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Review Article

The Borrowed Servant Doctrine: A Scientific Legal Review with special Reference to Indian Medical Case Law

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Abstract

The Borrowed Servant Doctrine is a nuanced principle of agency and vicarious liability law that assigns responsibility when an employee temporarily performs duties under a third party's control. While well-developed in common law jurisdictions, the doctrine's contours in India especially in medical negligence jurisprudence remain intertwined with broader principles of hospital liability and duty of care. This review provides a comprehensive analysis of the doctrine's historical origins, legal tests, and its medico legal applicability in Indian courts. Indian High Courts and the Supreme Court have navigated overlapping supervisory relationships in healthcare settings, emphasizing control, delegation, and foreseeability in liability attribution. Incorporating recent judgments and medico-legal literature, this article argues that Indian jurisprudence implicitly incorporates borrowed servant reasoning within established vicarious liability doctrines rather than treating it as an independent principle. The review further highlights the doctrine's forensic significance in analysing complex medical negligence cases involving outsourced services, visiting consultants, and multi-institution care teams. Clear understanding of these legal mechanisms is essential for forensic practitioners, legal professionals, and institutional policymakers to ensure accountability while safeguarding professional autonomy.

1. Introduction

'Medical negligence litigation often raises complex questions of responsibility where multiple parties are involved in patient care, including hospitals, visiting specialists, trainees, and ancillary staff. Traditional vicarious liability principles encapsulated in respondent superior hold employers liable for their employees' negligent acts performed within the course of employment.[1] However, when a medical professional works under the supervision of an entity other than their nominal employer, as often happens in multi-disciplinary healthcare settings, courts must determine which institution exercised actual control at the material time.

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The Borrowed Servant Doctrine, which originated in 19th and 20th-century common law, allocates liability based on supervision and control rather than contractual status. Its forensic relevance in Indian medical jurisprudence arises where hospital accountability intersects with delegated clinical practice. Medical negligence litigation in India frequently involves questions of vicarious liability, as healthcare delivery often requires teamwork among employees with varying degrees of employment affiliation. Situations such as visiting surgeons using hospital facilities, anaesthetists employed separately, outsourced laboratories, and private specialists working in government hospitals create ambiguity in identifying the legally liable party.The borrowed servant doctrine addresses this ambiguity by focusing on effective control over the medical professional at the time of the alleged negligent act.

This doctrine becomes a decisive tool in determining whether liability attaches to:

- the hospital (borrowing employer),
- the original employer (general employer), or
- both (shared control scenarios).

It is extremely important to clarify this ambiguity as there are incidence of violence against doctors, nurses and other staff as well as destruction of hospital property by the relatives of patient citing the medical negligence.[2,3,4,5]

2. Origin and Conceptual Analysis

The borrowed servant doctrine holds that an employee lent by one employer to another becomes the servant of the latter if the latter has the right to control the manner and method of work. Consequently, liability shifts to the temporary employer. The essential inquiry focuses on who had the right of control over the employee's detailed work at the time of the tortious act, a principle remarkably applicable in healthcare where institutional hierarchies and delegation are commonplace. While traditional tests for borrowed servant status include the control test, the scope of employment, and whose business was being advanced, courts prefer a fact-intensive approach to establish the party exercising functional oversight.

This control-centric analysis aligns with the underlying social policy: liability should rest with the entity that directs and benefits from the acts performed, especially in contexts like medical care where patient reliance is paramount.

In healthcare:

- Medical teams often include externally hired anaesthetists, technicians, or specialist consultants.
- Hospital staff may work under the direct supervision of a specialist surgeon or department head.
- Certain services (e.g., diagnostic labs, blood banks, physiotherapy) may be outsourced.

In these situations, the doctrine clarifies who had operational control of the professional conduct that allegedly constituted negligence.

3. Key Indian Medical Case Laws Involving Borrowed Servant Principles

While Indian courts rarely label cases explicitly as "borrowed servant doctrine," the reasoning is unmistakably aligned with it. These cases revolve around the control test, supervision test, and integration test.

3.1 Achutrao Haribhau Khodwa v. State of Maharashtra (1996)

Facts: A surgical mop was left inside the patient's abdomen.

Held: The State was held liable for negligence by hospital staff even though the negligent O.T. personnel were not directly hired by the government. The Supreme Court emphasized that the hospital had complete control of the operation theatre environment.

Relevance: This case supports the idea that when a hospital has operational control over staff regardless of employment origin, it becomes vicariously liable.[6]

3.2 Savita Garg v. National Heart Institute (2004)

Facts: A patient died due to negligent post-operative care by nursing and ICU staff.

Held: The hospital was liable because the staff, whether full-time employees or contract workers, functioned under the hospital's direct control.[7]

Relevance: The Court noted that hospitals cannot escape liability by claiming that negligent employees were not on permanent employees which is perfectly consistent with the borrowed servant principle.[7]

3.3 Dr. Lakshman Balkrishna Joshi v. Trimbak Bapu Godbole (1969)

Though focused on doctor's individual duty, the Court recognized that during surgical procedures, control is temporarily transferred from the hospital administration to the surgeon.

Relevance: This case recognizes the reality that control during surgery may shift to the operating surgeon, potentially making the surgeon the

temporary employer of nurses, anaesthetists, or technicians.[8]

3.4 Samira Kohli v. Dr. Prabha Manchanda (2008)

This landmark case on consent indirectly reflects borrowed servant reasoning: during surgery, the consulting surgeon controlled the entire medical team.

Relevance: The Court highlighted that surgical team members act under the direction of the surgeon, a conceptual pillar of borrowed servant liability.[9]

3.5 Spring Meadows Hospital v. Harjot Ahluwalia (1998)

Facts: Negligence by a nurse and trainee doctor caused severe harm.

Held: The hospital was held liable even though the negligent trainee doctor was not a permanent hire.

Relevance: Operational control by the hospital was the decisive factor, another application of borrowed servant principles.[10]

4. Outsourced Laboratory Cases

When a hospital outsources a test to a third-party lab, **the hospital and/or lab can be held responsible** if the error causes harm then the courts have held that outsourcing does *not* absolve liability. The hospital remains vicariously liable under the legal *doctrines qui facit per alium facit per se ("he who acts through another does so himself") and respondent superior*.

Indian Cases and Legal Precedents Involving Outsourced Lab Negligence

4.1 Lifeline Laboratory vs Anjana Agrawal

- A consumer complaint was filed because a **wrong blood group report** was issued by Lifeline Laboratory, leading to the cancellation of a planned kidney transplant.
- This case was fought under **the Consumer Protection Act, 2019**; it involved an outsourced laboratory whose erroneous results impacted treatment decisions.[11]

4.2 Consumer Court Decisions on Diagnostic Errors

- In another case, a **state consumer commission found Dr Lal Pathlabs liable** for issuing significantly incorrect urea and creatinine results, which triggered unnecessary hospitalization and trauma for the complainant. The laboratory was ordered to pay ₹3.5 lakhs in compensation.[12]

4.3 **Outsourced lab errors are treated just like other medical negligence** if:

- The report is **incorrect or delayed**, leading to misdiagnosis or wrong treatment.
- There is **failure to adhere to standard practices** (ICMR guidelines, SOPs).
- The error leads to **financial loss, mental trauma, or actual physical harm**

5. Vicarious Liability in Medical Negligence: Indian Legal Doctrine

Under Indian law, hospitals owe a non-delegable duty of care to patients and can be held vicariously liable for negligent acts of their staff and associated professionals. The Supreme Court in cases such as Indian Medical Association v. V.P. Shantha underscores that medical services fall within consumer protection jurisdiction, reinforcing institutional accountability.[13] Likewise, in Managing Director, Kamineni Hospitals v. Peddi Narayana Swamy & Anr. (2025), the Supreme Court upheld a finding of vicarious liability for a hospital alongside the attending doctor, ordering compensation for medical negligence, and reaffirming that a hospital's liability may not be negated based on contractual structures alone.[14]

Indian High Courts have also developed jurisprudence relevant to control and supervision in negligence contexts. For example, the Delhi High Court recently quashed an FIR in a medical negligence case where a surgical counting error occurred, emphasizing that unintentional errors although serious may not always amount to criminal liability, particularly where compensation has been paid and professional accountability assessed in civil remedies. Such cases underscore the courts' analytical balance between professional error and negligence tied to institutional responsibility.[15]

The Allahabad High Court in 2025 criticized private healthcare practices prioritizing profit, terming them detrimental to patients' interests, and reaffirmed that negligent practice cannot be shielded by financial motivations.[16]

Other High Court observations, such as the Kerala High Court ruling that doctors should not be blamed for every adverse outcome absent gross negligence, further illuminate judicial sensitivity to professional autonomy within the duty of care framework, a factor often assessed alongside control when assigning institutional liability.[17]

6. Tests and Forensic Application in Healthcare Control as Primary Determinant

In medico-legal disputes involving borrowed servant questions, courts typically examine:

- Who directed the detailed performance of medical services;

- Who benefitted from the services rendered at the time of the tortious act;
- Whether the professional acted under the institutional protocols, policies, and supervision of the healthcare provider.

These factors overlap with forensic determinations about *standard of care* and *foreseeability of harm*, where expert testimony and institutional records play key roles in judicial assessment.

7. Indian High Courts and Borrowed Servant Reasoning in Practice

While Indian judgments seldom label decisions as applying the Borrowed Servant Doctrine explicitly, their reasoning often reflects its core logic:

- Courts assess whether a hospital's infrastructure and supervisory staff guided the healthcare professional's actions.
- Institutional policies and standard operating procedures (SOPs) become evidence of control.
- Patient reliance on hospitals for comprehensive care influences liability irrespective of the employment contract.

For instance, when a visiting surgeon uses hospital facilities and nursing staff, the hospital may be held jointly liable where procedures and supervision fall within its functional domain, even if formal employment is absent, a practical application of borrowed servant logic in liability attribution.[18,19]

7. Comparative Jurisprudence and International Perspectives

The Centrality of "Control" in Liability Allocation

Across jurisdictions, control over the manner and means of work has consistently emerged as the dominant criterion for determining liability in healthcare negligence cases. This reflects a broader evolution of vicarious liability from a narrow master, servant conception to a more functional and policy-oriented analysis.

Healthcare delivery is inherently complex, involving layered hierarchies, professional autonomy, and institutional protocols. Courts internationally have adapted traditional tort principles to ensure that organizational responsibility keeps pace with modern healthcare realities.

United Kingdom: Institutional Integration and Vicarious Liability

Cassidy v Ministry of Health (1951)

Cassidy remains a foundational authority in English medical negligence law. The court held the Ministry of Health liable for the negligent acts of hospital-employed doctors, emphasizing:

- The organizational integration of doctors into the hospital system
- The hospital's responsibility for patient care as a composite service
- The patient's lack of choice or control over individual practitioners

The court rejected the argument that a doctor's professional independence negates vicarious liability. Instead, it recognized that hospitals hold themselves out as providers of comprehensive medical services and must bear responsibility for failures within that system.[20]

Evolution beyond Strict Employment

Subsequent UK jurisprudence expanded liability even where traditional employment relationships were absent. The courts increasingly apply the "enterprise risk" and "close connection" tests, holding institutions liable where:

- The tort is closely connected to the institutional role assigned to the professional
- The institution created or significantly enhanced the risk of harm

This approach reflects public policy considerations—particularly patient protection and loss distribution.[21,22]

United States: Borrowed Servant and Apparent Agency Doctrines

The U.S. has developed a more fragmented but conceptually rich framework.

Under this doctrine, liability turns on who had the right to control the specific negligent act at the time it occurred. Courts examine:

- Who directed the work
- Who controlled the manner of performance.
- Whether the general employer relinquished control

However, rigid application has proven inadequate in hospital settings, where control is often diffused.[23,24]

Apparent or Ostensible Agency

To overcome these limitations, U.S. courts widely apply apparent agency, especially in hospital negligence cases. Liability arises when:

- The hospital represents the doctor as its agent
- The patient reasonably relies on that representation
- The patient does not meaningfully select the physician independently.

This doctrine explicitly centers patient perception and reliance, reflecting consumer-protection logic.[25]

Convergence of International Principles

Despite doctrinal differences, UK and U.S. approaches converge on key principles:

- Control need not be micromanagement; systemic and structural control suffices
- Professional autonomy does not immunize institutions
- Patient reliance and institutional representation are decisive
- Liability is shaped by policy considerations, not merely formal contracts.[26]

Critical Discussion

Indian medico-legal practice reflects a pragmatic adaptation of borrowed servant reasoning within the broader cause of patient protection. Instead of rigidly applying borrowed servant rules, courts emphasize whether institutions exercised sufficient control over medical acts and whether patients justifiably relied on those institutions for competent care. This approach aligns with international medico-legal standards and ensures victims have effective recourse against negligent healthcare providers.[6,7,10,13]

8. Conclusion

The Borrowed Servant Doctrine's conceptual emphasis on control and supervision remains highly relevant in medical negligence litigation. While Indian case law does not frequently invoke the doctrine by name, its principles are implicitly applied in vicarious liability and duty of care analyses. Recent High Court interventions, reflecting both accountability and equitable justice, demonstrate evolving judicial engagement with complex liability questions in healthcare. For forensic medicine and legal practice, a nuanced understanding of these doctrines enhances analysis of multi-agency cases where institutional responsibility must be traced amid overlapping supervisory roles.

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