HIGH COURT OF JUDICATURE FOR RAJASTHAN AT JODHPUR

S.B. Criminal Misc(Pet.) No. 7844/2024

1. Vinod Shaily S/o Late Shri Purshottam Shaily, Aged About 59 Years, General And Endoscopic Surgeon At Vasundhara Hospital, 11 Sector, C.h.b. Jodhpur.
2. Jitendra Khetawat S/o Shri Bhanwar Lal Khetawat, Aged About 42 Years, Anaesthetist And Critical Care Consultant At Vasundhara Hospital, 11 Sector, C.h.b. Jodhpur.

----Petitioners

Versus

1. State Of Rajasthan, Through Pp
2. Sahiram Bishnoi S/o Nathuram, R/o A225, Saraswati Nagar, Basni, Jodhpur (Rajasthan)

----Respondents

Connected With

S.B. Criminal Misc(Pet.) No. 7770/2024

1. Sanjay Makwana S/o Mr. Sudhakar Makwana, Aged About 60 Years, Vasundhara Hospital, Sector 11, Chopasni Housing Board, Jodhpur, 342008.
2. Dr. Renu Makwana W/o Dr. Sanjay Makwana, Aged About 58 Years, Vasundhara Hospital, Sector 11, Chopasni Housing Board, Jodhpur, 342008.

----Petitioners

Versus

1. State Of Rajasthan, Through Pp
2. Sahiram Bishnoi S/o Nathuram, A 225, Saraswati Nagar, Basni, Jodhpur, Distt. Jodhpur (Raj.)

----Respondents

For Petitioner(s)	:	Mr. Dhirender Singh, Sr. Advocate assisted by Ms. Priyanka Borana Mr. Muktesh Maheshwari Ms. Vandana Bhansali
For Respondent(s)	:	Mr. Deepak Chaoudhary,AAG

Mr. Vikram Singh Rajpurohit,Dy.G.A.
Mr. Naman Mohnot

HON'BLE MR. JUSTICE FARJAND ALI

Order

Reportable

ORDER PRONOUNCED ON ::: 05/05/2025
ORDER RESERVED ON ::: 07/04/2025

1. By way of filing these instant criminal misc. petitions under Section 528 of the Bharatiya Nagarik Suraksha Sanhita, the petitioners seek quashing of F.I.R. No. 388/2024 registered at Police Station Chopasni Housing Board, District Jodhpur on 25.10.2024 for the alleged offence under Section 105 of the Bharatiya Nyaya Sanhita and all consequential/subsequent proceedings arising therefrom.

2. The foundational facts as alleged in the First Information Report (FIR) are as follows:

   The complainant, alleges grave medical negligence in relation to the treatment administered to his daughter-in-law, Mrs. Priyanka Bishnoi, who was admitted to Vasundhara Hospital on 05.09.2024 for a minor uterine fibroid surgery. It is claimed that she was assured of the simplicity of the procedure, and shortly after admission, without comprehensive diagnostic work-up or pre-operative preparedness, she was rushed into surgery involving hysteroscopy, laparoscopy, and trans-cervical resection of myoma. The complainant contends that essential pre-

surgical protocols, including the INR (International Normalized Ratio) test, were not conducted. Post-operatively, the patient's condition reportedly deteriorated rapidly, with persistent unconsciousness, yet she was transferred to a general ward without requisite neurological assessment or CT brain imaging. The attending medical staff allegedly downplayed the gravity of her condition and attributed her non-responsiveness to minor cerebral inflammation without diagnostic confirmation. Despite signs of severe hemorrhage and administration of multiple blood transfusions, the hospital allegedly continued to misrepresent her clinical condition as stable. On 07.09.2024, when her condition worsened further, she was referred to Marengo CIMS Hospital, Ahmedabad. There, clinicians immediately diagnosed her with critical intracranial hemorrhage—confirmed via CT scan—and opined that prior failure to undertake such imaging and timely intervention constituted a breach of medical protocol. A report by a committee constituted under the District Collector's order revealed stark inconsistencies between the hospital's version and that of the patient's attendants. The committee also recorded that the patient suffered from post-operative sepsis, MODS (Multiple Organ Dysfunction Syndrome), and DIC (Disseminated Intravascular Coagulation), none of which were promptly or appropriately addressed. It also highlighted the failure to conduct a CT brain scan despite neurologists recommending it, terming it a serious clinical lapse.

Further, the complainant asserts that the hospital's director, Dr. Sanjay Makwana, later attributed Priyanka's deterioration to a congenital AVM (arteriovenous malformation) and a brain tumor. However, imaging conducted at CIMS Hospital reportedly refuted the presence of any such conditions. Priyanka Bishnoi succumbed on 18.09.2024. The complainant holds that her death resulted from deliberate medical negligence and concealment of critical facts by the treating doctors and hospital staff. He submitted complaints to the police authorities on 17.10.2024, yet no FIR was registered; instead, a Marg report was initiated.

3. It is this sequence of events, culminating in the registration of the impugned FIR, that has constrained the present petitioners—who are neither the treating physicians nor directly implicated in the clinical decision-making—to invoke the extraordinary jurisdiction of this Court under Section 528 of BNSS, seeking quashing of the said FIR and all consequential proceedings arising therefrom.

4. In furtherance of the investigation, a factual report dated 04.04.2025 was received from the Office of the Additional Deputy Commissioner of Police, Women Crime Investigation Cell, Jodhpur West, summarised as under:

   As per the factual report dated 04.04.2025 from the Office of the Additional Deputy Commissioner of Police, Women Crime Investigation Cell, Jodhpur West, the case arises from a

private complaint by Shri Sahiram Bishnoi regarding alleged medical negligence at Vasundhara Hospital, Jodhpur, in the treatment of his daughter-in-law, Priyanka Bishnoi (R.A.S.), who was admitted on 05.09.2024 for a minor fibroid surgery. It is alleged that the hospital neglected critical pre-operative protocols such as INR testing and failed to respond to post-operative complications including unconsciousness, delaying appropriate neurological evaluation and referral. She was eventually shifted to Marengo CIMS Hospital, Ahmedabad, where she was diagnosed with severe intracranial hemorrhage, sepsis, MODS, and related conditions, and died on 18.09.2024. Subsequent investigation involved collection of hospital records, witness statements, postmortem, histopathology, and FSL reports, and CCTV footage from six sealed hard disks sent to FSL Jaipur. A state-level medical committee reviewed records, including those provided via letters VHL/LET/2025-26/08 and 09 dated 22.02.2025, and convened at SMS Hospital, Jaipur on 03.03.2025. The committee concluded that while intracranial hemorrhage and MODS were established causes of death, the precise cause of rapid sepsis and DIC within 24 hours of surgery could not be determined scientifically. Though such complications can occur despite appropriate care, negligence could not be definitively established beyond reasonable doubt. The committee advised further investigation and permitted scope for a secondary expert review if deemed necessary. Additional records from Vasundhara Hospital and visual

evidence, including postmortem videography and photographs, were included in the case file. As per the cumulative investigation to date—including earlier district and state-level committee reports—the evidence does not establish prima facie negligence by the hospital doctors.

5. Written Submissions of Petitioners

The learned counsel for the petitioners submitted that the allegations in the FIR, even if taken at face value, do not disclose a prima facie case of criminal medical negligence, much less any act that could be construed as grossly reckless or unlawful under Section 105 of the Bharatiya Nyaya Sanhita. It is argued that the surgical intervention was carried out in accordance with standard operative protocols, and there is no material to show that the treating doctors failed to exercise reasonable skill or diligence. It is further contended that the initiation of criminal proceedings without first obtaining a competent and independent medical opinion is contrary to the settled law laid down by the Hon'ble Supreme Court in ***Jacob Mathew v. State of Punjab [(2005) 6 SCC 1],*** wherein it was held that criminal prosecution of doctors should be preceded by an expert medical assessment from an impartial source applying the Bolam standard. In the present case, no such pre-requisite expert opinion existed at the time of lodging the FIR, thereby rendering the prosecution premature and procedurally flawed. Reliance is also placed on ***Dr. Rajesh***

Batra v. State of Madhya Pradesh [2024 SC], where it was held that criminal proceedings against doctors based on private complaints are impermissible unless supported by credible expert analysis. It is submitted that the FIR was registered in reaction to the unfortunate death of the patient and not on the basis of any structured or professional medical review. The petitioner also invokes the ratio in ***Dr. Suresh Gupta v. Govt. of NCT of Delhi [(2004) 6 SCC 422]***, which was later affirmed in Jacob Mathew (supra), reiterating that mere error of judgment, inadvertent omission, or unfortunate outcome cannot *ipso facto* constitute criminal negligence. The threshold under criminal law requires conduct so grossly negligent that no prudent medical professional would have acted in such a manner. The submissions stress that no such level of culpability is evident from the record, and in fact, the State Expert Committee itself refrained from attributing negligence. Thus, the petitioner contends that the initiation and continuation of proceedings amount to a misuse of the criminal process, contrary to judicially established safeguards and principles intended to protect medical practitioners from vexatious litigation.

6. Written submissions of Respondent

Respondent No. 2 has opposed the petition, asserting that the case involves serious and specific allegations of gross medical negligence, meriting a full-fledged criminal

investigation and trial. It is contended that the treating doctors failed to conduct the INR (International Normalized Ratio) test, which is a basic and mandatory pre-operative investigation to assess coagulation status and surgical risk. The omission of such a test, despite the patient being taken under general anesthesia, is argued to be not merely procedural but a flagrant violation of the standard of medical care. It is further submitted that when the patient's condition began to deteriorate post-operatively, a neurological consultation was reportedly undertaken and a CT Scan was advised, but the same was deliberately withheld, thereby obstructing timely diagnosis and intervention. It is alleged that false information was disseminated by the hospital, suggesting that the deceased suffered from an AV Malformation, whereas the CT Scan conducted later at CIMS Hospital, Ahmedabad, categorically ruled out such a condition, thereby exposing a misleading narrative. Reliance is placed on the State Expert Committee report and opinions from CIMS Hospital to argue that there was a clear deviation from protocol, including resistance to neurological imaging and the withholding of critical treatment interventions. It is also submitted that two materially different versions of the patient's admission record have surfaced—one submitted to the Expert Committee and another produced before investigating authorities—raising serious concerns of forgery and retrospective fabrication of medical documents. Respondent No. 2 further relies on binding precedents of the

Hon'ble Supreme Court, including ***Jacob Mathew v. State of Punjab [(2005) 6 SCC 1], Kusum Sharma v. Batra Hospital [(2010) 3 SCC 480], and Dr. Suresh Gupta v. Govt. of NCT of Delhi [(2004) 6 SCC 422]***, to argue that the conduct of the hospital and its doctors amounted to recklessness and gross incompetence attracting criminal liability. Foreign precedents such as ***Montgomery v. Lanarkshire Health Board ([2015] UKSC 11) and Roe v. Minister of Health ([1954] 2 QB 66)*** are also cited to bolster the contention that failure to disclose risks and suppress critical diagnostics constitutes actionable negligence. Additionally, it is alleged that there was apathy on part of the investigating authorities in registering the FIR and examining material evidence, further justifying judicial scrutiny at the pre-trial stage.

7. Heard learned counsels present for the parties and gone through the materials available on record as well as written submissions provided by the parties.

8. The foundational principle governing adjudication of medical negligence is encapsulated in the Bolam Test, laid down in the landmark English decision of ***Bolam v. Friern Hospital Management Committee [1957] 1 WLR 582.*** As per this test, a medical professional cannot be held liable for negligence if it is shown that the conduct in question was in accordance with a practice accepted as proper by a

responsible body of medical men skilled in that particular art. The Hon'ble Mr. Justice McNair, in his seminal pronouncement, authoritatively held:

"A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way around, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

9. This legal formulation, recognized and followed by the Hon'ble Supreme Court of India in ***Jacob Mathew v. State of Punjab [(2005) 6 SCC 1],*** reflects the judicial restraint warranted in matters involving complex questions of medical judgment. Courts are not to substitute their lay opinions for the specialized views of qualified medical experts, nor are they to criminalize *bona fide* errors in medical decision-making, unless the negligence is so gross and reckless as to evince a disregard for life and safety.

10. In the present case, the allegations pertain to the alleged medical negligence resulting in the death of Mrs. Priyanka Bishnoi following a fibroid surgery performed at Vasundhara Hospital, Jodhpur. The complainant has sought initiation of criminal proceedings against the treating physicians under Section 105 of the Bharatiya Nyaya Sanhita (formerly Section

304 IPC), alleging culpable negligence in the conduct of surgery, omission of essential pre-operative tests, and delay in critical diagnostic procedures post-surgery.

11. However, in consonance with the Bolam principle, this Court must necessarily examine whether the medical decisions taken were so palpably unreasonable or reckless as to fall outside the ambit of what a competent body of professionals would endorse. In this regard, the matter was referred, out of abundant caution, to a State-Level Medical Expert Committee, which, after a thorough evaluation of the clinical records and procedural chronology, unequivocally concluded that no prima facie evidence of medical negligence was found. It was further observed that the complications which ensued were known medical risks, and that the line of treatment adopted was within the scope of acceptable clinical discretion. This Court takes judicial note of the State-Level Committee Report dated 21.09.2024, constituted pursuant to directions issued by the Directorate of Medical Education, Rajasthan, to examine the clinical management, institutional protocols, and possible medical lapses in the treatment of the deceased, Mrs. Priyanka Bishnoi. The Committee, after a physical inspection of Vasundhara Hospital and detailed analysis of the records, observed that the patient developed postoperative sepsis with Disseminated Intravascular Coagulation (DIC) and multi-organ failure, and that while she was treated in an NABH-accredited facility equipped with

standard infrastructure, the absence of complete documentation—particularly from the referral hospital at Ahmedabad—and the non-availability of conclusive post-mortem histopathology reports precluded the committee from determining the precise cause of death or ruling out systemic lapses. Notably, the Committee refrained from making any definitive finding that would amount to a charge of medical negligence. These findings assume significance in the context of the criminal allegations raised and must be weighed with circumspection.

12. It is a trite proposition that when a duly constituted medical board comprising domain experts has opined against the existence of negligence, and when no contra expert opinion has been produced to establish a reckless or impermissible departure from the standard of care, criminal prosecution under Section 105 BNS cannot be sustained. The law requires that for an act to constitute criminal medical negligence, it must transcend mere error of judgment and amount to a gross dereliction of duty, evidencing either *mens rea* or an utter disregard for patient safety—a threshold not satisfied in the instant case.

13. Having regard to the allegations made and the circumstances surrounding the demise of the complainant's daughter-in-law, this Court is conscious of the settled position of law pertaining to allegations of medical negligence which may give rise to

criminal culpability. A mere adverse outcome of a medical procedure does not, *ipso facto*, constitute medical negligence. A private complainant, lacking in medical expertise, cannot conclusively impute criminal negligence to a medical practitioner solely on the basis of an unfortunate result or post-operative deterioration. The domain of medical negligence squarely falls within the realm of expert knowledge, and the threshold for initiating criminal prosecution against medical professionals is placed significantly high to protect *bona fide* medical judgment from frivolous or misconceived litigation.

14. In the present matter, it is evident that the medical procedure carried out upon the deceased was indeed preceded and followed by complications, as narrated in the complaint. However, this Court finds it imperative to evaluate whether the conduct of the medical practitioners crosses the threshold from civil negligence into the domain of gross or criminal negligence under Section 304 IPC or Section 105 of the Bharatiya Nyaya Sanhita, as alleged.

15. To ascertain this, the matter was duly referred to a State-Level Medical Expert Committee purely as a measure of abundant caution. The committee, upon examination of the relevant medical records, procedural steps undertaken, and statements of the attending professionals, categorically opined that there was no prima facie material indicative of

culpable medical negligence. Notably, even the expert neurologist consulted during the course of internal inquiries had recommended certain diagnostic protocols, but omission thereof, in the expert's view, did not rise to the level of deliberate or reckless indifference amounting to criminal misconduct.

16. The District-Level Medical Expert Committee, in its report dated 19.9.2024, after reviewing the hospital records and statements of the attending medical professionals, found no willful negligence in the treatment provided. However, discrepancies in the statements of the patient's attendant and the hospital staff were noted, warranting further investigation. Additionally, the omission of a CT Brain scan, despite a neurologist's recommendation, also requires further scrutiny.

17. It is a cardinal principle that unless the medical expert's opinion lends support to the charge of medical negligence—particularly of such gravity that it shocks the conscience of a prudent man—criminal prosecution should not be allowed in routine. The opinion of a duly constituted expert committee, having denied the existence of medical negligence in unequivocal terms, cannot be brushed aside in favour of speculative inferences.

18. While the Court acknowledges the petitioner's anguish and the tragic loss suffered, it is well settled that penal consequences under the criminal justice system must flow only from established culpability supported by cogent evidence, not from conjecture or mere suspicion. The invocation of Section 105 of the Bharatiya Nyaya Sanhita (akin to Section 304 IPC) necessitates a stringent degree of proof of gross negligence or recklessness with knowledge of likely fatal consequences—something that is palpably absent in the instant case in view of the committee's findings.

19. The Hon'ble Supreme Court, in ***Kusum Sharma & Ors. v. Batra Hospital & Medical Research Centre & Ors., (2010) 3 SCC 480,*** distilled this principle further by laying down eleven guiding tenets for determining culpability in medical negligence cases. Most relevantly, the Court reiterated that:

- Negligence must be gross or culpable to attract criminal consequences—not merely based on a difference in diagnosis or judgment.
- Doctors must be allowed to function without fear, and criminal law must not become an instrument to intimidate or pressure.

  A mere failure of treatment or an unfortunate outcome does not establish liability, absent a demonstrable breach of a standard that no ordinary, competent practitioner would commit.

20. In the present case, the petitioner alleges gross negligence by medical personnel at Vasundhara Hospital in the course of surgical treatment administered to his daughter-in-law, the late Mrs. Priyanka Bishnoi. The allegations pertain to omission of pre-operative tests, delay in critical diagnostics, and improper post-operative care, ultimately leading to her demise. However, applying the Bolam and Kusum Sharma standards, it becomes abundantly clear that a criminal charge cannot be founded on inferential assumptions, speculative allegations, or retrospective dissatisfaction with the medical outcome. The matter was duly placed before a State-Level Medical Expert Committee and District-Level Medical Expert Committee, which concluded that there was no prima facie evidence of medical negligence. These expert opinions carry significant probative value and must guide judicial determination at this stage.

21. Mere dissatisfaction with the result of medical treatment, however tragic, cannot in itself constitute grounds for criminal prosecution unless supported by cogent evidence pointing to gross recklessness or culpable negligence, as delineated by the Hon'ble Supreme Court in ***Jacob Mathew v. State of Punjab [(2005) 6 SCC 1]***. The threshold for initiating criminal proceedings against medical professionals is not satisfied merely by alleging procedural lapses or adverse consequences, but requires demonstrable conduct that falls

palpably outside the realm of accepted medical standards. It is also pertinent to emphasize that in the course of clinical management, not every minor or routine diagnostic omission can be elevated to a charge of criminal indifference. As recognized in ***Dr. Suresh Gupta v. Govt. of NCT of Delhi [(2004) 6 SCC 422],*** only conduct that exhibits a high degree of gross negligence or recklessness that shocks the conscience of a prudent man may warrant criminal culpability. In the present case, there is no such material on record that crosses this high threshold. Further, it is wholly unreasonable to expect that minute-to-minute details of the ongoing medical procedures or evolving diagnostic considerations would be exhaustively shared with the patient's attendants, particularly in a high-pressure post-operative setting. Diagnostic reports, including those recommended but not undertaken, are part of the internal clinical deliberations and are generally accessible through proper channels; their non-disclosure to laypersons in real time does not, in and of itself, imply suppression or malafide intent. Allegations of non-disclosure must be evaluated in light of clinical exigencies, standard protocols, and practical limitations faced by the attending staff. Hence, the contention that there was deliberate suppression of diagnostics or intentional withholding of information lacks the evidentiary foundation necessary to invoke criminal liability in a medical negligence framework.

22. Moreover, this Court is also mindful of the fact that the reputation and functional credibility of private medical institutions are inherently tied to their standards of care and patient outcomes. In the modern healthcare ecosystem, no private hospital or its professional staff can reasonably be presumed to operate with a wilful disregard for human life, especially when such conduct would directly undermine their institutional standing, public trust, and economic viability. A medical practitioner operating within a private setup is guided not merely by the clinical interest of the patient but also by the ethical and reputational constraints of the institution under whose aegis he functions. It must further be appreciated that a single adverse outcome, if even remotely attributable to a negligent act, has the potential to cause irreparable damage to the professional standing of both the doctor and the hospital. In a sector where public confidence serves as the cornerstone of survival, the mere perception of substandard care can derail years of painstakingly built credibility. Private healthcare institutions operate not just as treatment facilities but as trust-based service entities—heavily reliant on goodwill, word-of-mouth, and community validation. The inflow of patients, which sustains the operational and financial viability of such institutions, is directly proportional to the public's perception of their clinical integrity. Consequently, even from a purely pragmatic or commercial standpoint, it defies logic to assume that a doctor or institution would deliberately risk such reputational capital

by engaging in rash or negligent medical practices. The risk of professional ruin, economic decline, and eventual institutional collapse acts as a natural deterrent against any willful lapse in the standard of care. Indeed, the very business model of private healthcare is predicated on the maintenance of —professional goodwill and ethical reliability. The erosion of this trust, through real or perceived negligence, would cause a rapid attrition of patient inflow, leading not only to financial instability but to the eventual dismantling of the entire clinical establishment. Thus, the likelihood of a private medical practitioner, knowingly or recklessly, compromising patient care is not merely implausible—it is antithetical to both professional instinct and institutional self-preservation.

23. It is inconceivable that a licensed and qualified medical professional, having undergone rigorous academic training and extensive clinical exposure over several years, would intentionally pursue a line of treatment with the objective of endangering human life. The record unequivocally reflects that the attending physician, confronted with a critical and dynamically evolving clinical scenario, exercised his judgment in real time, acting with the singular intent to preserve and restore the patient's health. The actions undertaken were rooted in his medical wisdom and situational appraisal, not in any form of disregard for the patient's well-being. Whether the chosen course of treatment ultimately succeeded or failed

pertains to the unpredictability inherent in medical science and the complexity of human physiology—not to any criminal malintent. Medical decisions taken within the four walls of an operation theatre are often made under acute pressure, with constrained time and information, and under conditions where immediate response is paramount. It is imperative to recognize that the treating doctor, positioned bedside and bearing direct responsibility, exercises clinical discretion shaped by years of training, personal experience, and the unique circumstances presented by the patient at that precise moment. The retrospective assertion that "another action should have been taken," or that "a different decision might have yielded a better result," is often a manifestation of hindsight bias, and not a valid metric for assessing professional culpability. In medical jurisprudence, it is inappropriate—indeed, legally impermissible—to superimpose an idealized course of action derived from post-facto analysis over the real-time decisions made in emergent and life-threatening situations. The clinical process, particularly in emergency operative settings, is governed not by hypothetical perfection but by a constrained equilibrium of risk and benefit, filtered through the doctor's best judgment at the time. The standard is not omniscience but reasonableness. It is a fallacy to presume that because an alternate method appears preferable in the calm of retrospect, the course actually followed was negligent or reckless. The treating physician, being physically present with

the patient and having direct access to the intra-operative cues and unfolding clinical variables, is in the most competent position to determine the immediate course of action. His decisions, though potentially open to debate in hindsight, are protected under the law so long as they conform to the accepted standards of practice prevailing at the time. Furthermore, such decisions must be evaluated in light of the circumstantial exigencies rather than the sterile certainty of hindsight. The legal test is not whether a different doctor, in an ideal scenario, might have adopted an alternative approach, but whether the conduct fell below the standard of care expected of an ordinary competent practitioner placed in similar circumstances. To hold otherwise would render every adverse medical outcome susceptible to criminal indictment, thereby instilling a culture of defensive medicine detrimental to public interest. Equally illogical is the assumption that a private tertiary care institution—whose very sustenance and reputation hinge upon public trust—would either promote or tolerate reckless or cavalier treatment protocols. In an era of heightened regulatory scrutiny and increasing public awareness, any deviation from recognized norms of care would not only expose such a facility to debilitating legal consequences but also irreparably tarnish its standing in a fiercely competitive healthcare ecosystem. Hence, imputing mala fide intention or gross neglect to the institution or its medical personnel, absent concrete and compelling material,

is not only legally unsustainable but wholly inconsistent with the evidentiary record before this Court.

24. To draw an analogy, just as it would be irrational to critique the choice of traveling by bus by exalting, in hindsight, the comparative merits of train travel after the journey is complete, similarly, the appropriateness of a medical decision cannot be impugned merely because another theoretical path might have yielded a different or more favourable result. Medicine, like transportation, offers multiple routes to a destination; the mere availability of alternatives does not negate the reasonableness of the chosen path. The practice followed by the treating physician in the present case, as borne out from the record, is one that falls within the ambit of recognized and acceptable medical practice, and not one that warrants the invocation of criminal culpability.

25. These realities underscore why the law—as stated in Kusum Sharma and Bolam—requires courts to distinguish between an adverse result and actionable negligence, and even more stringently, between negligence and criminal culpability. The absence of mens rea, or a wilful, gross departure from standard medical practice, stands at the heart of this distinction.

26. Before proceeding further, it becomes imperative to examine the doctrine of vicarious liability as sought to be applied in

the present matter against the petitioners, who are functionaries of the private medical institution. The invocation of vicarious liability in criminal jurisprudence is not as expansive or readily inferred as in civil liability. In the realm of criminal law, especially when dealing with allegations of negligence under Section 105 BNS, the attribution of criminal responsibility to a party who has not directly committed the act necessitates a heightened threshold. There must be a clear demonstration of either active participation, wilful neglect, or an institutional failure so grave that it amounts to complicity or conscious disregard of established medical protocols. The petitioners in the present case(CRLMP 7770/2024) are neither the treating physicians nor shown to have played any proximate role in the clinical decision-making that led to the adverse outcome. No material has been presented that suggests the petitioners directed, advised, coerced, or otherwise influenced the specific medical intervention undertaken by the attending doctor. In fact, the foundational principle behind vicarious criminal liability requires that the employer or institutional head be proven to have either (a) authorized the wrongful act, (b) neglected to prevent a known and foreseeable risk, or (c) failed in a non-delegable statutory duty. None of these conditions are fulfilled herein.

Furthermore, it is a well-acknowledged tenet in legal jurisprudence that a private hospital, although an employer in the administrative sense, cannot be held criminally liable for

every clinical decision undertaken by an independently functioning medical professional, unless there is compelling evidence of institutional breakdown or gross supervisory failure. The treating doctor, in the exercise of his independent medical judgment, acted autonomously in the course of surgery—a domain that neither the petitioners nor the institution can realistically be said to micro-manage in real-time. The doctrine of respondeat superior has its limitations in criminal law, particularly in professions that require independent application of discretion and skill. To impose criminal vicarious liability on the hospital management in such circumstances would be to stretch the doctrine beyond its doctrinal limits, and set a dangerous precedent whereby administrative or managerial personnel are rendered liable for acts over which they exercised neither control nor contributed by any omission. In the absence of any allegations of policy failure, administrative dereliction, or evidence of systemic apathy, the attempt to fasten vicarious liability upon the petitioners is not only legally unsustainable but also contrary to the jurisprudential safeguards established by the Hon'ble Supreme Court in matters involving medical negligence.

27. Furthermore, while assessing the question of criminal negligence, this Court cannot disregard the broader philosophical construct that underpins legal reasoning itself—that every culpable act must have a rational foundation in intent, knowledge, or gross omission. In the context of

medical negligence, these three pillars must be rigorously tested. First, the possibility of intentional harm is, in most cases involving qualified medical professionals, inherently absurd. A physician who has sworn to uphold the Hippocratic Oath, who has dedicated his professional life to healing, and who thrives on the trust placed in him by patients and institutions alike, has no conceivable motive to deliberately act in a manner likely to cause death. To attribute such intent, without overwhelming evidence, would not only defy logic but also insult the integrity of the profession itself.

28. Second, the notion that the act was done with knowledge that it may cause death must be evaluated in the context of the actor's training and habitual function. A doctor is presumed to possess not only clinical competence but also ethical awareness. It would be against the very fabric of medical ethos—and virtually inconceivable—that a skilled professional, consciously aware of the fatal implications of his actions, would proceed regardless. The Supreme Court in Kusum Sharma rightly observed that in situations of complexity or clinical emergency, a medical practitioner may adopt a procedure involving risk if, in their professional judgment, it offers a higher chance of recovery. This choice, though fallible, cannot be equated with guilt.

29. Third, if the act was done without knowledge—that is, in a manner that may be viewed as a lapse or error in judgment—

it still falls short of the high threshold required for criminal liability. The law recognizes that death is the inevitable conclusion of all life, and every death—even if occurring under clinical care—cannot be viewed as a consequence of criminal negligence unless supported by clear, cogent, and compelling evidence. To criminalize every clinical complication or suboptimal outcome would create a climate of fear, deeply impairing medical practice and public interest alike. It must also be emphasized that legal proceedings cannot be legitimately instituted solely on the basis of sentiments or emotional anguish, however intense or sincere they may be. The administration of justice must rest on objective standards of culpability and evidentiary thresholds, not on grief or public sympathy alone. This Court, too, is not impervious to the sorrow arising from the untimely demise of a young and capable officer—a woman of notable administrative acumen and promise. Her loss is, without doubt, tragic and deeply unfortunate. However, the solemn obligation of the legal system is to distinguish between misfortune and culpability, and to ensure that human suffering, however profound, does not substitute for proof required under the law.

30. This tripartite framework—of intent, foreknowledge, and culpable negligence—forms the very backbone of criminal jurisprudence, and its application must be especially cautious in the medical field. The treating physician in this case acted within the bounds of his expertise, during an exigent clinical

scenario, with the aim of saving life—not endangering it. There is no credible evidence of intentional wrongdoing, reckless indifference, or disregard for standard care, especially when an independent expert committee has found no lapse warranting further action.

31. In light of the above, it would be wholly unjust to subject the petitioners to the rigours of criminal trial when the cumulative material, including expert committee findings, fails to establish even a prima facie case of gross medical negligence. The continuation of proceedings would not only be contrary to the principles laid down in Bolam, Jacob Mathew and Kusum Sharma (supra), but would also result in the undue harassment of medical professionals and strike at the very root of responsible clinical autonomy.

32. Accordingly, in light of the authoritative expert opinion and in the absence of any credible material disclosing a prima facie offence under the penal law, further continuation of criminal proceedings in relation to FIR No. 388/2024 registered at Police Station Chopasni Housing Board, District Jodhpur, would be an abuse of the process of law.

33. Resultantly, this Court allows the instant petitions. FIR No. 388/2024 and all consequential proceedings arising therefrom are hereby quashed.

34. The stay petitions stand disposed of.

(FARJAND ALI),J

30-Mamta/-