiveness of professional self-regulatory bodies as an alternative source of accountability. Investigative reporting has found that a large proportion of complaints filed with state medical councils remain undecided for years, with one such inquiry finding that a state medical council had taken action against only a handful of doctors over an entire decade. Where neither the courts nor the profession's own regulators readily supply independent evidence of substandard care, the burden placed on the complainant by decisions such as the present one can operate, in practice, as a near-insurmountable barrier.[13] This leaves many legitimate victims of incompetence in their cases because they are unable to get access to the evidence themselves that the court demands. The judgment should be appreciated for bringing balance to the two competing interests of the community; patient protection from negligent medical practice and the protection of doctors from unreasonable liability for reasonable professional practice. The judgment is correct in condemning the practice of defensive medicine. Such a protection of doctors must be balanced by accountability. The real value in the judgment is not in immunizing doctors from liability. This value is found in requiring courts to distinguish an unlucky outcome in a medical case from a clear departure from the accepted standard of practice.

It is worth situating this deference to professional consensus within a broader comparative trend. Commentators tracking Indian medical negligence jurisprudence have observed a gradual, if uneven, shift away from purely Bolam-style deference toward a more patient-centred standard that also scrutinises whether the patient's autonomy and right to information were respected. Read alongside that trend, the Sreekumar judgment's emphasis on professional consensus may be better understood

[13] D Arora, 'In India, Medical Negligence Law Exhibits an Unhealthy Reliance on Expert Testimonies' (The Caravan, 7 January 2016) <https://caravanmagazine.in/vantage/in-india-medical-negligence-law-exhibits-an-unhealthy-reliance-on-expert-testimonies> accessed 19 August 2026.

as addressing the narrower question of clinical competence, rather than as a comprehensive template for every dimension of the doctor-patient relationship.[14]

CONCLUSION

The Sreekumar decision demonstrates the Balancing Act the Supreme Court does to strike the right cord between patient protection and medical practitioner's right to professional autonomy. The decision states that poor medical outcomes do not equate to negligence. To prove negligence, a personal injury/medical malpractice attorney needs to prove the medical professional's actions fell outside what a prudent practitioner would have done in the same circumstances. With the Bolam Test and Jacob Mathew v. State of Punjab, the court established that a Medical Practitioner should not be liable for negligence if another medical practitioner would have taken that same course of action.

The balance struck in Sreekumar continues to be tested in subsequent litigation. In 2024, a two-judge Bench of the Supreme Court itself observed that the precedent bringing doctors within consumer protection law might warrant reconsideration by a larger Bench, though a subsequent review petition seeking such reconsideration was dismissed in 2025. This unresolved debate underscores that the tension between patient protection and professional autonomy identified in the present case remains a live and unsettled question in Indian law.[15]

It is concerning that the decision does nothing to address access to justice for patients. The High Threshold of cogent and expert evidence will probably be impossible for the average patient to satisfy. The great difference in the medical profession knowledge, access to medical records, and the availability of expert medical professionals will make the examination of whether the proper standard of care was provided almost impossible. It will help to serve the patient's interests to have medical liability cases structured differently where the evidence would not be almost exclusively in the possession of the medical professionals.

What is most significant about the decision is that it does more to help Medical professionals avoid unwarranted professional negligence suits. The Bolam Test should not provide medical practitioners absolute professional negligence immunity. Professional judgment should be subject to appropriate

[14] K Kannan, 'From Tort to Trial: Medical Negligence, Consumer Protection, and Rise of Defensive Medicine' (LiveLaw, 18 May 2025) <https://www.livelaw.in/articles/law-on-medical-negligence-in-india-critical-analysis-292573> accessed 19 August 2026.

[15] 'Supreme Court Refuses to Review Order Affirming Doctors' Liability under Consumer Protection Act' (LiveLaw, 18 February 2025) <https://www.livelaw.in/top-stories/supreme-court-doctors-consumer-protection-act-review-petition-against-order-refusing-reconsideration-of-vp-shantha-judgment-dismissed-284299> accessed 19 August 2026.

judicial review when there is evidence of a departure from acceptable practice, inadequate care, or a lack of respect for patient autonomy.

Judgment directs us toward balance: law must accommodate the right of doctors to exercise professional judgment, but it must protect the interests of patients from violence caused by negligence. For this reason, medical negligence law must balance the scope of professional judgment, patient safety, and the right of patients to an effective remedy.