PATIENTS' RIGHT TO SEEK REDRESSAL IN MEDICO - LEGAL LITIGATION IN INDIA: A CRITICAL ANALYSIS

Dissertation submitted to the National University of Advanced Legal Studies, Kochi, in partial fulfilment of the requirements for the award of L.L.M Degree in Public Health Law.

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CERTIFICATE

I hereby certify that Ms. Georgiya Mariya George (Reg. No. LM0324005) has submitted her dissertation titled, **'PATIENTS' RIGHT TO SEEK REDRESSAL IN MEDICO - LEGAL LITIGATION IN INDIA: A CRITICAL ANALYSIS'** in partial fulfilment of the requirement for the award of Degree of Masters of Laws in Public Health Law to the National University of Advanced Legal Studies, Kochi under guidance and supervision. It is also affirmed that the dissertation submitted by her is original, bonafide and genuine.

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DECLARATION

I declare that this dissertation is titled **'Patients' Right to Seek Redressal in Medico - Legal Litigation in India: A Critical Analysis'** researched and submitted by me to the National University of Advanced Legal Studies in partial fulfilment of the requirement for the award of Degree of Master of Laws in Public Health Law, under the guidance and supervision of Dr. Ambily P is an original, bonafide and legitimate work and it has been pursued for an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this University or any other University.

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PREFACE

This dissertation titled Patients' Right to seek Redressal in Medico - Legal Litigation in India: A Critical Analysis presents a comprehensive study of the evolving landscape of patient rights, duties of medical professionals, and the legal responses to medical litigation within the Indian context. The research critically analyzes the intersection of law and medicine, particularly focusing on how the Indian legal framework addresses claims of medical negligence, the scope of patient rights, and the responsibilities imposed on healthcare providers.

The idea of undertaking this study stemmed from a growing concern about the increasing number of medico-legal disputes in India and the complexity involved in balancing the rights of patients with the obligations of medical professionals. The subject is of contemporary relevance, especially considering the shifts in healthcare delivery, patient awareness, and the introduction of new legislative instruments such as the Consumer Protection Act, 2019 and Bharatiya Nyaya Sanhita, 2023.

This research delves into statutory laws, judicial precedents, and ethical frameworks governing medical practice in India. It draws attention to the challenges faced by litigants in pursuing claims of medical negligence, analyzes significant case law shaping the jurisprudence, and reflects on the role of judicial activism in this domain.

I chose this topic out of both academic interest and a personal aspiration to contribute to the development of a fair, patient-centric legal ecosystem. The intricate balance between the duties of care owed by medical professionals and the right of patients to receive competent, ethical, and safe treatment is not just a legal issue but a matter of public welfare. I would like to express my deepest gratitude to everyone whose guidance, encouragement, and critical feedback were indispensable throughout the course of this research. Lastly, I remain thankful to my family and friends for their unwavering support, patience, and motivation, which helped me persevere and complete this work with diligence.

LIST OF ABBREVIATIONS

1. AC - Appeal Cases
2. ACJ - Accident Claim Journal
3. AIR - All India Reporter
4. All E.R - All England Law Reports
5. BIS - Bureau of Indian Standards
6. BNS - Bharathiya Nyaya Sanhitha
7. CDSCO - Central Drug Standard Control Organization
8. CE - Clinical Establishment
9. CIC - Consumer Issue Commission
10. CLD - Consumer Law Digest
11. CPA - Consumer Protection Act
12. CPJ - Consumer Protection Judgments
13. CPR - Consumer Protection Reporter
14. DCDRC - District Consumer dispute Redressal Commission
15. Ex. - Exchequer Reports
16. FSSAI - Food Safety & Standards Authority of India
17. GCP - Good Clinical Practice
18. GNCTD - Government of National Capital Territory of Delhi
19. HIV - Human Immuno Deficiency Virus
20. HL - House of Lords
21. ICMR - Indian Council of Medical Research
22. IMA - Indian Medical Association
23. IPC - Indian Penal Code
24. KLJ - Kerala Law Journal

25. Mad. - Madras
26. Mo. Ct. App. - Missouri Court of Appeals
27. MOHFW - Ministry of Health and Family Welfare
28. NABH - National Accreditation Board for Hospitals & Healthcare Providers
29. NC - National Commission
30. NCDRC - National Consumer Disputes Redressal Commission
31. NCT - National Capital Territory
32. NHRC - National Human Rights Commission
33. NI - Nasotracheal Intubation
34. NMC - National Medical Commission
35. Ors - Others
36. Or. App. - Oregon Court of Appeals
37. PGI - Post Graduate Insistute of Medical Science
38. RMP - Registered Medical Practitioner
39. SCC - Supreme Court Cases
40. SCR - Supreme Court Reports
41. S. W - South Western Reporter
42. Tex. App. - Texas Court of Appeals
43. TT - Tracheostomy Tube
44. UOI - Union of India
45. V - Versus

LIST OF CASES

1. Achutrao v. State of Maharashtra 1996 (2) SC 664
2. Achutraq H. khodwa v. State of Maharashtra AIR 1996 SC 238
3. Agarwal @ Vicky v. Ashok Arora 1993 1 CPJ 113
4. Aparna Dutt v. Appollo Hospital Enterprises ltd. (2002) ACJ 954
5. A.S Mittal v. State of U.P (1992) 2 SCR 815
6. Ashish Kumar Mazumdar v. Aishi Ram Batra Charitable Hospital Trust (2014) 9 SCC 256

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7. Balchandra Alias Bapu v. State of Maharashtra 1968 SCC 766
8. Balram Prasad v. kunal Saha (2014) 1 SCC 384
9. Bandhua Mukti Morcha v. UOI AIR 1984 SC 802
10. Blyth v. Birmingham Water works Co. 11 ex.781 (1856)
11. Bourhill v. Young (1943) A.C 92
12. Bolam v. Friern Hospital Management committee (1957) 2 All E.R 118

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13. Calcutta Medical Research Institute v. Bimalesh Chatterjee (1999) CPJ 13 (NCDRC)
14. Consumer Education & Research Center v. UOI AIR 1995 SC 922
15. Consumer Unity and Trust Society Jaipur v. Chairman and Managing Director Bank of Baroda 1995 (2) SCC 150

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16. Day v. Harkins & Munnoz 961 S.W 2d. 135.136 (Tex.APP.1997)
17. Devendra Madan v. Shakuntal Devi 2003 1 CPJ 57
18. Devesh Singh Chauhan v. State 2017 SCC Online Del 8130
19. Dougherty v. Gifford 826 S. W 2d 668,675 (Tex.App 1992)
20. Dowell v. Mossberg 226 or.173,190 (1961)

21. Dr. Janak Kantimathi Nathan v. Murlidhar Eknath Masane (2002) 2 CPR 138

22. Dr. Kunal Saha v. Dr. Sukumar Mukherjee (2006) 3 CPJ 142

23. Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godpole AIR 1969 SC 128

24. Dr. M. Gourikutty v. M. K Madhavan AIR 2007 Ker. 398

25. Dr. Prem Luthra v. Ifthekar (2004) 11 CLD 37

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26. Gazula Dasaratha Rama Rao v. State of A.P AIR 1961 SC 564

27. Global Motors Service Ltd. V. R.M.K Veluswamy AIR 1962 SC 65

28. Gross v. Butt S.W 3d 213,227 (Mo. Ct. App. 2004)

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29. IMA v. V. P Shantha AIR 1996 SC 550

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30. Jackson v. Issac 76. S. W 3d 177 182 (Tex. App.1997)

31. Jacob Mathew v. State of Punjab Anr (2005) 6 SCC 1

32. Jewson v. Mayo Clinic 69 F.2d 465,391 (8th Cir.1982)

33. Johnson v. Sibley 558 S.W.2d 135, 136 (Tex.App. 1977)

34. Jones v. Malloy 412 N. W 2d 837,84 (Wed 1987)

35. Joseph v. Dr. George Moonjerly 1994 (1) KLJ 782

36. Jyoti Devi v. Suket Hospital (2024) 8 SCC 655

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37. Kanhaiya Kumar Singh v. Park Medicare & Research Centre CPJ 1999 WC 9

38. Kalyani Rajan v. Indraprastha Apollo Hospital &Ors (2024) 3 SCC 37

39. Kharak Singh v. State of U.P AIR 1963 SC 1295

40. K.S Puttuswamy v. UOI (2017) 10 SCC 1

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41. Lopez v. Aziz 852 S.W 2d 303, 306 (Tex. App 1993)

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42. M. A Bivji v. Sunia AIR 2023 SC 5527
43. Malay Kumar Gangulay v. Sukumran Mukherjee (2009) 9 SCC 219
44. Martin D'Souza v. Mohd Ishfaq (2009) 3 SCC 6
45. Mead v. Adler 231 P 3d 118 (Or. App. 2009)
46. Mohanan v. Prabha G. Nair & Ors 1 (2004) CPJ 2 SC
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49. Neeraj Sud v. Jaswinder Singh AIR 2024 SC 5625
50. Nisha Priya Bhatia v. Institute of Human Behaviour and Allied Science GNCTD CIC/ AD/ A/ 2013 001681- SA
51. Nizam Institute of Medical Science, Hyderadad v. Prashantha S. Dhananka 2009 6 SCC 1

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52. Oil and Natural Gas Commission v. Natural Gas Consuming Industries Gujarat AIR 1990 SC 1851
53. Orissa Road Transportation Co. Ltd v. Umkant Singh 1987 ACJ 133

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54. Paramand Katara v. UOI (1989) 4 SCC 28
55. Paschim Banga Khet Mazdoor Samity v. State of West Bengal AIR 1996 SC 2426
56. Poonam Verma v. Ashwin Patel (1996) 4 SCC 332
57. Prabhat Kumar v. Directorate of Health Service CIC/ SA/ A 2014/ 00004
58. Pravat Kumar Mukherjee v. Ruby General Hospital (2005) CPJ 35 (NC)

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59. QT, Inc v. Mayo Clinic Jack Sonville 2006 US Dist. LEXIS 33668

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60. R v. Adomka (1994) 3 AII ER 79

61. R. P Sharma v. State of Rajasthan AIR 2001 Raj 1

62. Raghunanth Raheja v. Maharashtra Medical Council AIR 1996 Bom 198

63. Rajappan v. Sree Chitra Tirunal Institute for Medical Science and Technology 2004 (2) KLT 157

64. Rajmal v. State of Rajasthan AIR 2001 Raj 80

65. Ramesh Chandra v. Regency Hospital Limited (2009) 9 SCC 709

66. Ramiraz v. Carreras 10 S.W 3d 76 (Tex.App.1999)

67. Ravichandran Iyer v. Justice A. M Bhatta Charjee (1995) 5 SCC 457

68. Rekha Gupta v. Bombay Hospital Trust & Another 2003 (2) CPJ 160 (NCDRC)

69. Ricks v. Budge 91 Utah 307,64 P. 2d 208 (1937)

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70. S. Dhanaveni v. State of Tamil Nadu AIR 1997 Mad 257

71. S. P Gupta v. President of India AIR 1982 SC 149

72. Samira Kohli v. Dr. Prabha Manchand AIR 2008 SC 138

73. Sharda v. Dharmapal AIR 2003 SC 3450

74. Shirk v. Kelsey 617 N.E 2d 152 (I 11 App. Ct. 1st Dist 1995)

75. Shri G. R Rawal v. Director General of Income Tax Investigation CIC/ AT/ A/2007/ 00490

76. Sidhraj Dhada v. State of Rajasthan AIR 1994 Raj 68

77. Stanford v. Cannon 2011 W.C 257, 8856

78. State of Haryana v. Smt. Santra AIR 2000 5 SCC 182

79. State v. Herendern 613 S.E 2d 647 (Ga 2005)

80. State of Punjab v. Mohinder Singh Chowla (1997) 2 SCC 83

81. State of Punjab v. Ram Lubhaya Bagga (1998) 4 SCC 117

82. State of Punjab v. Surinder Kaur 2001 ACJ 1266

83. Suresh Gupta v. Government of NCT (2004) 6 SCC 422

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85. V. Kishan Rao v. Nikhil Super Speciality Hospital 2010 5 SCC 513

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CHAPTER 1

INTRODUCTION

"The very first requirement in a hospital is that it should do the sick no harm"

Florence Nightingale[1]

1.1 INTRODUCTION

The legal and medical arena are the most strictly curbed fields in the country. The fundamental principle of legal field is justice while the medical field mainly focuses on the health and safety. And both these fields are dealt under the novel title labeled as medico legal field. Medical law and Medical Jurisprudence are the main two branches of these fields. Medical law is a legal discipline that deals with the responsibilities of medical practitioners, patient rights and health care activity in general. [2] The legal perspective of practicing of medicine is called Medical Jurisprudence. The different ways in which risk occurs in the practice of medicine are when the medical professionals act carelessly towards their patients or if they use their medical expertise in vicious manner. In the way of the practice of medicine the medical professionals are always steered and guarded by some of the medical ethics, codes and legislation. According to some notion medical jurisprudence is the branch of science which mainly discuss about the practicality of medical and surgical knowledge and administration of law. It consist of all legal topics containing a medical outlook.[3]

Now a days the guiding principle of medical field is profit. It is mainly due to the business centric thinking of medical field. The fact that people are becoming increasingly dissatisfied and demanding more from their doctors and this contributes to rise in medico legal litigation. In India medico legal litigation means any legal action brought by patients or their representatives against doctors and other healthcare providers on suspicion of medical malpractices or carelessness as well as breach of patient rights. There are two legal areas for addressing medical litigation: civil and criminal. Patient may seek civil liability and seek compensation for harm brought on

[1] A Conversation With Florence Nightingale, Am. ass'n of Critical-Care Nurses, (2019) https://www.aacn.org/nursing-excellence/nurse-stories/a-conversation-with-florence-nightingale (Last visited on May 18, 2025)
[2] Suncica Ivanovic et al., Medical Law and Ethics, 52 AMM 67, 67-73 (2013), Edward Premdas Pinto, Health Justice in India 89 (1st ed.2021)
[3] Apurba Nandy, Principles of Forensic Medicine Including Toxicology 88 (3d ed. 2010).

by careless medical care. When a patient is killed or seriously harmed due to egregious negligence criminal liability may be invoked. Furthermore, medical services are regarded as service under consumer protection Act therefore the patients have a way to pursue compensation. The Indian Judiciary has a major influence on the field of medico legal litigation. Important precedents concerning professional behaviour, medical care standards and the extent of liability have been set by well-known cases like Indian Medical Association v.V.P. Shantha[4] and Jacob Mathew v. State of Punjab[5].The fragmented facets of medical negligence and patient rights is a defining feature of medico legal litigation in India. It is difficult for patients to seek justice and for health care practitioners to fulfil their legal responsibilities because of the complicated and frequently inconsistent system that result from this fragmentation.

The main factors which lead to medico legal litigation are failure to diagnose or delayed diagnose, complication from treatment or surgery, breach of patient rights and negligence.[6]When medical professionals fail to address medico legal difficulties in clinical practice with elegance, it frequently led to medical negligence.[7]

1.2 PATIENT RIGHTS

Patient is any person who is a user of health services, seeking any kind of medical attention from the medical facilitators including doctors, nurses, hospitals, clinics etc. A patient while using health services may be healthy or sick.[8]

Patients are frequently the victims of medical malpractices committed by those who profit from the commercialization and privatization of the health care sector by unfairly exploring their vulnerabilities. Due to these commercialization and privatization patient rights violation occurs. National Human Rights Commission (NHRC) was instructed by Ministry of Health and Family Welfare (MOHFW) to form a roll of patient rights.[9] It come out with a charter of patient rights which comprises set of rights that all Indian patients are entitled specifically. They are:

[4] Indian Medical Association v. V.P Shantha, AIR 1996 SC 550
[5] Jacob Mathew v. State of Punjab & Anr., (2005) 6 S.C.C. 1
[6] Swaranjali Gajbhiye & Swapnil Patond, Medico-Legal Aspects of Medical Negligence Amongst Medical Students, 10 J. Res. Med. Dent. Sci., 226-30 (2022).
[7] Id
[8] World Health Organization, Declaration on the Promotion of Patients' Rights in Europe, (1994).
[9] Supra note 2.

- Right to information;
- Right to records and reports;
- Right to emergency care;
- Right to informed consent;
- Right to confidentiality, human dignity and privacy;
- Right to second opinion;
- Right to transparency in rates and care according to prescribed rates wherever relevant;
- Right to non-discrimination;
- Right to safety and quality care according to standards;
- Right to choose alternative treatment options if available;
- Right to choose source for obtaining medicines or tests;
- Right to proper referral and transfer, which is free from perverse commercial influence;
- Right to protection for patients involved in clinical trials;
- Right to protection of participants involved in biomedical and health research;
- Right to take discharge of patient, or receive body of deceased from hospital;
- Right to patient education;
- Right to be heard and seek redressal[10]

1.3 NEGLIGENCE

Negligence is a civil wrong or tort in legal terminology, but it is also a criminal and consumer law. Which suggests that if a behaviour is guilty since it does not meet the legal threshold that a reasonable person would have in order to safeguard people from predictable dangerous or harmful behaviours. When an injury occurred to any person due to the carelessness of another person then he has the right to get compensation for the injury occurred to his mental and physical health. [11]

It is universally accepted that interpreting negligence is arduous. However, in jurisprudence the term negligence has been accepted and conceded. In Jacob Mathew

[10] Ministry of Health & Family Welfare, Charter of Patients' Rights (2018), https://nhrc.nic.in/sites/default/files/charter_patient_rights_by_NHRC_2019.pdf. (last visited on May 22, 2025)

[11] Anmol Mahani & Rudranath Zadu, Ensuring the safety of healthcare professionals: A review of current challenges and legal frameworks in India, IJFCM, 152-158 (2024)

v State of Punjab[12] the honourable Supreme court has interpreted the term negligence which is harm or injury occurred to the plaintiff due to the defendant remissness and the defendant has owed a duty to the plaintiff.

B. Alderson provided the classic definition of negligence. In his famous statement in Blyth v Birmingham waterwork company[13], made in 1856 J. says that "The failure to take action that a reasonable man, directed upon those factors which typically control how human matters are conducted, or doing something that a sensible and prudent man would not do." Therefore, in legal terms, negligence is basically an unintentional violation of a valid duty that typically involves someone else. The law considers those detrimental behaviours to be guilty overall as a prudent and sensible individual would anticipate to be appropriate.

1.3.1 KEY COMPONENTS OF NEGLIGENCE

In Poonam Verma case[14] the supreme court established the fundamental elements of negligence as follows:

- An obligation to use reasonable caution under the law.
- A breach of duty
- Consequential damages

For making the defendant liable for negligence the plaintiff has to proof the above components of negligence.[15] The supreme court ruled that an essential component of this tort is damage. Despite demonstrating the doctor's negligence, the plaintiff will not be able to obtain any damages if he cannot demonstrate that the patient suffered any harm or loss.[16]

1.4 MEDICAL NEGLIGENCE

Medico legal claims basically mean the claims based on instances of medical negligence.[17] Medical negligence refers to the carelessness that results from a physician failure to perform medicine in accordance with the norms that a normally and reasonably competent man in the name of his profession would follow. There are

[12] Supra note 5.
[13] Blyth v. Birmingham Waterworks Co., 11 Ex. 781 (1856).
[14] Poonam Verma v Ashwin patel (1996) 4 S.C.C. 332
[15] Supra note 5.
[16] Sidhraj Dhadda v. State of Rajasthan AIR 1994 Raj. 68
[17] L. Prinsen, The Leading Causes of Medicolegal Claims and Possible Solutions, 113 S. Afr. Med. J.,1140, 1140-42 (2023).

a lot of situations where a medical practitioner could act in a careless situation. When the facilitator is not using reasonable prudence, skill and care whilst treating a patient then the outcome will be patient get injured or dies. It occurs when a health care provider fails to provide the standard of care that is expected of them, causing injury to the patient.[18]

Medical Negligence has overall three ramifications. They are:

- A mindset that is contrary to the aim.
- Careless conduct.
- The violation of duty to take care mandated by statutes or common law.

1.4.1 NEGLIGENCE AS A MENTAL STATE

Mens rea can also be attributed to negligence or wrongful intent. Essentially one of these two other forms is mandated by laws as a necessary prerequisite for declaring the wrongdoer liable. A deliberate or willful offender is someone who intends to cause harm. One who lacks the motivation on to refrain from doing so is the negligent perpetrator.[19]Negligence as a "state of mind" hence does not imply an action or display to convey them. However, it suggests a lack of care or attention to safety in the event that such an act or omission does place.

1.4.2 CARELESS CONDUCT

A person who is acting in an indifferent way or not acting in a prudent manner and not even bothered that his conduct will cause an injury to other is a person who is doing careless conduct. It does not imply that a duty of care has been broken, but merely denote the wrong doer's negligent behaviour. Careless behaviour combined with negligence is the antithesis of diligence.

1.4.3 THE VIOLATION OF DUTY TO TAKE CARE MANDATED BY STATUTES OR COMMON LAW

Negligence is the violation of duty to take care which is lawfully required to give for another person has not been given by the defendant. Negligence is the failure to exercise the care that we are legally required to provide for another person. In accordance with the negligence law, professionals who possess specialized skills

[18] Y.V. Rao, Law Relating to Medical Negligence 4 (2d ed. Asia L. House 2010).
[19] John Salmond, Charlesworth on Negligence 21 (6th ed. 2013).

include doctors, lawyers, architects and others. Any work that these specialists must complete require a unique set of skills. The medical professionals may or may not be held accountable for a medical mishap or failure. Therefore, such carelessness must inevitably be handled differently.[20]Medical negligence generally refers to failing to act in a way that would have been expected of reasonably qualified medical man at the time.[21]

Medical negligence is described as a doctor's willful or lack of reasonable care and skill in accepting a patient, taking their history, doing an examination, diagnosing a condition, conducting an investigation, providing medical or surgical treatment etc that causes harm to the patient. Damage in this context refers to the patients financial, emotions or physical harm. There are two criteria are used to evaluate the professional. Therefore, if a professional does not possess the necessary expertise that he claims to have and does not use it with appropriate case and caution, he may be considered negligent.[22]

1.4.4 ACTIONABLE MEDICAL NEGLIGENCE

'Actionable Negligence' is defined as those which transfers or imports the doer's liability. It should be demonstrated by the patient in order to prove clinical negligence liability.

- The patient has the right to access care from the doctor and the doctor has an obligation for providing care to the patients.
- The patient right has been violated by the doctor due to the non-fulfilment of his duty.
- The patient has incurred damage as a result of violation[23]

A claim of clinical or medical negligence cannot be made unless all three of these requirements are met at the same time.

1.4.5 DUTY OF CARE

A person who is offering medical consultation or medical care implies that he has mastery over that. When a patient takes advice from the person who is offering medical care then he has the liability to perform certain duties. They are

[20] Supra note 5.
[21] H.M.V. Cox, Medical Jurisprudence and Toxicology 77 (6th ed. 1990).
[22] Martin D'Souza v. Mohd. Ishfaq, (2009) 3 S.C.C. 6
[23] Ratan Lal & Dhiraj Lal, The Law of Torts 458 (2nd ed. 2005)

- Duty to determine what medical care is to given
- Duty to determine how the medical care is to administer.

There will arise a suit for negligence by the injured party if any of these duties are violated.[24]The injured party must prove that the miscreant owed him a specified legitimate obligation to deal with, which he has breached, because the legal obligation and the ethical, strict or social obligation are not exactly the same. A person only needs to follow the care guidelines when he has a duty or responsibility to exercise caution. Therefore the "obligation or duty" could be defined "as the relationship between individuals who forces upon a legitimate commitment for the advantage of other". In other words, the duty is" a promise, regarded by the law as keeping a strategic distance from situations where there is an under risk of harm to others. "In this way, the tort feasor's obligation to the aggrieved party becomes significantly influenced by the existence of a duty towards them. Reasonable foreseeability to the plaintiff determines whether or not the defendant owes them a duty. The defendant has to take reasonable precaution at the moment of conduct and use all necessary precaution for not causing harm to the plaintiff and the defendant will be liable if he not taken the precautionary steps. This obligation is owed to those to whom harm could be reasonably and likely result in harm to others.[25]

In S. Dhanaveni v state of Tamil Nadu[26] the deceased fell into a pit that was filled with rainwater throughout the night. To prevent a fall, he grabbed on to a nearby electric pole. Because of electric leaks he was electrocuted in the pole. The respondent who was responsible for the deceased death, was found negligent in maintaining electric pole.

In Orissa Road Transport co.ltd v Umakant Singh [27] the bus driver was found accountable for the death of two passengers when he attempted to cross the level crossing but was unable to do so because of a truck mechanical issue. He knew about the mechanical flaw and had enough time to cross the level crossing. Consequently, he was held negligent.

[24] Yogesh V. Nayyar & Laxman, Medical Negligence and Medical Evidence 49 (1st ed. 2024).
[25] Bourhill v. Young, (1943) A.C 92
[26] S. Dhanaveni v. State of Tamil Nadu, A.I.R. 1997 Mad. 257
[27] Orissa Road Transport Co. Ltd. v. Umakant Singh, 1987 A.C.J. 133

1.4.6 OBLIGATION TO EXERCISE SKILL AND CARE

"Obligation to exercise skill and care" is the mandatory requirement for proving the liability of medical negligence. The core idea of the obligation to exercise care is giving reasonable care for eliminating danger in every aspect of case. "Obligation to exercise care" makes a restriction or control over the defendant's freedom which forces him to act like a reasonable prudent man. The legal viewpoint of "Medical Negligence" means providing subpar care.

Only once a doctor patient relationship is formed does the obligation to use skill and care become apparent. This relationship will develop as a result of doctor accepting a patient or when a charge is paid. This doctor patient relationship is established in an emergency situation as soon as the physician meets a patient to treat him. Any violation of this obligation can serve as justification for negligence. The criteria needed in a given situation is determined using the idea of a "reasonable foresight". The foresight of a "reasonable prudent man" is referred to as reasonable foresight. A rational individual will refrain from creating likely unfavourable outcomes. That is the typical norm for caution behaviour. The behaviour in question is considered negligent if it does not meet the criterion.[28]Simply, a practitioner who possesses a reasonable level of expertise and applies it with a reasonable degree of attention is said to have a "reasonable foresight" under a medical negligence case. Therefore, a doctor is considered to have treated a patient with due care, skill and diligence as long as his actions are consistent with the standards of the medical profession.[29]

The rudimentary concept underlying the law of medical negligence is Bolam rule[30]. It is commonly known that a man does not necessarily need to be the most skilled specialist. Negligence in a medical professional's case refers to acting contrary to the standard of medical professional who was reasonably competent at the time. There may be one or more appropriate criteria and he is not considered negligent if he complies with one of them.

1.4.7 CAUSING BREACH IN OBLIGATION TO TAKE CARE

The second requirement for proving the medical negligence of the defendant by the plaintiff is to prove that the defendant has violated his obligation to take care. The

[28] M.N. Shukla, The Law of Torts 122(13th ed. 1990).
[29] Achutraq H. Khodwa v. State of Maharashtra, A.I.R. 1996 S.C. 2383
[30]Bolam v. Friern Hospital Mgmt. Comm., [1957] 2 All E.R. 118.

occurrence of breach of obligation to take care takes place mainly in two situations they are:

- Performing an act which a reasonable prudent man abstains from doing that act
- Failing to perform an act which a reasonable prudent man would do.[31]

1.4.8 CONSEQUENTIAL DAMAGES

In the act of negligence, the injured person has not only to prove that the defendant was negligent but also to prove that there occurred an actual damage and the main cause of this damage is the negligent act of the defendant. For the injury he had suffered damages have been granted to the injured party for restoring him to the same position before the harm has occurred. compensation is the redressal concept in tort case and the precise amount of damages is determined by how much the plaintiff's has endured in his earnings, life expectancy and other injuries.[32]

1.5 SCOPE OF THE STUDY

It scrutinizes the regulatory framework that supervises medico-legal disputes in India in general, as well as rights of patients and liability of the healthcare professionals if they are ever found guilty in medical negligence matters. It delves into the three-dimensional character of medico-legal conflicts by discussing statutory legislation including the Consumer Protection Act, 2019, the Law of Torts, and the Bharatiya Nyaya Sanhita (BNS), 2023. The research further examines how judicial pronouncements guide the medico-legal sphere, particularly due to a lack of holistic codified legislation. Further, it analyzes the Charter of Patients' Rights promulgated by the Ministry of Health and Family Welfare, and examines the duties of medical practitioners under the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulation, 2023. Adopting a doctrinal research methodology, this dissertation establishes the lacunae, duplication, and issues in the existing medico-legal system and determines the gaps to be filled and the need for reforms and codification so that effective redressal mechanisms are put in place for wronged patients. The research is limited to the Indian legal environment and relies on

[31] Supra note 14
[32] W. Wyatt-Paine, The Law of Torts 140 (7th ed. 1921).

important case laws, legislation books, and regulatory frameworks to suggest a more consistent and responsible medico-legal framework.

1.6 OBJECTIVE OF THE STUDY

- To understand the various factors that lead to medico legal litigation
- To analyse the existing Indian legal framework addressing the issues relating to patients that leads to medico legal litigation.
- To examine the approach of judiciary in addressing medico legal litigation in India and assess various judicial pronouncements relates to medico legal aspects.

1.7 RESEARCH QUESTION

- Is the current legislative framework insufficient to address the issues relating to patients that leads to medico legal litigation?
- To what extent has Judicial interpretation contributed to the provision of remedies in medico legal litigation?
- Has the Indian Judiciary performed a key role for the evolution of medico-legal system in India?

1.8 STATEMENT OF PROBLEM

The prevailing situation of the Indian medico-legal system is characterized by a disjointed inconsistent body of laws that fail to adequately protect patients' rights or provide timely and effective compensation for medical negligence. There is no codified or consolidated legislation that specifically deals with the challenges of medico-legal litigation, even though several statutes, such as the Consumer Protection Act, the Law of Torts, and the Bharatiya Nyaya Sanhita, provide partial redressal. This plethora of legal remedies often leads to ambiguous standards of care, prolonged court cases, and a lack of accountability for healthcare providers. Patient susceptibility is promoted by the increasing commodification of the healthcare sector, making it increasingly difficult to ensure justice in medical negligence matters. The absence of clear legal standards for healthcare providers and an over-reliance on judicial interpretations have created a legal void that affects the rights of patients and the delivery of quality care. Therefore, in a bid to safeguard patients and hold liable negligent medical practitioners, there is a need to scrutinize the existing legal framework critically and encourage codification and wholesale legislative overhaul.

1.9 HYPOTHESIS

1. In India, there is a pressing need to codify laws addressing Medico legal litigation for effectively redressing the rights of patients.

2. Judicial decisions has played a key role in the development of medical laws vis - a - vis the legislation.

1.10 RESEARCH METHODOLOGY

The study is on the basis of doctrinal research method. Here the researcher aims to refer into various legislation, judicial pronouncements, regulations, Statutes, Books, online resources articles, newspapers etc on the aspect of Medico legal litigation to accomplish the objective of the dissertation. The primary sources gone through in this dissertation are legislation, regulations, guidelines, judicial pronouncements, the secondary sources used in this study contains journal articles, blogs etc.

1.11 CHAPTERIZATION

Chapter 1- Introduction

An outline of the whole chapters is delivered in the first chapter. It contains a brief introduction to the topic and contains the scope, objectives, research questions, hypothesis and methodology adopted for the study and concludes with chapterization.

Chapter 2- Patients' rights and duties of doctors

The second chapter mainly discuss about the term patient, doctor patient relationship, various sorts of doctor patient relations and different models of doctor – patient relationship and its comparison. In the light of Patient Charter 2018 the chapter elaborately discuss the seventeen set of rights which is recognized in India. And on the last phase of this chapter converse about the obligations of medical practitioner towards their patients on the basis of the Indian Medical Council (professional conduct, etiquette, and ethics) Regulations, 2002 and National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulation, 2023.

Chapter 3 - Indian legislative framework and medico legal litigation

India's legal regime governing medical practice is a complex amalgamation of consumer protection, criminal, and civil laws. The legislative regime governing medico-legal disputes is critically analyzed in this chapter, with specific reference to statutory instruments such as the Law of Torts, Consumer Protection Act, 2019, and

the Bhartiya Nyaya Sanhita, 2023,. It analyzes how these regulations place obligations on medical professionals and provide redressal avenues to aggrieved patients.

Chapter 4 - Judicial Trend with respect to Medico Legal Litigation

This chapter describes the manner in which the Indian judiciary has played an instrumental role in shaping medico-legal jurisprudence. It delineates the evolution of court judgments that have made significant contributions to patient rights and liability of medical professionals. The concept of medical negligence, patient autonomy, and informed consent has been formulated by landmark judgments such as Indian Medical Association v. V.P. Shantha, Jacob Mathew v. State of Punjab, and Samira Kohli v. Dr. Prabha Manchanda. Through framing legal norms and filling legislative vacancies, the court has become a significant architect of a patient-driven medico-legal system.

Chapter 5 - Conclusion and Suggestions

Chapter 5 provides a detailed recap of the key findings of the dissertation and recommends drastic changes to strengthen India's medico-legal system. The key reasons for medico-legal litigation are once again asserted to be medical negligence and violation of patient rights. In addition to regulatory norms and landmark court judgments, the research studied the legal framework through laws like the Law of Torts, Consumer Protection Act, 2019, and Bharatiya Nyaya Sanhita (BNS), 2023. The chapter emphasizes the need for a particular medico-legal law to grant clear-cut rights to patients and duties to doctors and to enshrine judicial principles. It recommends establishing specialist Medico-Legal Tribunals with expert personnel to ensure rapid and informed decisions. Other recommendations are hospital accreditation with annual audits, introducing stable and fair standards for damages in negligence cases etc.

1.12 REVIEW OF LITERATURE

Yogesh V. Nayyar & Laxman, Medical Negligence and Medical Evidence 49 (1st ed. 2024).

By concentrating on the legal assessment of medical negligence, Yogesh V. Nayyar & Laxman's Medical Negligence and Medical Evidence (1st ed. 2024) is an extensive work that unites the domains of medicine and law. Key medico-legal ideas are explained in the book, including the duty of care that healthcare providers have, what

constitutes a breach of that obligation, and how negligence cases prove causation. It highlights how important expert opinions and medical evidence are when defending or bolstering legal claims. This book assists legal professionals and medical professionals in understanding their rights, responsibilities, and liabilities by examining judicial techniques and legal norms related to medical practice.

Edward Premdas Pinto, Health Justice in India 89 (1st ed.2021)

Health Justice in India by Edward Premdas Pinto explores how social justice, law, and healthcare intersect and emphasizes the need for stricter legal accountability in the healthcare industry. The book calls for a health rights perspective and demonstrates how systemic flaws in the healthcare system disproportionately affect underprivileged communities. It highlights the shortcomings of current legal remedies for medical negligence and suggests significant changes to guarantee patient rights, ethical regulation, and accessible justice in the medico-legal system.

K Kannan, A textbook of Medical Jurisprudence and Toxicology, (Lexis Nexis 26th ed 2019)

Justice K. Kannan's revision of A Textbook of Medical Jurisprudence and Toxicology (26th edition, 2019) is a thorough and reputable text that is important to the medico-legal community in India. Originally written by Dr. Jaising P. Modi, the book has long been a reliable source for experts in the fields of medicine and law. The revised version by Justice Kannan brings the book up to date with the changing field of medical law by incorporating significant legislative and judicial developments. Topics include medical ethics, physician responsibilities, criminal and civil culpability, postmortem examinations, injury interpretation, and toxicology are all covered in great detail in the book.

Manoj Kumar Singh, A Comparative Study of Bhartiya Nyaya Sanhita 2023 with Indian Penal Code 1860: Modernization or Mere Replacement?, J. Indian Legal Stud. 112-34 (2023).

Manoj Kumar Singh analyzes the major modifications made by the Bharatiya Nyaya Sanhita (BNS) 2023 in his article titled, "A Comparative Study of Bhartiya Nyaya Sanhita 2023 with Indian Penal Code 1860: Modernization or Mere Replacement?" He focuses especially on Section 106, which deals with medical negligence. Medical practitioners were not particularly mentioned in Section 304A of the former Indian

Penal Code (IPC) of 1860, which dealt with causing death by negligence. Section 106 of the BNS 2023 takes a more thorough approach, specifically addressing the function of registered medical practitioners.

Singh, S. et al., Knowledge of consumer protection act among doctors from government and private sectors of union territory, Chandigarh, 68 Indian J. Med. Sci. 5 (2016).

In this article it discuss about a cross-sectional survey conducted with 440 doctors from government and private hospitals in Chandigarh in their 2016 study "Knowledge of Consumer Protection Act among Doctors from Government and Private Sectors of Union Territory, Chandigarh" to evaluate the doctors' knowledge and perceptions of the CPA. The average knowledge score was 15.83 out of 25, which indicated that although doctors had a moderate understanding of the CPA, there were still significant knowledge gaps. The research emphasized the necessity of consistent training and educational initiatives to improve physicians' comprehension of the CPA, which will improve patient care and lower the likelihood of legal issues.

M.S. Pandit & Shobha Pandit, Medical negligence: Criminal prosecution of medical professionals,importance of medical evidence: Some guidelines for medical practitioners, 25(3) Indian Journal of Urology (2009)

M.S. Pandit and Shobha Pandit examine the changing nature of medical negligence in India in their Article titled "Medical Negligence: Criminal Prosecution of Medical Professionals, Importance of Medical Evidence: Some Guidelines for Medical Practitioners" that was published in the Indian Journal of Urology. They pay special attention to the criminal prosecution of healthcare professionals. They observe that more lawsuits are being filed as a result of the commercialization of medicine and changing doctor-patient relationships.

CHAPTER 2

PATIENTS' RIGHTS AND DUTIES OF DOCTORS

2.1 INTRODUCTION

Doctor patient relationship can be defined as a fiduciary relationship.[33]The more experienced doctor is obligated to help less experienced and vulnerable patient because of this two-way trust connection.[34]Patient always chooses a doctor who is expert in the medical field and uses his expertise to treat the patient under a trust. In this case, the doctor makes a unilateral decision about what treatment is "beneficial" to the patients without obtaining their consent.[35]

Furthermore, because of their superior medical knowledge, doctors frequently believe they have the final say when determining a patient's needs. Additionally, they don't think it's necessary to talk to the patients about the diagnosis and suggested course of therapy.[36]

But as a result of scientific advancements, technological advancements, and the digital revolution, medical practitioners are increasingly faced with moral conundrums.[37] Doctor's hegemony in the medical field is well explained by Susan Sherwin in the following words:[38]

Until recently, good doctors were actually taught to treat their patients in a paternalist manner, using their own discretion to determine what would be best for their patients, with minimal consideration for the individual viewpoints or inclinations of each patient. The main aspect which deals in the healthcare is patient's personal life for example, lifestyle of patient, illness, mental well-being etc and it is very challenging to a doctor to take decisions that match with the patient's interest. Since modern medical care raises concerns about privacy, autonomy, etc the paternalistic approach in which patients obediently follow a doctor's orders has become obsolete.

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[33] Simon, R.I. & Shuman, D.W., The Doctor-Patient Relationship, 5 J. Lifelong Learning Psychiatry 423 (2007)
[34] Ian kennedy, Treat me right: Essays in Medical law and Ethics 387 (Clarendon Press 1991).
[35] Chin, J J, "Doctor-patient Relationship: From Medical Paternalism to Enhanced Autonomy", 43 Singapore Med J 152 (2002).
[36] Neda Milevska, Patients' Rights as a Policy Issue in SEE - the Transition Context, at 2, IPF Fellow, Open Society Inst.-Budapest (2005)
[37] Dya Eldin M. Elsayed & Rabaa Elamin M. Ahmed, Medical Ethics: What Is It? Why Is It Important?, 4 Sudanese J. Pub. Health 234,(2009).
[38] Susan Sherwin, A Relational Approach to Autonomy in Healthcare, in The Politics of Women's Health: Exploring Agency and Autonomy 21 (Francoise Baylis et al. eds., Temple Univ. Press 1998)

Nowadays, patients are more informed, want to be involved in healthcare decisions, and have higher expectations for the treatment they receive.[39]As a result patient rights are now more widely recognized.

2.2 WHO IS A PATIENT?

The genesis of the English word patient is from the Latin term patiens, which means to suffer or bear.[40]In law the person who have accessed any medical or psychiatric care is called as patient.[41] Any person who is approaching a clinic or hospital for health care service is a patient. A patient can be both outpatient and inpatient. The term "patient" is defined in only one international document i.e, the European Declaration on the Promotion of patient's rights. This document defines patient is the "person who avails the medical care".[42]Countries with law acknowledging patients' rights have defined the term "patient" as follows: Lithuanian law defines a patient is "a person who is approaching the hospitals or clinics for the medical care regardless of his health status".[43] Kansa defines a patient is a person who communicates with the doctor about his health status and seeks remedies for his health condition". [44] According to this definition, identifying a person as a patient for the purposes of the Act is the primary goal of the examination. The privilege does not apply if the examining physician has no intention of providing advice or treatment. In a number of situations, patients may rely on a doctor or their family physician in an emergency, or they might invite a doctor to visit them at home or another location to provide medical care. For example, people are also considered "patients" in legal terms since a doctor can be held accountable for medical malpractice in these situations as well.[45]

The relationship between a patient and physician is the most basics in health care. For getting standard care, and better outcome for the treatment the mandatory requirement is maintaining a good relationship between a doctor and patient.[46] The doctor patient relationship is marked "as a special relationship but on the flip side it is considered as

[39] A. Goic, It Is Time to Think About Patient's Rights, 128 Rev. Med. Chil 371, 371–73 (2000)
[40] Henry Campbell Black, Black's Law Dictionary 1126 (6th ed. 1993).
[41] Id.
[42] European Declaration on the Promotion of Patients' Rights art. 7 (1994),
[43] Law on the Rights of Patients and Damage Done to Patients art. 1(1) (1996), https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.42491 (last visited on May 20, 2025)
[44] Kan. Stat. Ann. 60-427(a)(1) (2023), https://www.ksrevisor.org/statutes/chapters/ch60/060_004_0027.html (last visited on May 20, 2025)
[45] R v. Bateman, (1925) 94 L.J.K.B. 791 (Eng.)
[46] Susan Dorr Goold, The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies, 14 J. Gen. Internal Med. 26 (1999).

the most complicated relationship".[47]There are no laws defining the conditions that give rise to doctor patient relationship. Many facets of the connection between a patient and their doctor remain unclear after more than a century of discussion mainly about the legal definition of a patient and the duties that go along with it.

2.3 DOCTOR-PATIENT RELATIONSHIP

In the medical profession the keystone of medical practice is popularly known as doctor- patient relationship. But on the other hand, in the medical field this relationship is named as the most multiplex relation and it includes not only the consultation and patient care but also the confidentiality, trust, informed consent are all the part and parcel of this relationship. There are various types and models of relations in the doctor patient relationship which will be discussed in detail in the below part of this chapter.

2.3.1CONTRACTUAL RELATIONSHIP

A patient enters into a contract with the doctor when he consults the doctor for treating any of his health condition.[48] The doctor will admit the patient only after making a thorough examination.

The doctor patient relationship is a consensual relationship. The main requirement for this relationship is the consent of both parties.[49] This relationship creates an explicit or implicit agreement that permits the doctor to treat the patient with appropriate level of expertise.[50] Lord Templeman stated that 'the doctor and patient have a contractual relationship in which the doctor perform services in exchange for payments from the patient' held in Sidaway v. Bethlem Royal Hospital Governors.[51] Irrespective of whether the patient is receiving care from the private or public hospital it is universally accepted that the nature of medical care is always contractual.[52] Thus, in QT, Inc. v. Mayo Clinic Jacksonville,[53] the doctor patient relationship was defined as a contractual one. Here the patient voluntarily submits him before the doctor and

[47] Cecil Helman, Introduction: The Healing Bond, in Doctors and Patients: An Anthology 1 (Cecil Helman ed., Radcliffe Med. Press 2003).
[48] Dogra & Abhijit Rudra, Lyon's Medical Jurisprudence and Toxicology, 171, (The Delhi Law House,11 th Edn 2022)
[49] Supra note.33
[50]James L. Rigelhaupt, What Constitutes Physician-Patient Relationship for Malpractice Purposes, 17 A.L.R. 132 (2001).
[51] Sidaway v. Bethlem Royal Hosp. Governors, [1985] 1 All E.R. 643, 693
[52]Andrew Grubb, The Law of Tort 858 (Lexis Nexis, 2d ed. 2007).
[53] QT, Inc. v. Mayo Clinic Jacksonville, 2006 U.S. Dist. LEXIS 33668

converse with the doctor about his health condition and after hearing the patient the doctor agrees to treat the patient. Private practice doctors have significant flexibility over the terms of their contracts with the patients and are free to choose how much they want to charge for their services.[54] But this choice does not apply to the doctor in the case of emergency situations.

In Ricks v. Budge[55] the Dr. Budge treated a patient who has got injury to the hands. Later on, there occurred a severe infection to his hands. Due to arrears in bill the doctor denied to treat the patient. And he falsely informed to the patient that there is no appropriate medical facility in this hospital and advised him to access the nearby hospital. The doctor operated then it was eventually severed, although the doctor operated right away. Since it is commonly known that a doctor or surgeon, while performing an operation, establishes a relationship with the patient. Here the court held that when the patient consults the Dr.Budge at the first time then there starts the doctor patient relationship. Here the doctor is duty bound to provide treatment to the patient until the patient get cures because there is no time bound agreement between the doctor and the patient. A doctor can retire from treating a patient only after explaining the reasons for the withdrawal to the patients and properly instruct him to access other medical care. If a doctor does not do so they may be held legally and morally accountable for leaving their patient.[56] Furthermore, it was established in Shirk v. Kelsey[57] A surgeon's responsibility will not end after the surgery. His responsibility is a continuing process. It will end only after the follow up treatment and the patient has to recover from the surgery. Regrading Jewson v. Mayo Clinic,[58] it held that if the doctor is in a helpless condition with regard to treating the patient, then his obligation to treat the patient comes to an end. It should not note that specific doctor-patient interactions are rarely covered by an express written contract.[59]When a doctor examines a patient at the request of a third party or out of his professional interest then there will not forms a doctor patient relationship. In Lopez v Aziz[60] the court held that the doctor patient relationship will not arise when the doctor gives

[54] Barry R. Furrow et al., Health Law 260 (2d ed. 2000).
[55] Ricks v. Budge, 91 Utah 307, 64 P.2d 208 (1937).
[56] Id
[57] Shirk v. Kelsey, 617 N.E.2d 152 (Ill. App. Ct. 1st Dist. 1993).
[58] Jewson v. Mayo Clinic, 691 F.2d 405, 391 (8th Cir. 1982).
[59] Jones v. Malloy, 412 N.W.2d 837, 841 (Neb. 1987).
[60] Lopez v. Aziz, 852 S.W.2d 303, 306 (Tex. App. 1993).

advice to the colleague other than the patient. In Mead v Adler[61] the court concluded that the on-call neurologist had a responsibility that was different from "curbside consults" where a doctor shows professional politeness to another doctor without having any obligation to the patient.

No doctor patient relationship occurs when a diagnosis is conducted by the doctor on the basis of a request from a third party because here the diagnosis is mainly conducted for giving answers to the third party. Here the third party may be either the court, employer or the insurance company.[62]According to the ruling in Johnson v Sibley[63] the court held that when a patient is examined by a doctor for the purpose of granting him workmen compensation no doctor patient relationship arises. Because here the doctor's only duty is to assess him without creating injury to the patient. Before a relationship can be formed, the patient must receive the treatment from the doctor.[64]A legal contract is created when a doctor voluntarily starts a connection with a patient in and the doctor is then obligated to treat the patient going forward or to end the relationship appropriately. The doctor's duty of care exists even in cases where care is given without charge and is not contingent on payment of fees.[65]It results from the physician's consent to provide, as well as patient's dependence on it. The people who come to hospitals for the treatment have a primary obligation of care.[66] Texas court of Appeal held the following in Gross v Burt[67] when a consulting or referred specialist physician examines a patient in a hospital, they do not have an ongoing obligation to ensure that follow-up is maintained after providing the results to the primary or referring physician. If the obligation to provide ongoing treatment to all patients seen by consulting doctors outside of hospitals were to be extended based only on the fact that the patient saw the doctor in the hospital, the doctor patient interaction would continue. However, it is evident that self -limiting relationships are recognized by Texas law.

[61] Mead v. Adler, 231 P.3d 118 (Or. App. 2009).
[62] State v. Herendeen, 613 S.E.2d 647 (Ga. 2005).
[63] Johnston v. Sibley, 558 S.W.2d 135, 136 (Tex. App. 1977).
[64] Day v. Harkins & Munoz, 961 S.W.2d 278 (Tex. App. 1997).
[65] Jackson v. Isaac, 76 S.W.3d 177, 182 (Tex. App. 2002).
[66] Supra note.33
[67]Gross v. Burt, 149 S.W.3d 213, 227 (Mo. Ct. App. 2004).

2.3.2 FIDUCIARY RELATIONSHIP

There is a credulous relationship between a patient and a doctor. This relationship always forms an ethical obligation to the doctors for giving more emphasize to the patients' needs rather than their own interest and fight for the well-being of their patients.[68] An obligation of fiduciary duty may be owed by a physician to a patient.[69]Medical professionals generally owed a tortious duty of care to the patient's. According to Pippin v Sheppard the court held that when a doctor abandons a patient in a irremediable state it is contrary to the doctor's obligation to care the patient.[70]The Oregon supreme court stated in dicta in Dowell v Mossberg[71] in a doctor patient relationship there always arises an obligation for the doctor to give appropriate care to the patient during the treatment. If the doctor failed to give proper care to the patient during the treatment it results in the infringement of obligation to care. In addition, the court acknowledged in Ramirez v Carreras[72] that there is typically no prerequisite relation require for a duty to refrain from carelessly harming others. A doctor and patient may have a consensual relationship, according to the ruling in Dougherty v Gifford[73] wherein third parties have entered into a contract with the doctor on behalf of the patient. When assessing whether a relationship is consensual, it is crucial to consider whether the patient gave their express or implicit agreement or whether the service was provided for his benefit. A consenting doctor patient connection exists for the purpose of medical malpractice when health care services are provided for the patient in the absence of him. In Stanford v Cannon[74] the court held that on the basis of the doctor's and the patient's conduct and behavioral patterns there arises the doctor patient relationship.

It can be concluded that when the doctor examines and provide treatment to the patient there establishes a doctor patient relationship. And an obligation to care also arises when the doctor performs any medical service to the patient no matter regarding the quantum of charges.

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[68]Supra note.33
[69] Ian Kennedy, The Fiduciary Relationship and Its Application to Doctors and Patients, in Wrongs and Remedies in the 21st Century 119, 119 (Peter Birks ed., 1996).
[70]Pippin v. Sheppard, (1822) 11 Price 400 (Eng.)
[71] Dowell v. Mossberg, 226 Or. 173, 190 (1961).
[72] Ramirez v. Carreras, 10 S.W.3d 762 (Tex. App. 1999).
[73] Dougherty v. Gifford, 826 S.W.2d 668, 675 (Tex. App. 1992).
[74] Stanford v Cannon, 2011 WL 2518856

2.4 MODELS OF DOCTOR- PATIENT RELATIONSHIP

A doctor–patient relationship model can be defined as the lively exchange or interplay with the doctor and the patient. And the main obligation of doctor in this relationship model is to give medical care to the patient for the respective disease and the patient has the right to choose whether to accept the medical care offered by the doctor or not. The various models of doctor- patient relationship are discussed below:

2.4.1 PRINCIPAL – AGENT RELATIONSHIP MODEL

This model is commonly known as agency model relationship. Here the doctor acts like an agent and the patient is the principal. Here the doctors are more aware about the patient's health status and what medication is most suitable for them is well versed with the doctor. And the patients have also information about the medications and how it will be suitable for him. Here the patient communicates his choices to the doctor and the doctor performs like an agent of the patient. The main objective of this model is the patient's utility is maximised by the doctor considering that it was their own. But this model has certain criticisms. They are:

- Doctors and patients have different objectives when they both meet for medical care. And the doctor often failed to recognize the needs of the patients. This leads to an unsatisfaction among the patients and they will be reluctant to follow the suggestions of the doctors.
- The principal agent relationship in some circumstances will not become possible. Because the doctor may face several hindrance like administrative directions, time issue and personal needs.
- Sometimes the patient acts purely as principal and they will get a governing power over their treatment.

2.4.2 PATERNALISM MODEL

The control and authority which the doctor exercise over the patient to benefit them or for protecting them from any harm regardless of their informed permission is known as paternalism.[75] Another term for this model is Professional choice. Paternalism model is one of the conventional models in the doctor – patient relationship. Here the doctor acts like a specialist of the patient and he decides which treatment is most

[75] Marwan A Habiba, Examining the consent within the Patient- Doctor Relationship, Journal of Medical Ethics, 186 (2000)

appropriate to the patient. The patient has no right to choose which treatment is better for him here the patient role is just to obey the decisions of the doctor regarding their medical care. In this model the patient has only a passive role in their health care they are not an active party while making decisions regarding their health care. Here the doctors are making the decisions regarding the medical care of the patient without their consent and the doctors behaving under this model firmly believes that their decisions will be beneficial to the patients. In paternalistic model the doctor has the discretionary power to choose whether to disclose the actual health status of the patient to them or to hide with them in the case of fatal diseases.

One of the assertions that supporting the paternalism model is that the doctor is having better knowledge about the health status of the patient and he is well aware about what treatment and medication is well suited for them. This awareness helps the doctor to take decisions regarding the medical care of the patient that will be more suitable for them. And some of the scholars mentioned that practically a doctor can act only in a paternalistic manner because there are certain hinderance may face by the doctor for revealing the proper health status of the patient. Here the doctor after recognizing the patient's condition prescribes him the proper medication.[76]

2.4.3 SHARED DECISION MODEL

In the doctor patient relationship, the shared decision model has two parties and both parties actively participate in the decision-making process. This model mainly comprises of four ingredients they are:

- In the decision-making process both parties i.e. the doctor and patient must actively participate.
- Both the parties have to share relevant information regarding their health status.
- The parties have to reveal their treatment choices.
- Once the parties have chosen their preference regarding their treatment then they both agree upon the treatment.

In this Shared decision Model both doctor and patient have equal status and equal power has been granted regarding the decision making. The main drawback of this

[76] C. Charles, Decision making in the physician-patient encounter: revisiting the shared treatment decision-making model, 49 Social Science and Medicine 651-661 (1999).

model is usually the patient take long time to make their decisions and sometimes the decision taken by the patient will be incorrect in some case the decision taken by the doctor will leads to a negligent act.

2.4.4 INFORMED DECISION-MAKING MODEL

In this model the doctor act as guide to the patient and provide all relevant information to the patient regarding their health condition. Here the information flows only from one side i.e. from the doctor's side. But here the patient's have given the right to choose which medical care is most suitable for them after analyzing the information given by the doctor regarding their health status. Here the doctor's role is to make aware about the patient about their health status by providing relevant information. The main drawback of this model is the patient takes a long time to take the decision regarding which treatment has to choose.

2.4.5 COMPARISON OF DOCTOR PATIENT RELATIONSHIP MODEL

The table in below compares the four models which is discussed above. This models mainly differentiated on the basis of patient autonomy.[77]

Aspects	Principal – Agent Model	Paternalism Model	Shared Decision Model	Informed Decision Making Model
Values of patient	Defined, established and understood by the patient	Sharing the goal and communication between the patient and the doctor	Conflicting and inchoate, needing clarification	Welcoming to improvement and modification through a moral discourse
Obligation of Physician	Delivering pertinent factual data and carrying out the patient's selected intervention	Encouraging the patient's health regardless of their preferences	Clarifying and interpreting pertinent patient values, educating the patient and carrying out the action that the patient has chosen	Communicating and convincing the patient of the most admirable principles, educating the patient and carrying out the patient's chosen course of action

[77] Emanuel E.J.et al. Four models of physician patient relationship, 11 (3) JAMA, 208-211 (2010).

Conception regarding autonomy of patient	Control and choice over medical treatment	Adhering to impartial principles	Self-awareness in relation to health care	Moral growth in relation to health care
Role of Physician	Capable technical specialist	Guardian	Counsellor	Companion

2.5 PATIENT RIGHTS AS PER THE CHARTER OF PATIENT RIGHTS

The Universal Declaration of Human rights is giving more importance to the equality and dignity of human beings. The main outcome of this is the patient rights has evolved globally.

Every patient should have access to a set of fundamental rights on a global scale. Numerous laws and legal document in India contain provision pertaining to patient rights such as Art 21 of Indian Constitution, The Drugs and Cosmetics Act, 1940, The Consumer protection act, 2019, The Clinical Establishment Act,2010, and a number of rulings from the National Consumer Redressal Commission and the Honourable Supreme Court of India.

The charter of patient rights adopted by National Human Rights Commission[78] of India announced by the Ministry of Health and Family Welfare, Government of India, on August 30, 2018.

One of the main goals of the charter is to creating awareness about the patient or the public as what sort of medications have to expect from the health care providers or from the government as a human or patient. The patients can raise up the level of the medical field in the country when they become acquainted with their rights and responsibilities. Each state's human rights commission have to adopt the patient's charter for serving as a guiding light for protecting the patient rights.

As per the charter patient has got seventeen rights which will be discussed here under.

2.5.1 RIGHT TO INFORMATION

In healthcare, the patient's position has evolved from being a passive recipient of the doctor's orders or guidance to an active participant in the therapeutic alliance.[79]In

[78] Supra note.10
[79] Don Malcolmson, The Patient's Right to Know, 101 J. Med. Regul. 32 (2015).

order for the patient to actively participate, they need to be informed about pertinent details regarding their care.

According to Level 1 hospitals minimum standards of CE, patients or their representatives are entitled to sufficient, pertinent information regarding the type of illness, its cause planned investigation and care, the anticipated outcomes of treatment, potential side effects and anticipated expenses.[80]According to the charter, patients have the right to sufficient information regarding any preliminary or verified diagnoses made about them, and these pertinent details must be made available and explained to the patient in the language they are familiar, at their comprehension level.[81]Furthermore, the doctor or trained helpers must present this information in the most straight forward manner possible without overwhelming the patients with excessively complex terms or confounding them. Patients are entitled to get information about the medication's name, dose and any potential side effects.[82] Each CE has to prominently display patient's rights so that patients and their companions have the best chance to become acquainted with the particular set of rights they are entitled to when seeking medical care. Every patient has the right to know about the doctor who is caring them, his qualifications etc. The hospital administrators are obligated to inform these details to the patients and it must be informed in writing along with an acknowledgment.[83]The certificate of registration must be prominently displayed in the CE so that anyone visiting the CE can see it.[84]Along with the certificate, CE must also display the specific pricing information for each category of services and facilities offered by the CE in both English and the local

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[80] Clinical Establishments (Registration and Regulation) Act Standards for Hospital Level 1, Annexure 8, https://clinicalestablishments.gov.in/WriteReadData/147.pdf. (Last Visited on May 22, 2025)

[81]Supra note 10

[82] National Accreditation Board for Hospitals & Healthcare Providers (NABH), Charter of Patients' Rights (2018), https://nabh.co/Images/pdf/Patient_Charter-DMAI_NABH-new.pdf. (Last visited on May 22, 2025)

[83] Supra note.10

[84]Clinical Establishments (Registration and Regulation) Act, 2010, Sec. 18, https://www.indiacode.nic.in/bitstream/123456789/7798/1/201023_clinical_establishments_%28registration_and_regulation%29_act%2C_2010.pdf. (Last Visited on May 22, 2025)

language.[85]These are required in order to provide patients with basic information about the physician or staff who are treating them, as well as about legitimacy of the hospital or clinic's establishment in general. The CE's registration may be cancelled if any of the aforementioned are not presented correctly.

Every patient or those who accompany them, has the right to full disclosure of the anticipated expense of care. Any variation in expenses brought on due to the variation in physical status of patient's have to be communicated in writing. Additionally, patients are entitled to information regarding the hospital's policies and procedures.[86]The patient has the right to get itemized bill with all of the charges and expenses after the course of treatment is over.[87] Services which are given in medical field are covered under the Consumer Protection Act and the patients are classified under the title of consumer when they are availing medical service.[88]

2.5.2 RIGHT TO RECORDS AND REPORTS[89]

The patients medical record preservation is an important aspect in an hospital. This develops into legitimate documentary proof that can be presented to future authorities. The doctor's sole means of ensuring that treatment is effective for the patient and other authorities. The main aim of keeping or preserving the medical records in the hospital is for proving to the patients and other authorities that proper treatment has given from the hospital.[90]

Medical records in different areas have to fulfil different criteria's but some of the information's were common in every place they are patient name and address, the doctor's qualifications, the medicines prescribed for the patient, the current health condition of the patient, time of admission and discharge and the follow up details.[91] Medical records must be kept either digitally or physically.[92]The involved individual or hospital is responsible for ensuring the confidentiality, security, and integrity of

[85] Clinical Establishments (Central Government) Rules, 2012, Rule 9, https://clinicalestablishments.gov.in/WriteReadData/386.pdf.(Last visited on May 22, 2025)
[86] Supra note.82
[87]Supra note.10
[88] Supra note.4
[89] Supra note. 10
[90] Thomas Joseph, Medical records and issues in negligence, 25 Ind. J. Urol. 384 (2009)
[91] Hayley Rosenman, Patients' Rights to Access Their Medical Records: An Argument for Uniform Recognition of a Right of Access in the United States and Australia, 21 Fordham Int'l L.J. 1500, 1503 (1997).
[92] Supra note 80, Sec 9.2

such records.[93] In accordance with applicable laws and court decisions inpatient records must be kept up to date.[94]The doctor is required to maintain correct medical records of the concerned indoor patient in the format prescribed for three years after the start of treatment.[95]Medical records must be provided by physician upon request from the patient or competent person or authorities, in a span of 72 hours.[96]If a doctor does not disclose medical records within the specified time after being asked by the individual in question, the relevant authority may draw a negative conclusion.

In Rajappan v Sree Chitra Tirunal institute for Medical Science and Technology[97] the Kerala High Court ruled that when a patient requested for the medical records the hospital authorities have to provide photocopy of the complete sheet kept by the hospital at free of cost.

The discharge summary is entitled to the patient or their companions or family members are entitled to obtain a death summary and the original investigational documents. It is the responsibility of the hospital administration to supply these documents and reports, as well as to give instructions to the accountable hospital employees to guarantee that the same are always and completely adhered to.[98]Clinical Establishment Act standards for Hospital Level 1 Annexure 10 [99] specifies what should be included in the discharge statement and how it should be presented in a format that the patient can understand.

The Bombay High court ruled in Ragunanth Raheja v Maharashtra Medical Council[100] that right to get medical records of the patient is one of the fundamental rights guaranteed to the patient. Further the court held that medical council should ensure that all the medical professionals have properly trained for providing medical records to the patients when they needed. Additionally, hospitals cannot claim confidentiality or secrecy concerns when it comes to providing the patient with such documents.

[93]Supra note.80, Sec 9.3
[94] Supra note 80, Sec 9.4
[95] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 ,Appendix 3
[96] Id. Reg 7. 7.2.
[97] Rajappan v. Sree Chitra Tirunal Institute for Medical Science and Technology, 2004 (2) KLT 157
[98] Supra note.10
[99] Id
[100] Raghunath Raheja v. Maharashtra Medical Council, AIR 1996 Bom 198

In Ozair Hussain v Union of India[101] the Delhi high court ruled out that each and every consumers have the right to know about the product details. In Nisha Priya Bhatia v Institute of Human Behaviour and Allied Sciences, GNCTD[102] the central information commission expanded the application of Ozair Hussain concept to medical services, ruling that a patients have the right to know about all the information regarding their health status. Customers have not only the right to knowledge about the goods and services but also, they have the right to know about the health care.[103]

In the case of Prabhat Kumar v Directorate of Health Services and ors[104] the court held that both private and public hospitals have to give the medical records to the patients. If any of the hospitals irrespective of whether it is private or public hospital have not given access to the medical records is considered to be violation of Art 14 of the Indian Constitution.

2.5.3 RIGHT TO EMERGENCY MEDICAL CARE [105]

The right to life and personal Liberty is enshrined under Art 21 of Indian constitution. It declares that no one shall be deprived of his life or personal liberty except according to the procedure established by law.[106]The Supreme court has defined the term "life" as something more than the mere animal existence.[107] The supreme court has interpreted Art 21 in different angles and included various other rights that are important to envision right to life. One of the example for such right is right to health which is interpreted by the Supreme court under Art 21.[108]Citizen's health should be prioritized in order to obtain optimal results as well as to give life purpose.[109] The government is obligated to provide the necessary medical services and facilities for exercising right to health.[110]It was held that right to health is a part of Art 21 when read with article 39 (e), 41 and 43 of the constitution .[111]

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[101] Ozair Husain v. Union of India, AIR 2003 Delhi 103
[102] Nisha Priya Bhatia v. Institute of Human Behaviour and Allied Sciences, *GNCTD*, CIC/AD/A/2013/001681-SA
[103] *Id* at para 12
[104] Prabhat Kumar v. Directorate of Health Services, CIC/SA/A/2014/000004
[105] Supra note 10
[106] Indian Constitution Art.21
[107] Kharak Singh v. State of U. P., AIR 1963 SC 1295
[108] Bandhua Mukti Morcha v. Union of India, AIR 1984 SC 802
[109] State of Punjab v. Ram Lubhaya Bagga, (1998) 4 SCC 117
[110] State of Punjab v. Mohinder Singh Chawla, (1997) 2 SCC 83
[111] Consumer Education and Research Centre v. Union Of India, AIR 1995 SC 922

A PIL was filed in Paramanda Katara v union of India[112] based on a newspaper article that stated that an accident was turned away from a neighbourhood hospital and sent 20 kilometres away to a hospital that was permitted to handle medico legal issues. On the way patient passed away. Here the Supreme court mentioned the importance of safeguarding the life of humans. Every medical professional irrespective of whether they are working in government or private hospitals has to use their medical knowledge for safeguarding the life of humans.

There is a question raised that the legal procedures have to follow before providing treatment in emergency situation, the court held that in such situations there is no legal impediment on to the medical professionals. Saving the patient from the serious condition is the main aim of the doctors, police force or any other persons who is the part and parcel of the accident. Consequently, no law or government action could interfere with or postpone the fulfilment of the doctor's primary duty, and any legislation that prevents emergency medical care ought to be repealed.[113]

In Pachim Banga Ket Mazdoor Samity v State of West Bengal [114] due to the inadequate medical facility in the government hospital for emergency condition the patient was shifted to the private hospital that charged an outrageous price for medical treatment. The court held that inadequate medical facility in the government hospital violates the patients right to life.[115]The Supreme Court further ruled that, despite the fact that emergency care requires financial resources, state have constitutional duty to provide their citizens with adequate medical care, and as such, all necessary steps must be taken to guarantee emergency medical care.[116]

Doctors are allowed to choose who they treat; they should always be prepared to treat patients who are ill or injured, and they shouldn't turn away patients without cause in an emergency.[117]The doctor ought to respond to an urgent medical request without reluctance and after considering a case, not ignore the patient or stop treating them without telling the patient or their family first.[118]

[112] Parmanand Katara v. Union of India, (1989) 4 SCC 28
[113] Id at para 8
[114] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, AIR 1996 SC 2426
[115] Id at para 9
[116] Id at para 16
[117] Supra note 95 Reg. 2.1
[118] Id Reg. 2.4.

2.5.4 RIGHT TO INFORMED CONSENT[119]

In the present days informed consent is the most relevant topic in the medical field.[120]The idea that patients must give their consent before receiving any kind of treatment is well established. One definition of it is "the patient's consent is required for an act to be performed by a physician, including a medicinal, surgical or diagnostic operation".[121]A number of ethical concerns are brought up by the idea of informed consent's absolute applicability.

The fundamental idea of respecting and valuing an individual's autonomy, as stated in the Nuremberg code of 1947, is the foundation of modern informed consent.[122] The World Medical Association's 1964 Declaration of Helsinki places a strong emphasis on getting the research participant's voluntarily informed consent. Upholding an individual's autonomy and right to make a reasoned decision is the goal of informed consent.[123]Respecting a patient's autonomy entails granting them the freedom to express their thoughts, make decisions, and act in ways that are consistent with their values and beliefs.[124]The basis of Informed consent and other essential components of rights which are guaranteed to the patients are mainly on the ground of right to autonomy which is enshrined under Art 21 of Indian constitution. The written consent of the patient has to be taken before conducting any tests or treatments.[125] According to the information listed in Annexure 9[126] of the clinical establishment Act standards for hospital level 1[127] the informed consent has to procure from the patient or from the bystanders if the patient was unable to give consent and it must be in the language which is known by the patient. It is necessary to clarify any possible dangers or consequences associated with the diagnosis or treatment.

Before performing an operation, the patient or his spouse, parent, or guardian should provide written agreement. If the procedure results in sterility, the husband and wife

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[119]Supra note 10
[120] Omprakash Nandimath, Consent and Medical Treatment: The Legal Paradigm in India, 25 Indian J. Urol. 343 (2009).
[121]Samira Kohli v. Dr. Prabha Manchanda, AIR 2008 SC 138 at para 14
[122] Cecilia Nardini, The Ethics of Clinical Trial, https://pmc.ncbi.nlm.nih.gov/articles/PMC3894239/ (last visited on May 22, 2025)
[123] Furkhan Ali et al., Consent in Current Psychiatric Practice and Research: An Indian Perspective, 6 Indian J. Psych. 667 (2019).
[124] Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics 57 (5th ed. 2001).
[125] Supra note 80, Annexure 8
[126] Supra note 80, Annexure 9
[127]Supra note 80, Sec 10.23

must also provide their approval.[128] Obtaining informed consent is supposed to be done with the highest care and openness, and if a doctor fails to acquire the consent in any of the aforementioned situations, he could be held accountable for misconduct. The hospital administration has to give proper training to the healthcare professionals for acquiring informed consent from the patients.[129]

The Supreme Court ruled in Samira Kohli v Prabha Manchanda[130] the doctor has the right to perform only the conduct which the patient have given consent i.e., when the patient has given consent for diagnosis then the doctor can perform only the diagnosis procedure not beyond that. In this case, the 44-year-old single patient gave permission to have a laparoscopy for diagnosis and surgery, as well as laparotomy if necessary. Here the doctor has done hysterectomy, when the patient was under the influence of anaesthesia and obtained consent from the mother of the patient. There was no urgent or serious condition for conducting surgery by obtaining consent from her mother. Here the physician has to wait for the patient for getting back her consciousness and to obtain proper consent from her for doing the surgery.

The informed consent has certain exception. It may not apply to emergency medical treatment.[131]In the case of Ozair Hussein v UOI[132] held that lifesaving drugs are intended to combat illness and preserving life, it was decided that patient do not need to be informed about them.

2.5.5 RIGHT TO PRIVACY, CONFIDENTIALITY AND HUMAN DIGNITY

The patient's right to autonomy has ramifications for privacy and confidentiality. Similar to informed consent, patient autonomy serves as a foundation for privacy and secrecy. Respect and dignity are enhanced by privacy and confidentiality.[133]Therefore, it is relevant to the establishment and maintenance of a productive and professional clinical relationship.[134]The term privacy describes the authority and right to limit the degree to which others can interfere with one's physical, behavioural or intellectual existence. Physical and informational privacy are

[128] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Reg.19 A.
[129]Supra note.10
[130] Supra note.121
[131] Pravat Kumar Mukherjee v. Ruby General Hospital, II (2005) CPJ 35 (NC)
[132] Supra note 101
[133] Mohammad Mohammadi et al., Do Patients Know That Physicians Should Be Confidential? Study on Patients' Awareness of Privacy and Confidentiality, 11 J. Med. Ethics & Hist. Med. 1 (2018).
[134] Hui Zhang et al., Patient Privacy and Autonomy: A Comparative Analysis of Cases of Ethical Dilemmas in China and the United States, 22 BMC Med. Ethics 1, 8 (2021).

two of the most crucial types of privacy with regard to patients. In K S Puttaswamy v UOI[135] the Supreme Court held that the main constituent of right to privacy is right to life and personal liberty guaranteed by the Constitution.

Right to privacy, human dignity, and confidentiality are the fundamental rights guaranteed to every patients.[136]The doctor has to keep the medical records and health status of a patient in a highly confidential manner except when the disclosure is essential for the public health or when it is required by the law or court.[137] Aside from the aforementioned situations, a doctor is not allowed to post patient photos or case reports anywhere without the patient's permission, unless their name or identity is kept secret.[138]

Female patients are entitled to have another female present when a male practitioner performs a physical examination on them, and the hospital must guarantee this. The medical facilitators are expected to respect the patient's cultural and special preferences. Additionally, hospital administrators need to make sure that their employees respect patient's dignity at all times. The data collected from patients must be properly safeguard to prevent leaks.[139]The right to confidentiality and privacy is not an absolute right, and as was previously mentioned, there are situations in which violating it is both morally and legally justified. The situations are when it is good for the public or if there is any law or court order.[140]The Supreme court while in Sharda v Dharmpal[141] the boundaries between privacy and the greater good were drawn with a bias towards the latter. Due to the wife's mental illness the husband approached the court for divorce. Here the court ordered for the medical examination. But the wife claimed that her health status is to kept in a confidential manner so, conducting medical examination is the violation of her privacy. But the court rejected her claim and held that it is not an absolute right and the case would suffer if such information lacks.[142]

[135] K.S. Puttaswamy v. Union of India, (2017) 10 SCC 1
[136] Supra note.80
[137] Supra note.95,Reg. 2.2,7.14
[138] Id Reg 7.17 .
[139] Supra note 10
[140] Mr. X v. Hospital Z, AIR 1999 SC 495, 499-500
[141] Sharda v. Dharmpal, AIR 2003 SC 3450
[142] Shri G.R. Rawal v. Director General of Income Tax (Investigation), CIC/AT/A/2007/00490

2.5.6 RIGHT TO SECOND OPINION AND RIGHT TO CHOOSE ALTERNATIVE TREATMENT OPTION IF AVAILABLE[143]

Right to autonomy and self-determination is the basis of a sick person's right to opt for second opinion and alternative treatment. Many illness are inherently complicated, and there are no obvious answers for a precise diagnosis or the best course of treatment and in certain cases, the primary accountable physician might not have enough experience. [144] No matter how careful medical professionals or hospital administrators are in unexpected situations involving incorrect diagnosis, incorrect treatment or medication overdose are a risk that cannot be totally disregarded.[145] For keeping a scientific balance it is essential to approach a doctor for a second opinion balance.[146]It is every patient right to have a second opinion from a qualified clinician of their choice.[147]It is the duty of the hospital authorities and doctors to give the medical records of the patient whenever they needed especially in the case when the patient is seeking second opinion or alternative treatment. And the medical records have to given to the patients at free of cost.

2.5.7 RIGHT TO CHOOSE SOURCE FOR OBTAINING MEDICINES OR TESTS[148]

It is the discretionary power of the patients to select from where to purchase the prescribed medications or from where the test or diagnosis has to done. Patients can approach any licensed pharmacy for obtaining the recommended medication or substance in accordance with their autonomy and preference. The same is true when a test, diagnosis, or investigation is recommended for a specific condition; they have the right to have the test performed as they fit by any registered laboratory or diagnostic facility with trained staff.[149]

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[143]Supra note 10
[144]Inder Maurya, Medical 2nd Opinion – Trends & Challenges https://bwhealthcareworld.com/article/medical-2nd-opinion-%E2%80%93-trends-challenges-179592 (last visited on May 22,2025)
[145] Nomal Chandra Borah, Doctors' Dilemma and Patients' Right to Second Medical Opinion, ECON. TIMES: HEALTH Doctors' dilemma and patients' right to second medical opinion - Health Files by Dr. Nomal Chandra Borah | ET HealthWorld (last visited on May 22,2025)
[146]Daniel Wechter & Donna Harrison, A Second Opinion: Response to 100 Professors, 29 Issues L. & Med. 147 (2014).
[147] Supra note 80
[148] Supra note 10
[149] *Id*

2.5.8 RIGHT TO TRANSPARENCY IN RATES AND CARE ACCORDING TO PRESCRIBED RATES WHEREVER RELEVANT[150]

CE law laid down that all CE's working in India has to exhibit the price for all the treatments and facilities they are providing. The exhibit must be made in both the vernacular and English language. Additionally, the rates that each CE charges for service and facilities must fall within the range that the Central Government determines and issue after consulting with State Government.[151]CE's must abide by certain regulation in order to be registered and to continue operating. The hospital administration must make an effort to inform the patient and his companions about the fees through booklets, table positioned at eye catching angles or brochures. The patient is entitled to thorough, itemized bill. When providing medical care, doctors put their patient's interest first and avoid conflicting with their financial interests. The rates that a doctor charge should be disclosed before the surgery or treatment is started, not after it has started. The amount and format of the compensation must be precisely agreed upon before the treatment begins. As the fees of the treatment the doctor has to receive only the agreed sum of money which was agreed prior to the procedure. It is considered unethical for the doctors to engage in 'no cure no payment 'contracts. The government doctors should refrain from accepting any consideration from the patients.[152]In developing nations 40% of health care is spending for Drugs and other pharmaceuticals.[153]Nonetheless, a sizable portion of the populace frequently does not have access to the most basic medications. This crisis may be influenced by a number of circumstances, including poverty. World Health Organization defines essential medications are the drugs that cater the healthcare wants of most of the people in the society.[154]

2.5.9 RIGHT TO NON – DISCRIMINATION

Individuals who belong to vulnerable, marginalised, or socially disadvantaged groups deal with a variety of health issues. The main reason for the health issues faced by these individuals is mainly due to the discrimination they faced on the grounds of sex,

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[150] *Id*
[151] Supra note 85, r. 9(i)-(ii)
[152] Supra note. 95 ,Regulation 1.8
[153] Rituparna Maiti et al., Essential Medicines: An Indian Perspective, 40 Indian J. Cmty. Med. 223 (2015).
[154] WHO Expert Comm. on the Selection & Use of Essential Medicines, The Selection and Use of Essential Medicines, WHO Tech. Rep. Series No. 914 (2002).

place of birth, race, or ethnicity, or religion.[155]The fundamental rights outlined in Article 14, 15, 16 of Indian Constitution support the idea of equality in treatment are a component of a set of rights that are guaranteed by the Indian Constitution.[156]Equal status and opportunity are guaranteed under the constitution for socially behind in terms of education and economics.[157]Equality is guaranteed under Art 14. Art 15 forbids discrimination on the basis of religion, ethnicity, caste, sex or place of birth. Another aspect that ensures equality in public employment is Art 16.[158]Art 15 and 16 are instances of the same right permitted in a particular circumstance, but Art 14 is a general right. [159] Therefore, the constitution forbids discrimination in all fields, including health care. The Indian constitution guarantees every patient for the right to access the healthcare without any discrimination on the ground of HIV Status, religion, caste, ethnicity, gender, age, sexual orientation, linguistic, or geographic or social backgrounds.[160]It's the appropriate responsibility of the hospital administration to guarantee that no patient is the target of any kind of discriminatory action or treatment, and this needs to be constantly and sternly explained to the staff and physicians[161].

2.5.10 RIGHT TO SAFETY AND QUALITY CARE ACCORDING TO STANDARDS[162]

Hospitals have several obligations to their patients. Beyond medical errors, administrative errors can also result in patient safety and security issues. [163] In Thompson v. Nason Hospital[164], the Pennsylvania Supreme court held that every hospital's have mainly four obligations regarding the patient care they are:

- The availability of high standard facilities and equipment's for the patient care.

[155] Joshua G. Rivenbark & Mathieu Ichou, Discrimination in Healthcare as a Barrier to Care: Experiences of Socially Disadvantaged Populations in France from a Nationally Representative Survey, Discrimination in healthcare as a barrier to care: experiences of socially disadvantaged populations in France from a nationally representative survey | BMC Public Health | Full Text (last visited on May 22, 2025).
[156] State of Kerala v. N. M. Thomas, AIR 1976 SC 490 at para 21, 54
[157] Id at para 44
[158] Id at para 54
[159] Gazula Dasaratha Rama Rao v. State of Andhra Pradesh, AIR 1961 SC 564
[160]Supra note 10, Supra note 80
[161]Supra note 10.
[162] Id
[163] Mukesh Yadav & Pooja Rastogi, Patient Safety Due to Administrative Negligence: Neglected Area in India?, 1 Annals of Int'l Med. & Dental Res. 72 (2015).
[164] Thompson v. Nason Hospital, 527 Pa. 330 (1991)

- Appointment of qualified medical professionals for health services.
- Superintending the health care professionals with the respect to the patient care they are providing.
- For offering standard health care implementing appropriate guidelines for patient care.[165]

In Ashish Kumar Mazumdar v. Aishi Ram Batra Charitable Hospital Trust[166] the lower court decision was upheld by the Supreme court. That a hospital's responsibility extends beyond diagnosing and treating of the patient but also goes beyond ensuring their security and safety, especially for those who are ill or using medication. The hospital authority's primary duty is to maintain necessary attention for the patient's safety. It was because of the absence of proper attention the patient, in spite of his ill health, was able to wander around and was hurt.[167] In a similar case wherein a patient was allowed to roam around in the hospital admitted for de-addiction due to acute usage of drugs and alcohol, the patient was found to have committed suicide in the hospital. The National commission held that when a patient was admitted in the hospital it is the duty of the hospital authorities to ensure that the patient was safe in the premises. [168] Patients are therefore entitled to safety and security within the hospital and on its grounds. The hospital authorities are obligated to provide healthcare for patient in a hygienic environment with sufficient drinking water which satisfy BIS/FSSAI requirements.

The CE laws have established guidelines for how each CE should operate, and it is required that these guidelines be followed. To guarantee patient safety, the central government has released Standard Treatment Guidelines for practically all of the CE's major departments and excellent medical attention.[169] Patients are entitled to the

[165] Id at para 15
[166] Ashish Kumar Mazumdar v. Aishi Ram Batra Charitable Hosp. Tr., (2014) 9 SCC 256
[167] *Id* at para 6
[168] Medical Superintendent, St. Gregorious Mission Hospital v. Jessy, III (2009) CPJ 61 (NC).

[169]Clinical Establishments (Registration & Regulation) Act, 2010, Ministry of Health & Fam. Welfare, http://clinicalestablishments.gov.in/En/1068-standard-treatment-guidelines.aspx (last visited on May 22, 2025)

minimal level of treatment that is required by the aforementioned standards, regulations, and NABH[170] certification requirements.

A person implicitly commits to having the necessary skills and knowledge when he states that he is prepared to offer medical advice or treatment.[171] The physician has certain obligation to the patient when he is treating a patient. They are:

- Obligation of care lies when a physician chooses to treat a patient.
- Obligation of care lies when a physician prescribes a treatment to the patient.
- Obligation of care lies when the physician carries out the treatment

The patient can file medical negligence or service deficiency complaint against the physician if any of the above-mentioned obligations violated. The medical professional must apply a reasonable level of competence and knowledge to his work and exercise a fair level of caution to guarantee the patients right to high-quality care in accordance with medical ethics tenets and beliefs. Therefore, the medial facilitators have an obligation to provide high-quality healthcare.

2.5.11 RIGHT TO PROPER REFERRAL AND TRANSFER, WHICH IS FREE FROM PERVERSE COMMERCIAL INFLUENCE[172]

When a patient who is suffering from life threatening disease, he has the right to get emergency medical care without any kind of discrimination. It is usually necessary for a patient to be transferred or referred to receive higher quality treatment when the facilities or services are subpar. When a patient is transferred from one hospital to another hospital the health professionals must explain to the patient the reason behind the transfer. The right to full information regarding the ongoing medical needs after discharge belongs to the patient or their companions. The transmitting authority make sure that the transfer has been verified on the receiving end as well. The safety of the patient receiving, shift in care must be guaranteed by the hospital administration. Before making any transfer or referral the health professionals has to consider the patient's interest in this subject and it must not be made by giving any bribe, incentives, or commission to anyone.[173]

[170] Chapter 6 (Patient Safety and Quality Improvement) and Chapter 8 (Facility Management and Safety) of NABH Accreditation Standards For Hospitals 2020
[171] Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole, AIR 1969 SC 128 para 11
[172] Supra note 10
[173] Id.

2.5.12 RIGHT TO PROTECTION FOR PATIENTS INVOLVED IN CLINICAL TRIALS[174]

The Central government has released New Drug and Clinical Trial Rules, 2019 under the purview of Drugs and Cosmetics Act. Consequently, it stipulates the requirements that must be fulfilled when conducting a clinical experiment. The term clinical trial is defined in rule 2(1)(j) of New Drugs and Clinical Trial Rules, 2019.The main goal of clinical trial is the assessment of drug safety, efficacy or tolerance. The aforementioned rule specifies the appropriate route for starting a clinical trial as well as other prerequisites. Only with the approval of Central Licensing Authority and an ethics committee established specifically for that reason may a clinical trial begin. The experiment must be registered with the ICMR maintained clinical experiment registry of India before it may begin. The Rules include sections that provide a detailed explanation of how human subjects or patients volunteering for the experiment must give their informed consent.

CDSCO has laid down Good clinical practice recommendations for conducting the clinical trials. According to GCP criteria, all clinical experiments involving humans must adhere to the Helsinki declaration and its core tenets, which include beneficence, non- maleficence, fairness and respect.

Every patient or participant in such clinical research must be involved only after providing informed consent that was acquired in compliance with the applicable laws or regulations, without error or carelessness. Every detail regarding the medication should be provided to the patient. Strict respect for patient right to confidentiality and privacy must be guaranteed. If any unfavourable circumstance arises during their involvement, they are entitled to free medical care for as long as necessary or until it is proven that the harm was not brought on by the trial. In the event of a disability or death, compensation must be given in the form of money and other support. When necessary, ancillary care may be given. According to the relevant Ethics Committee, appropriate institutional mechanisms should be established for insurance coverage of illnesses, injuries, or death that are directly related to trials or otherwise (ancillary care), as well as for the award of compensation when it is necessary for the

[174] Id

researchers to pay for it. The best treatment that the study has shown to be effective should be made available to the participants once the trial is over.[175]

2.5.13 RIGHT TO TAKE DISCHARGE OF PATIENT, OR RECEIVE BODY OF DECEASED FROM HOSPITAL[176]

Due to arrears in bill or due to any other procedural grounds the hospital authorities shall not deny the patient's right to discharge from the hospital and the bystanders right of receiving the body of the deceased one.[177]In Devash Singh Chauhan v state[178] the Delhi High court heard a habeas corpus writ filed by the petitioner to free his father who was hospitalized due to unpaid bills. The court ruled that the hospital could not refuse a patient because the patient's next of kin wanted to be in charge of getting them out of the hospital.[179]The hospital was ordered to provide the discharge summary and release the patient after the court disapproved of the procedure.[180]

2.5.14 RIGHT TO PATIENT EDUCATION[181]

The right to getting aware and educated about the patient's current health condition is one of the fundamental rights guaranteed to the patient. Additionally, they are entitled to education of their rights and obligations as well as pertinent information, insurance plans, and pertinent benefits that, in the case of non-profit hospitals. They also need to be educated on how to properly pursue remedies for their issues. The hospital or doctor must educate them in the vernacular language of the patient. Therefore, in accordance with the established standards and procedure hospital administrators and physicians have a duty to educate patients.

2.5.15 RIGHT TO BE HEARD AND SEEK REDRESSAL[182]

Expressing one's opinions is the fundamental freedom guaranteed to every individual. The patients also have this right. Patients, who are also consumers, are entitled to have their opinions about the services they get. As a result, each patient or companion is free to express their thoughts remarks or evaluations regarding the rendered service. They have the right to complain to the relevant authority about the service.

[175]Id.
[176] Id
[177] Id
[178] Devesh Singh Chauhan V. State, 2017 SCC Online Del 8130 (India).
[179] Id at para 8.
[180] Id at para 9.
[181]Supra note 10
[182] Id

Additionally, they can be told about how to submit a complaint, opinion, comment, or feedback to the relevant authority.[183] They can file a complaint with the official assigned by this charter or with the hospital, regulatory body, or tribunal that has been set up for this reason. If they feel that the order is unfair, they can also file an appeal. They are entitled to a prompt, equitable settlement of their grievances and to be informed of the complaint's outcome within fifteen days of the complaint being received. As required by the charter or applicable law, all hospitals and CE must set up an internal redressal process for this purpose and abide by its directives.[184]

2.6 OBLIGATIONS AND RESPONSIBILITIES OF DOCTORS AS PER THE INDIAN MEDICAL COUNCIL (PROFESSIONAL CONDUCT, ETIQUETTE, AND ETHICS) REGULATIONS, 2002

The foundation for professional behavior and medical ethics in India was largely shaped by the Indian Medical Council Act of 1956. The Medical Council of India (MCI) was given the power to establish professional conduct standards, medical etiquette, and an ethics code for medical practitioners under Sections 20A and 33(m) of the Act. These clauses gave the MCI the authority to create rules for ethical conduct, guaranteeing that medical professionals upheld the highest standards of professionalism and compassion. The MCI enacted the Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations, 2002[185], which described doctors' ethical duties to patients, coworkers, and society at large, in an effort to further preserve medical ethics.

2.6.1 DUTIES AND RESPONSIBILITIES OF THE PHYSICIAN IN GENERAL

- Upholding the honor and dignity of his profession is a duty of physicians. Financial gain is a secondary issue for the medical profession, which has as its primary goal serving humanity. To practice contemporary medicine or surgery, one must be registered with the appropriate bodies and possess qualifications approved by the Medical Council of India (MCI).[186]
- When patients entrust their care to doctors, they should earn their trust by providing them with the utmost care and dedication. Doctors should always strive

[183] Id
[184] Id.
[185] Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations, 2002
[186] Id Reg. 1.1

to increase their medical expertise and knowledge, and they should share the advantages of their professional accomplishments with their patients and colleagues. Physicians should only use scientifically based healing techniques, and they should avoid working with those who don't adhere to this rule. Physicians have obligations to society as well as to individuals, according to the respected ideals of the medical profession.[187]

- For at least three years from the commencement of treatment, doctors must keep track of indoor patients' medical data. Within 72 hours, requests for medical records must be addressed and completed; noncompliance may result in disciplinary action.[188]
- Whenever feasible, doctors should prescribe drugs under generic names to encourage responsible drug use and save patients money.[189]
- Dishonest or unethical behavior by members of the profession should be exposed by a physician without fear or privilege.[190]
- The doctor must abide by the national rules that govern the practice of medicine and refrain from helping others circumvent them. In the interest of public health, he ought to cooperate in the observance and implementation of sanitary laws and regulations.[191]

2.6.2 DUTIES OF PHYSICIANS TO THEIR PATIENTS

- A doctor should be prepared to assist the ill and injured, keeping in mind the high standards of his profession and the duty of treating everyone who seeks care. While it is appropriate to refer a patient to another doctor, the doctor is still required to treat the patient in an emergency. Although a doctor cannot refuse treatment without cause, they may refer a patient to another facility for appropriate care if the sickness is outside of their area of competence. Additionally, a medical professional who has any disability that could harm the patient or impair his performance in relation to the patient is not allowed to practice medicine.[192]

[187] Id Reg. 1.2
[188] Id Reg. 1.3
[189] Id Reg.1.5
[190] Id Reg. 1.7
[191] Id Reg. 1.9
[192] Id Reg. 2.1

- The severity of a patient's condition should not be overstated or understated by the doctor. He should make sure that the patient, his family, or responsible friends are informed about the patient's condition in a way that will benefit the patient and the family.[193]
- A doctor is free to decide who he will treat. In an emergency, he should, nevertheless, react to any request for his help. After accepting a case, a doctor is not allowed to ignore the patient or leave without giving the patient and their family enough notice. Medical professionals must refrain from willfully engaging in careless behavior that could deny patients access to essential treatment.[194]

2.6.3 DUTIES OF PHYSICIAN IN CONSULTATION

- Do not engage in unnecessary consultations. Nonetheless, the doctor should request consultation in cases of acute disease and in situations that are unclear or challenging, but in any event, the consultation should be justified and serve the patient's interests exclusively, without regard to any other factors.[195]
- In every consultation, the patient's benefit is the most important consideration. Every doctor working on the case should be open and honest with the patient and his caregivers.[196]
- When conducting consultations, a doctor should be on time.[197]
- When the attending physician refers a patient to a specialist, the expert should be provided with a case synopsis of the patient and should provide the attending physician with a written opinion.[198]

2.7 OBLIGATIONS AND RESPONSIBILITIES OF DOCTORS AS PER THE NATIONAL MEDICAL COMMISSION REGISTERED MEDICAL PRACTITIONER (PROFESSIONAL CONDUCT) REGULATION, 2023

National Medical Commission has issued certain regulations for the professional conduct of registered medical practitioners. It is well explained in National Medical

[193] Id Reg. 2.3
[194] Id Reg. 2.4
[195] Id Reg. 3.1
[196] Id Reg. 3.2
[197] Id Reg. 3.3
[198] Id Reg. 3.6

Commission Registered Medical Practitioner (Professional Conduct) Regulation, 2023[199] that the RMP's main responsibility is to protect their patients.

- The EMRB has given different enrolment ID to each freelance RMP. And the RMP has to incorporate this ID on all patient prescriptions, certificates and payment receipts.[200]
- There are certain conditions for putting medical degrees as suffix to the RMP's name. The first one is that they are certain degrees of medicine given in the guidelines of NMC only that degree has to put after the name of the RMP. And the last condition is that there are certain degrees published in the NMC website only that degree has to put after the name of RMP.[201]
- RMP cannot claim to be a clinical specialist unless they have had training and certification in that particular area of contemporary medicine that has been approved by the NMC.[202]
- Each RMP is required to practice the medical system in which they have received training and certification.[203]
- For determining whether the medical professional has qualified to practice medicine it is essential to analyse that whether his registration is completed according to the current Medical Acts. If he is not registered under the current Medical Acts then he is not competent to practice medicine.[204]
- It is mandatory that the appointment charge must be disclosed to the patient before the medical advice, operation or treatment is given. RMP has the discretion to choose whom he wants to treat. But this will not apply in two scenarios they are: (1) if the doctor is serving in government service (2) life endangering circumstances.[205]
- The RMP should prescribe the medicine in generic names with decipherable handwriting.[206]

[199] National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulation, 2023
[200] Id Reg.3A.
[201] Id.Reg.3B.
[202] Id.Reg.3C.
[203] Id.Reg.3D.
[204] Id.Reg.3E.
[205] Id.Reg.6.
[206] Id.Reg.8.

- In the media the RMP is authorised to post a message regarding the following subjects within a period of three months. They are:(1) Announcing that he is beginning the practice (2) Switching on to another department of medicine for practice (3) swapping to another address (4) taking a leave from practice (5) in the event of restarting the practice (6) posting the charges for each service.[207]
- No RMP is permitted to invite any patient through public education. But every RMP is authorised to conduct public education by using any type of media. The only restriction for the RMP in public education is, it should not be used as a medium for his own advertisement.[208]

2.7.1 REGARDING THE SELLING OF DRUGS RMP's AUTHORITY

- The RMP's are permitted to sale medications for their own patients. But no RMP is authorised to run a pharmacy for selling medications prescribed by other RMP's.[209]
- As long as patients are not being exploited, RMP is permitted to prescribe or provide medications, treatments, or appliances. The generic name of a medication should be clearly stated on any prescriptions written by RMP or purchased for a patient from a pharmacy.[210]
- RMP's are not allowed to prescribe, administer, or distribute secret therapeutic substances whose composition or mode of action in the body are unknown to them. It is forbidden to produce, market, or utilize these remedies.[211]

2.7.2 RESPONSIBILITY OF RMP REGARDING MEDICAL RECORDS

- Every freelance RMP is obligated to preserve the medical records of the patient up to three years. The three years is to calculated from the day in which the patient last consulted the RMP. The RMP has to preserve the medical records of the patient according to the guidelines established by the NMC.[212]
- For accessing the medical records of the patient an application has to forward to the RMP who has the authority in the patient record. The application has to

[207] Id.Reg.11A.
[208] Id.Reg.11C.
[209] Id.Reg.12A.
[210] Id.Reg.12B.
[211] Id.Reg.12C.
[212] Id.Reg.13A.

submit by the patient or his legal representatives. And the authorised RMP has to provide the documents within five working days.[213]

- All attempt has to make for getting the medical records to the patient expeditiously especially at urgent medical situation.[214]
- To improve security and speed of retrieval, efforts will be made to computerize patient medical records.[215]
- In some situations, RMP are required by law to provide certifications, notice, reports, and other documents of a similar nature, or they may occasionally be asked to do so. These documents must be signed by the RMP in their official role and used later in court, administrative settings, or for other purposes. Such records, certificates, or reports must not be in accurate, deceptive or improper. An RMP who works for themselves must keep a register with all of the information about the certificate they have issued.[216]
- Without fear or favour, RMP will assist in the examination of other professionals who exhibit incompetent, dishonest, corrupt, or unethical behaviour.[217]
- The RMP should respect the doctor patient relationship's limit and refrain from taking advantage of the patient for social, professional or personal gain.[218]

2.7.3 INFORMED CONSENT

- Before any clinical procedure, surgery, diagnosis the RMP has to procure from the patient informed consent which is in a signed and documented format. If the patient is incapacitated to grant consent due to his illness or any other condition then the RMP has to procure the consent from the legal representative of the patient. The medical records must include the operating surgeon's name. Both the husband and the woman must agree to an operation that could cause sterility.[219]

[213] Id.Reg.13B.
[214] Id.Reg.13C.
[215] Id.Reg.13D.
[216] Id.Reg.13E.
[217] Id.Reg.14.
[218] Id.Reg.17.
[219] Id.Reg.19A.

- RMP is prohibited from publishing patient case reports or photos in any medical or other journal that could reveal the patient's identity without the patient's agreement.

2.7.4 RMP OBLIGATION WITH REGARD TO THEIR PATIENTS

2.7.4.1 KEEPING APPOINTMENTS[220]

- Medical practitioner has to make an effort to provide patients with timely care and will adhere to visiting /consultation hours and appointments. The patient should be notified if there is a legitimate basis for the RMP's delay.
- The RMP has to prefer or suggest another RMP who is expert in treating the patient's disease when it requires.
- The first aid and other assistance in accordance with his training and the resources at hand prior to referral has to given to the patient in life threatening situations.[221]

2.7.4.2 INCAPACITY

A registered medical practitioner is not allowed to perform their profession if there any impairment (induced or otherwise) that could harm their patients or their professional practice and impair their ability to make decisions or treat patients. No RMP is permitted to use liquor or any other drugs or perform his duty according to its influence in the working hours. If he uses drugs or something that could affect his professional performance then it will be marked as professional misconduct.[222]

2.7.4.3 CONFIDENTIALITY

One of the fundamental rights of the patient is to keep the communication between him and the RMP in confidential by the RMP. So, the RMP has to hold all the details of the patient in confidential. The RMP has no right to disclose any information of the patient either it is private or regarding his or her health status. But under two condition the RMP can disclose the communications between him and the patient they are

- The state law prescribes him to disclose

[220] Id Reg.22.
[221] Id.
[222] Id.Reg.23.

- If the RMP does not disclose the information it will create threat to the patient's or public health.[223]

2.7.4.4 TRUTH-TELLING

RMP has to converse honestly about the present condition of the patient. He should not overemphasize or understate the health condition of patient. It is the duty of the RMP to make sure that the patient or their legally designated representative is well informed about the patient health status and they are equipped to take a decision that is best suited for the patient.[224]

2.7.4.5 PATIENT CARE

The RMP has the option to choose the person whom he wants to treat but this condition is not applicable in situation which affect the life of the person. After accepting a case, the RMP must give the patient and his family enough warning before abandoning them or leaving the case unattended. If an RMP must give the patient and his family enough warning before abandoning them or leaving the case unattended. If an RMP modification is required (for instance, the patient requires a process performed by another RMP), the patient's or guardian's approval should be sought. The RMP who treats the patient will be held completely responsible for his conduct and will be paid the correct amount. The RMP has the authority to record and report violent, disruptive, and abusive patients or family members as well as decline to treat them. These patients ought to be sent somewhere for more care.[225]

2.7.4.6 REFERRAL

Only when the patient requests a follow up consultation be scheduled. Similarly, the patient's laboratory tests should be supported by evidence. The abstract or summary of the clinical status will be given at the moment of referral and it includes the reason for the referral. Referrals to specialists must be made solely for the patient's benefit and well supported by medical records.[226]

[223] Id Reg.24.
[224] Id Reg.25.
[225] Id Reg.26.
[226] Id Reg.27.

2.7.4.7 SIGNATURE

The RMP's name and NMC registration number should contain in every signature in the prescriptions, records, summaries of discharge and referral, certificates. If the orders / prescriptions are in the electronic generated format it helps in the mechanization of this information.[227]

2.7.4.8 CONSULTING THE PATIENTS THROUGH TELEMEDICINE

By following the Telemedicine practice Guidelines, the RMP can consult his or her patients through Telemedicine.[228]

Medical ethics and contemporary healthcare requirements are in line with the more comprehensive and detailed National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations, 2023. They create new standards for digital conduct and ongoing professional development (CPD), make generic medication prescriptions mandatory, and tighten regulations on dealings with pharmaceutical corporations. Along with extending a doctor's duties in areas like telemedicine, online conduct, and public health advocacy, they also use the Code of Ethics as a framework to guarantee moral and competent behavior in contemporary healthcare. Following protests from medical organizations, this regulation is kept in abeyance.

2.8 CONCLUSION

The keystone of medical profession is considered as the doctor- patient relationship and that relationship is ingrained in mutual trust, confidentiality and ethical obligation between patient and doctor. This relationship is transformed from various stages i.e. in the earlier stage it was a paternalistic approach and currently the doctor patient relationship is a patient – centric model that focuses more on autonomy of patient and informed decision making. This evolution has occurred due to various factors like improvement in medical science and various judicial pronouncements.

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[227] Id Reg.28.
[228] Id Reg.29.

The recognition of charter of patient rights in India made an important step for giving quality and transparent health services to the patients. According to the patient charter it provides almost seventeen rights to the patients like informed consent, privacy, emergency care etc. These rights are reinforced through various judicial pronouncements and legislative frameworks like Consumer protection Act, 2019 this includes medical services under its ambit and provides compensation to patients in medico legal cases which will be discussed in detail in the coming chapter.

When legal provisions and various judicial pronouncements protects patient rights, the healthcare professional's acts must be on the basis of certain legal and ethical obligations. The National Medical Commission Registered Medical Practitioner (professional Conduct) Regulation, 2023 prescribes the duties and responsibilities of RMP towards their patients. This regulation main objective is to making a balance between the patient's rights and the duties of RMP's and make sure that the RMP's follows the code of conduct which hierarchize patient welfare over their commercial interest.

Mainly a good doctor patient relationship consists of dual approach i.e. safeguarding the rights of patients and holding medical professionals accountable for ethical and legal compliances. Bridging the gap between legal provisions and their implementation is very important for fortifying the medico legal framework. For improving the awareness of patients regarding their rights, and addressing the gap in implementation of these rights requires a persistent effort. By addressing these issues, the medical field can move forward for achieving a framework which gives more importances to the patient rights and medical professionalism, ultimately fostering an efficient medico legal system.

CHAPTER 3

INDIAN LEGISLATIVE FRAMEWORK AND MEDICO LEGAL LITIGATION

3.1 INTRODUCTION

The laws, rules and guidelines enacted to regulate the medical profession are collectively known as medical legislation. This includes law pertaining to medical education, termination from medical practice and so on. An important part of medical legislation is the chapter that deals with the legal duties placed on the medical professionals and the repercussions of breaching of those duties. Medical legislation comprises the area of the law that deals with the trial of law suits, complaints, and cases originating from the medical field.

In accordance with a survey, it was found that the number of complaints against Indian doctors had risen by an amount of 2300. At the age of 45 years, up to 36 percentage of doctors in low-risk specialities and 88 percentage of doctors in high-risk specialities in the USA had experienced their first claim. By the age of 65, this rose to 75 percentage and 99 percentage respectively.[229] One of the main reasons for the rise in disputes is the lack of communication between patients and physicians.[230] The average rating for the patient-doctor relationship in a Chandigarh study by Singh et al. was 50 percentage of the total, while the mean score for consent and its validity was 62 percentage of the total. This indicates a significant gap which needs to be resolved.[231]

The usual positive interaction between the doctor and physician is considered to be normal and it does not contain any conflicts. The underlying reason for this is due to the fact that people usually select their doctors based on their experience and reputation. In addition, even after paying their fees, people express gratitude to their doctors for successful treatments. However, because their livelihood depends on their patient's belief in them, medical professionals are likewise grateful to their patients. But because of the commercialization of this relationship in recent decades, patients

[229] Seabury, Seth et al., Malpractice Risk According to Physician Specialty, 365 N.E. J. Med. 629 (2011).
[230] Moore, P. et al., A study of hospital complaints and the role of the doctor-patient communication, 139 Rev. Med. Chil. 880 (2011).
[231] Singh, S. et al., Knowledge of consumer protection act among doctors from government and private sectors of union territory, Chandigarh, 68 Indian J. Med. Sci. 5 (2016).

now demand doctors to treat their illness extravagantly, and doctors have turned to other sources of income. This leads to a negative impact in the medical field. Nowadays patients are being more aware than the earlier days they consider any adverse effects or complications occurred during treatment is because of the negligent act of the doctor. And the Physicians are frequently accused of being indifferent to their patient's need during the course of treatment, have seeked other sources to obtain money, and have failed to show to the patients the required attention they need during the course of treatment. The main reason behind the rise in frivolous medico-legal cases filed against Physicians is due to both of these incidents. The Supreme court established rules for the criminal prosecution of medical professionals in an effort to curb this annoyance and deter litigants. The number of fraudulent medico legal claims filed has decreased as a result of these standards, and doctors harassment has decreased as well. Proposals have also been made to provide training for physicians on appropriate protocols to follow during treatment, including documenting every stage of care so that it can be used as proof of any attempts made by litigious patients to harass or threaten them.[232]

Other than negligence or lack of service, there are several other grounds for convicting doctors. For example, the Transplantation of Human Organs Act hold physicians accountable for engaging in certain prohibited behavior mentioned in the Act. This lends further credence to the Supreme court's ruling that physicians are subject to prosecution. And the Supreme court has made it clear that no suits can be brought against the physicians for damaging their reputation and such type of suits are not entertained by the court at any cost.

The main content of this chapter is discussing the various legislation which is applicable in settling the medico legal disputes that has arising in India. Medical litigation in India is categorised under three different headings: Civil remedies under the Consumer Protection Act 2019, Tort law, Criminal liability under the BNS, 2023.

3.2 CONSUMER PROTECTION ACT,1986

The Consumer Protection Act, 1986 is a beneficial legislation and the main aim behind its passing is to provide protection to both the consumers and their rights. And

[232] M.S. Pandit & Shobha Pandit, Medical negligence: Criminal prosecution of medical professionals,importance of medical evidence: Some guidelines for medical practitioners, 25(3) Indian Journal of Urology. 381, 379-383 (2009)

to provide the redressal in fast, affordable way to the consumers at the central, state and district levels. Mainly it provides six rights to the consumers they are:

- The right to get protection from the marketing of dangerous goods and services
- The right to get information about the product or service cost, quality and quantity. In Natural Gas Commission v. Natural Gas Consuming Industries Gujarat[233] it was held that only reasonable price has to be charged by a statutory corporation even though they are not public utilities and must strictly comply with Article 39 of the Indian Constitution.
- The right to get guarantee on product and service variety.
- The right to be heard and the guarantee that all consumers interests will be suitably taken into account in pertinent forums.
- The right of ability to challenge unjust or constructive commercial practices.
- The right of entitlement to education for consumers.

3.2.1 CHARACTERISTICS OF CONSUMER PROTECTION ACT,1986

The Consumer Protection Act, 1986 is defined as the Magna Carta of consumer protection. The following are the main features of the Act.

- The Consumer Protection act, 1986 is applicable to all goods and services except the goods and services which is clearly mentioned by the Central government.
- It incorporates all sectors i.e., the Private, Public and Cooperative sectors.
- The provisions of this Act supplement those of previous Acts. No other law's applicability is restricted by this Act.
- This Act responds to consumer complaints in a clear, economical and dynamic manner within a time restriction.
- Other forms of consumer exploitation, such as underweighting, exorbitant prices, defective goods, subpar services and unfair commercial practices are also shielded by this act.
- With the purpose of advancing consumer rights, interests, and education and protection, the Act empowers the central and state government to form a consumer protection council.

[233] Oil and Natural Gas Commission v. Natural Gas Consuming Industries, Gujarat, AIR 1990 SC 1851.

- The Act is based on the compensation concept, which gives the aggrieved party fair compensation. To handle complaints a three – tiered quasi-judicial apparatus is in place.
- For filing a complaint under this act the complaint should be accompanied with the stipulated amount of fees as prescribed under the Act.[234]

Free services are specifically not included in the definition of service under the Consumer Protection Act of 1986, which states that anyone who employs services or makes purchases for payment is a consumer. The definition of service includes when a physician provides services to prospective patients in exchange for payment. Claims about shortcomings in hospital and medical or dental services are fully covered under the Consumer Protection Act's Provisions dealing to the resolution of consumer disputes and the granting of remedy under Section 14 of the Act.[235]

3.3 CONSUMER PROTECTION ACT, 2019

On the 15th of July 2020 the Consumer Protection Act,2019 was notified and it came into effect on the 20th July 2020. The main aim of enacting this law is to minimize the accumulation of complaints of consumers in the consumer forums and courts in the country.

3.3.1 NEED FOR THE CONSUMER PROTECTION ACT, 2019

In order to combat consumer rights abuses, unfair business practices, deceptive advertising and any other situation that jeopardizes consumer rights, the Indian legislature passed the Consumer Protection Act, 2019. Since online buying and selling of goods and services has grown significantly in recent years due to technical improvements, parliament intended for the Act to include provisions for e-consumers. By creating consumer protection councils to settle disputes and offer sufficient compensation to consumers whose rights have been infringed, the Act seeks to protect the rights and interests of consumers. Additionally, it uses alternative dispute resolution processes to quickly and effectively address consumer issues. In order to making the consumers aware about their rights and duties the Act motivates consumer education.

[234] K Kannan, A textbook of Medical Jurisprudence and Toxicology, 117, (Lexis Nexis 26th ed 2019)
[235] Agarwal @ Vicky v. Ashok Arora, (1993) 1 CPJ 113

3.3.2 MAJOR OBJECTIVES OF THE CONSUMER PROTECTION ACT, 2019

The main goal of the Act is to safeguard the consumer interests and create a reliable and efficient system for resolving consumer disputes.

- The Act's main objective is to stop the promotion of goods that endanger property and human health.
- Educate consumers about the standard, purity, quantity, potency and quality of products to shield them from deceptive business tactics.
- Create consumer protection councils to safeguard the rights and interests of consumers.
- Ensures that the goods available in the market are at competitive pricing.
- Seek remedies for unfair business practices or dishonest customer exploitation.
- Safeguard the consumers by appointing authorities to handle and resolve consumer problems in a timely and appropriate manner.
- Inform the consumers regarding the after effect of non- compliance of the statutes.
- When the consumer faces any problem or disagreement make promises to the consumer that their interest will be safeguarded in the appropriate forums.
- Offer consumer education so that consumers get aware about their rights.
- For resolving consumer complaints use alternative dispute resolutions.

3.3.3 MAJOR CHANGES INCORPORATED IN THE CONSUMER PROTECTION ACT 2019

The following modifications were made when the Consumer Protection Act of 2019 was passed:

- The District Commissions shall have the power to evaluate complaints regarding the transaction in issue if the entire value of the goods, services, or products that were paid to the seller as consideration is less than fifty lakh rupees.
- The State Commission will have the authority to hear complaints against the transaction in question if the value of the goods, services, or commodities paid to the seller as consideration is greater than fifty lakh rupees but less than two crore rupees.

- Provisions in the Consumer Protection Act of 2019 facilitates online complaint filing for consumers. The E-Dakhil portal, which was created by the Central government of India in this regard, provides consumers throughout India with an easy, rapid, and affordable way to contact the proper consumer forums in the event that a disagreement arises.
- The Act sets the guidelines for both direct sales and e-commerce.
- The Consumer Protection Act of 2019 contains provisions for mediation and other kinds of alternative dispute resolution, allowing parties to resolve their issues amicably without having to face the hassle and cost of going to court.
- Unfair contracts, Product liability, and three other unfair business practices are covered by the Consumer Protection Act of 2019. The Act also includes clauses addressing unfair contracts and product responsibility. The prior Act in comparison only specified six types of unfair business practices.
- The Act of 2019 created the Advisory committee on the promotion and protection of Consumer Rights.
- There are no provisions for selection committees under the Consumer Protection Act of 2019. Rather, it grants the Central Government the power to propose each and every board member.

The Indian Parliament consequently passed and implemented the Consumer Protection Act, 2019 to incorporate e- commerce laws in light of the shifts in the digital age. This is because digitization has made it possible for convenient payment methods, a wide range of options, better services etc.

3.3.4 ESSENTIAL PROVISIONS OF THE CONSUMER PROTECTION ACT, 2019

The most significant provisions in the Consumer Protection Act of 2019 are listed below:

3.3.4.1 CONSUMER PROTECTION COUNCIL

Establishing consumer protection committees at the national and state levels would allow the Act to protect Consumers rights on both levels.

3.3.4.2 CENTRAL CONSUMER PROTECTION COUNCIL

According to chapter 2 section 3 of the Consumer Protection Act, 2019 which was passed in 2019, the Central government must create the Central Consumer Protection Council, popularly known as the Central Council. As an advisory body, the Central Council must have the following people on its membership list: The minister-in-charge of the Central Government's Department of Consumer Affairs will serve as the Council's chairwoman. Other Council members will include any number of official or non- official representatives of the pertinent interests as defined by the Act.

Although the Central Council must hold at least one meeting every year, they are free to call meetings whenever they see fit. In order to carry out its mandate of protecting and promoting consumer's interests in compliance with the Act, the Central Council was founded.

3.3.4.3 STATE CONSUMER PROTECTION COUNCIL

Each state's government is in charge of establishing a State Consumer Protection Council, also referred to as the State Council, which will have jurisdiction over that state. The state Council is composed of the following individuals: any number of official or non-official members who represent interests required by the Act, additionally the Central government may designate a minimum of ten members for the purposes of this Act. The president of the council will be the state government's minister in charge of consumer affairs, together with any number of official or non-official members who are required under the act to represent relevant interests. In every year there must at least two meetings are to held by the State Councils.

3.3.4.4 DISTRICT CONSUMER PROTECTION COUNCIL

Each district must have a District Consumer Protection Council established by the state government in accordance with section 8 of the Act. The District Council is the name given to this council. According to the Act, the person in responsibility of tax collection in that district will serve as the chairperson of the District Council, together with any additional members who suitably represent the pertinent interests.

3.3.4.5 CENTRAL CONSUMER PROTECTION AUTHORITY

According to section 10 of the Consumer Protection Act, 2019 the Central government must create a central Consumer protection Authority, also known as the

Central Authority, to promote, protect, and enforce consumer rights and to regulate issue pertaining to unfair trade practices, consumer rights violations and deceptive or false advertisements that harm the publics and consumer's interests. This body will be in charge of advancing, defending, and upholding consumer's rights. The Central Government will be in responsibility of appointing the chief commissioner and the other Central Authority Commissioners in compliance with the Act's provisions.

Section 15 of the Act mandates that the Central Authority must establish a "Investigating Wing" in order to carry out an inquiry or investigation. The investigative wing must have a Director General in addition to the required number of Additional Director-General, Director, Joint Director, Deputy Director and Assistant Director positions filled with people who possess the requisite training and credentials in order to carry out their duties under this Act.

3.3.4.6 FUNCTIONS AND DUTIES OF THE CENTRAL AUTHORITY

The Central Authority's powers and duties are delineated in Section 18 of the Act and comprises the following:

- To protect and advance collective consumer rights and to stop their infringement.
- To stop unfair business practices: to make sure that no products or services are advertised in a false or deceptive manner: and to make sure that no one participates in such deceptive advertising.
- Perform an inquiry or investigation in cases involving unfair trade practices or violations of consumer rights.
- Submit Grievances to the relevant district, state, or national commission.
- Examine the matters concerning factors that prevent consumers from exercising their rights.
- To encourage the application of best international practices and international covenants pertaining to consumer rights.
- Encourage research and awareness regarding consumer rights.
- Create necessary standards to prevent unfair business practices and protect the interests of consumers.

The Central Authority may also launch an investigation in response to a complaint or instruction from the central government, or on its own initiative, in case where

unfair trade practices or violations of consumer rights occur. Furthermore, in the event that the Central Authority finds that unfair trade practices or a breach of consumer rights have taken place, it may:

- Eliminate the goods and service that pose a risk to consumers.
- Compensate the consumers the price of goods and services.
- Quit using tactics that are harmful to the consumers.

The Central Authority has the power to impose any person up to 10 lakh rupees for making deceptive and false advertisements under section 21 of the Act. The Central Authority must take into account a number of factors for determining the appropriate punishment for the offence, including the product's total sale revenue, the number of times the offence has been committed and the people get affected by it.

3.3.5 CONSUMER MEANING UNDER THE ACT

Any individual or a band of individuals who acquires goods and services for their private use and not for any other use especially not for any manufacturing or resale. Such type of individual is known as consumer. Sec 2 (7) of the Consumer Protection Act, 2019 defines the term consumer as a person who buys products or services for consideration and for their personal, commercial or resale use. In the explanation of the section, it clearly states that "buys any goods" and "hires or avails any services" includes all types of online transactions done through electronic means, teleshopping etc.

The 2019 Consumer protection Act has widened the definition of the term consumer. Any occurrence of medical negligence from the healthcare provider is considered to be a failure which is stated in section 42 (11) of the Consumer Protection Act, 2019. The medical services would fall under the consumer protection Act, 2019 was decided by the Kerala High Court in a recent decision. Two doctors petitioned before Justice N Nagaresh for declaring two statements i.e.

- That the medical profession and practice do not come under the purview of "service" defined under section 2(42) of the Consumer Protection Act, 2019.
- Consumer forums under the Consumer Protection Act, 2019 do not have authority to consider complaints about medical negligence and deficiencies in medical service.

The court continued by noting that the Consumer Protection Act's Section 2 (42) is extremely explicit that the parliament sought to expressly emphasize that some services, such as banking, financing, insurance, transportation etc., which are in the nature of public utility services, would fall under the category of "services" according to a reading of the inclusive part of section 2 (42). The definition is not encompassing, it is inclusive. Thus, all services offered to prospective customers would be covered by section 2 (42), with the exception of those provided for free or in accordance with a personal service agreement.

3.3.6 CONSUMER DISPUTES REDRESSAL COMMISSION

Each state district must have a District Consumer Disputes Redressal Commission (DCDRC), also called the District Commission, established by the state government in accordance with the Consumer Protection Act of 2019. A minimum of two members appointed by the Central Government and the President makes up the District Commission. When the value of the goods or services offered in return for payment is less than one crore rupees, the District Commission is permitted to evaluate complaints under Section 34 of the Act. A complaint on goods and services can be submitted to the District Commission by a consumer, a recognized consumer association, the Central Government, the Central Authority, the State Government etc.

3.3.7 IMPORTANCE OF CONSUMER PROTECTION ACT IN MEDICAL PROFESSION

The Supreme Court of India confirmed in its landmark ruling in Indian Medical Association v. V. P. Shantha and Others[236] that the Consumer Protection Act, 2019 applies to both Surgical and medical services provided to a patient. As a result, the Consumer Protection Act now oversees the entire medical field. It has established clear guidelines regarding professional negligence under the Consumer Protection Act of 2019.

In this case two divisive expressions i.e. "contract for service" and "contract of service" has been noted, defined, and carefully investigated by the Supreme Court. A "contract for service" is an arrangement in which one party agrees to render technical or professional services to other parties using his own expertise and discretion rather than being subject to strict guidance or control. A "contract of service denotes a

[236] Supra note 4

master-servant relationship and involves an obligation to follow directions on the job to be done and how it should be done. Consequently, the Supreme Court came to the conclusion that the services provided by a medical professional can be regarded as personal in nature since there is a degree of reciprocal confidence and trust in connection between the patient and the professional. However, because the doctor and patient do not have a master servant relationship, the doctor-patient contract cannot be regarded as a contract of personal service; and the service provided by the physician to his patient under such a contract are not covered by the exclusionary portion of the definition of "service" found in Section 2 (42) of the Consumer Protection Act, 2019. The aforementioned Supreme Court decision seems to have settled the controversy surrounding the Consumer Protection Act's applicability to India's medical industry. The Supreme Court established clear guidelines for identifying which treatments are permitted and which are not in this landmark ruling. However generally speaking, the Act covers medical treatments that are not given for free. There has been a wide range of responses to the Supreme Court's ruling. It has drawn both a claim and criticism. There might be advantages in the form of prompt decisions, affordable justice, simple processes, recompense for victims improved patient care quality and more careful physicians. However, it has been harshly denounced by the whole medical community. Consumer Protection Act coverage does not include the following "medical services": when a doctor performs professional services for his employer in his role as an employee, this is known as a contract of personal service. In other words, a medical treatment would not qualify as "service" under the Act if there was a master servant relationship between the patient and the provider. The Act is not applicable at a government or non- government hospital, health center, or dispensary if no payments are collected from patients, regardless of their financial situation. Over time, the conventional understanding of the doctor-patient relationship has undergone significant modification. It did not make sense to accuse or sue a doctor for negligence in the past, when the doctor-patient relationship was based on faith and trust. But throughout time, there has been a notable rise in lawsuits against physicians in addition to a rise in cases of medical malpractice on the part of physicians that have caused patients to suffer harm or pass away. As a result, physicians have also turned to certain methods of diagnosis and treatment. This could result in harm or death for the patient.

In Mohanan v. Prabha G. Nair and others [237]the Supreme Court denied the appellant's opportunity to provide evidence to the magistrate. A doctor cannot be held criminally responsible for his patient's death just because the patient passes away in the hospital; this does not prove that the doctor's negligence was the cause of the death. It must be demonstrated that he acted with reckless disregard for the patient's life and safety and that his carelessness or incapacity went beyond ordinary recompense. Only by scanning the material could it be ascertained that the doctor was negligent. The learned single judge's decision to reject the initial complaint was not warranted. Thus, the magistrate was given instruction to consider the case legally. "Consumer"[238] refers to any individual who hires, omits or benefits from any service for consideration that has been paid, promised, partially promised or under any system of deferred payment. It also includes any recipient of such services who is not the hirer, provided that the first mentioned individual has given their consent.

A consumer is a patient who pays for doctor or hospital services. Anyone who pays for the patient's care. Patient's legal representatives or heirs. Patient's spouse, parents and children. Payment in the form of a registration fee or a nominal administrative fee as in the case of government general hospitals, does not constitute consideration, therefore patients receiving care in such hospitals are not entitled to reimbursement under the Consumer Protection Act as consumers. A person who obtains free medical care in a government or nonprofit hospital is not considered a consumer under the Act. In the event of death of a patient who is a consumer, the deceased's legal heirs (representatives) shall be regarded as "consumers". If the payment was paid by a non-legal heir of the deceased, that individual will also be regarded as a "consumer". A consumer is also someone who purchases service from others. Free services are therefore not covered by this Act.

3.3.8 JUDICIAL INTERPERTATION ON PATIENT AS A CONSUMER

A patient who does not use the doctor's service is not considered as a patient. According to the Supreme Court decision in the Indian Medical Association v. V.P. Shantha and others[239] a medical professional's consultation, diagnosis and treatment both medical and surgical would be considered as services. Consumers as defined by

[237] Mohanan v. Prabha G. Nair and Others, 1 (2004) CPJ 21 (SC).
[238] P.V.Rama Raju - The Consumer Protection Act, 1986,Latest Edition 2003, S.Gogia & Company Section 2(l)(d) of The Consumer Protection Act.
[239] Supra note 4

the Act, unless a physician or hospital offers free services to all of its patients or under a private contract. According to the Act definition of "Service" a medical practitioner's consultation, diagnosis, and treatment both medical and surgical given to a patient or in accordance with an agreement would be regarded as "Service". Medical Services fall under the definition of "Service". Physicians and hospitals are subject to the act's summary jurisdiction, which allows them to provide compensation and other reliefs to those who have lost anything because of carelessness or inadequate treatment. The service includes medical and surgical diagnosis and treatment as well as consultation.

Professional men are required to demonstrate a certain fundamental degree of competence and use reasonable caution when doing their duties. Medical personnel are not immune from lawsuits and may be held liable in tort or contract for failing to use reasonable caution when doing their duties. Medical personnel are not immune from lawsuits and may be held liable in tort or contract for failing to use reasonable care and competence. Services provided at a government hospital, health center or dispensary where all patients free care are not covered under this Act. The registration fee won't be considered as payment for the services in these cases. Service rendered for free by a medical negligence practitioner connected to a hospital or nursing home are exempt from the Act. Services rendered by a medical officer working in a hospital or nursing home, where all services are rendered without charge are exempt from the Act. The Act does not cover services provided at a non- government hospital or nursing home where all patients, wealthy or not, receive free care and no payment is collected from them. The Act covers services offered at government hospitals, clinics and dispensaries, where certain services are given for free and others at a cost. The Act covers services that patients are required to pay for at a non- government hospital or nursing home. Services rendered at private hospitals or nursing homes where those who can afford to pay are required to do so and those who cannot afford to pay are given free treatment are covered by the Act.

The Act covers services rendered by a doctor, hospital or nursing home for which the patient's employer pays for and indemnifies the patient's and his family member's medical bills. Services rendered by a physician, hospital, or nursing home for which the patient receives payment and indemnification under the terms of a medical insurance policy contract are exempt from the Act. Medical service fall under the

category of "Service". In order to provide compensation and other reliefs envisioned by the act to someone who has suffered a loss as a result of negligence or inadequate service, doctors and hospitals are subject to the legislation's summary jurisdiction. The service includes diagnosis, treatment and consultation in medicine and surgery. Professional men ought to be at least somewhat competent and carry out their duties with due diligence. Medical Personnel are not immune from lawsuits and may be held liable in tort or contract for failing to use reasonable care and competence.

In the case of Consumer Unity and Trust Society, Jaipur V. Bank of Baroda Chairman and Managing Director[240] the Supreme Court of India held that if carelessness is proven to be the cause of the loss or damage, or if negligence is proven but the loss or injury is not proven, compensation cannot be given. Furthermore, unless a third component – namely a link between the two needs – is also proven, compensation cannot be given even in cases where loss or harm and negligence are proven. It is essential to show that the other party's negligence resulted in the loss or harm.

The Consumer Forum uses the same guidelines that apply to claims for any other type of negligence when determining compensation for loss or injury brought on by negligence. The Supreme Court has granted Rs. 1 crore as compensation for medical malpractice in the case of Nizam Institute of Medical Sciences V. Prashanth S. Dhananka and Others.[241] The complainant in this lawsuit requested 7.5 crore as compensation in total under the following headings:

- Loss of future profits
- Current and potential financial difficulties
- Financial crisis
- Life satisfaction and dwindling life expectancy
- Financial restitution for the complainant's maternal uncle, younger brother and parents.

The Supreme Court awarded the following damages in this case:

The Complainant is an IT engineer with a good education who works for living and makes Rs. 28 lacs a year. His job insists him to travel a lot. He is currently unable to move his own and is confined to a wheelchair. He needs an attendant driver.

[240] Consumer Unity and Trust Society, Jaipur v. Chairman and Managing Director, Bank of Baroda, 1995 (2) SCC 150.
[241] Nizam Institute of Medical Sciences v. Prasanth S. Dhananka and Others, 2009 (2) CPJ 61 (SC).

According to the court, it would be reasonable for him to need a driver cum attendant for 30 years after the commission's award date; Rs 2,000 per month for 30 years would need to be capitalized. It allotted Rs.7.2 lakh under this heading.[242]

The Supreme Court granted Rs. 4000.00 per month for 30 years or Rs. 14,400,000.00, in contrast to his claim of Rs. 49 lacs for nursing care, etc., which was based on a nurse's salary of Rs.43750.00 for 600 months. For 30 years it provided Rs. 3000.00 a month for physiotherapy and other expenses, for a total of Rs. 10,80,000.00. A lump sum of. 25 lac was granted by the court under each of these headings, for a total of Rs. 50 lac, taking into account the necessity for ongoing medical assistance requiring costly medications and other supplies as well as the loss of future earnings. The applicant received ten lakh rupees from the Supreme Court as compensation for his pain and sufferings. A total of one crore and five thousand rupees were given out.

The Supreme Court decided that it would be safe to utilize the multiplier technique, which uses a suitable number of year's purchase, to determine compensation in the event that the family breadwinner passed away.[243]

3.3.9 PHYSICIANS LIABILITIES FOR MEDICAL NEGLIGENCE

Professional or medical negligence refers to the unethical behaviour of physicians while they are performing jobs. Negligence to the community is being caused by the intrinsic commercialization of certain branches of the medical and surgical professions. A properly certified medical professional, such as a doctor, is permitted to practice medicine, surgery, and dentistry by registering with the state's medical council. If a doctor is found guilty for any professional misconduct it can be brought before the appropriate State Medical Council or Medical Council of India, the State Medical Council has the authority to warn, refuse to register, or remove from registration the doctor's name. The relevant Medical Council have the power to order the permanent or temporary removal of a licensed practitioner's name from the register or to impose any sanctions deemed necessary in the event that the practitioner is found guilty of serious professional misconduct. Until a medical professional has had a chance to be heard in person or through an advocate, no action can be taken against him.

[242] Id
[243] Global Motors Service Ltd. v. R.M.K. Veluswamy, AIR 1962 SC 65

The Supreme Court decided in favour of the plaintiff in the landmark case of Indian Medical Association v. V.P. Shantha and others.[244]The concept of medical negligence has resolved the legal dispute over the application of the Consumer Protection Act to healthcare providers, hospitals, nursing homes, including government hospitals, and non-profit organizations. Services rendered in a non- government hospital or nursing homes where no fees are charged to all patients are not covered under this Act.

Two competing Bolam test applications are frequently included in medical negligence claim. Three safety rules for healthcare providers were established in Bolam v. Friern Hospital Management: [245]

- The doctor must possess appropriate knowledge and skill in the area which he practices medicine.
- The doctor must use reasonable skill and diligence while treating a patient.
- The compensation must not be given on the basis of a slight negligence; the negligence must be directly related to the harm the complainant suffered.

Laxman Balkrishna Joshi [246]asserts that "the practitioner must exercise a reasonable amount of care and reasonable amount of competence and knowledge to his work." Depending on the particulars of each situation, the law does not require the highest or lowest level of care and skill. The doctor must either take action or not take action; they have no choice in the matter of criminal punishment.

3.4 LAW OF TORT

In the earlier eras, medical malpractice was considered a crime rather than a tort. For example, the earliest known text addressing medical malpractice is the code of Hammurabi, which was composed in Babylonia about 20 centuries before the start of the Christian period. If a doctor operated on a man to treat terrible wound and the person died as a result of the procedure, the doctor's hands were to be cut off. Other contemporaneous civilizations in the past also imposed harsh punishments of similar nature. Medical Malpractices was considered as a crime against the state or the public, for which the state acting as the people's agent, establish measures to punish the offender. Protecting and defending the interests of the public by penalizing the defender is the main objective of criminal justice system. Almost invariably, victims

[244]Supra note 4
[245]Supra note 30
[246] Supra note 171.

in criminal proceedings were not given any monetary benefits. But when common law evolved in England, the importance of this circumstance changed dramatically. Medical Malpractices has been viewed as a tort than a crime from the thirteenth century onwards. In contrast to criminal law, tort law focuses primarily on compensating injured patients or their families rather than bringing charges against the medical professional who caused the injury. In 1838, Chief Justice Tyndall stated that "Every person who joins a learned profession agrees to bring to the execution of that profession a fair degree of care and competence." This was in reference to the question whether a medical malpractice claim required a sufficient level of skill and care.[247]

The position on medical malpractice in civil law is particularly important since it addresses many different aspects on its own. Even if doctors provide free service, the courts have ruled that this idea is nonetheless significant under tort or civil law.[248] On the other side one could argue that tort law begins when the consumer protection Act ends.

According to the tort law, patients who feel that a doctor's or clinic's services do not qualify the "services" as defined by the Consumer protection Act may sue the doctor or establishment. In cases of medical malpractice, the patient bears the burden of proof, or the onus, to prove that his injuries were caused due to the hospitals or doctor's medical malpractices.

The transfusion of blood from the incorrect blood group, leaving a mop in the patient's abdomen following surgery, removing organs without the patient's consent, and providing the wrong medication that cause harm are all examples of medical malpractices.[249]

Professionals who provide medical advice and care implicitly affirm that they possess the knowledge and abilities needed to do so, that they are able to choose the care, to administer that treatment and able to decide whether to accept or not to accept a case.

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[247] Jyoti Dogra Sood, Responsibility of Doctors for Rash or Negligent Act, 46 J. Indian L. Inst. 588 (2004).

[248] Smreeti Prakash, A Comparative Analysis of Various Indian Legal Systems Regarding Medical Negligence, Legal Service India, https://www.legalserviceindia.com/medicolegal/mlegal.htm.(Last Visited on May 22, 2025)

[249] Talha Abdul Rahman, Medical Negligence and Doctor's Liability, 2 Ind. J. Med. Ethics 60, 60-61 (2005).

This type of commitment made by a medical professional is referred as an implied undertaking.

A number of requirements must be fulfilled before any consideration of responsibility can be made. The accused must have committed an act of omission or commission, and this must have been in violation of the accused duty, and this breach of duty must have resulted in damage to the injured party if these criterion are fulfilled then the accused is found guilty. By citing the most recent medical scientific facts and offering a competent medical opinion, the complainant must support the accusations made against the doctor.[250] In order to distinguish between carelessness under civil and criminal rules, the question of degree has always been crucial.[251]

3.5 INDIAN PENAL CODE, 1860

Until recently, the country's official criminal code was the Indian Penal Code (IPC). It provides the nation with a thorough legal framework for dealing with criminal acts. This indicates that it lists the definitions of different offenses and prescribes penalties. The Indian Penal Code having inherited from the British India.[252] The Indian Penal Code, 1860 contains provisions that can impose criminal liability, although they are general in nature and do not specifically address medical liability. In the case of medical malpractice resulting in a patient's death are dealt under section 304A of the Indian Penal Code, which addresses the death caused by any rash or negligent act and can result in imprisonment for up to two years.

In the Santra case,[253] the Supreme Court pointed out that while the amount of damages incurred determines culpability under civil law, the amount and degree of carelessness are factors in determining guilt for criminal offenses under criminal law. However, a number of elements must be demonstrated in order to determine criminal responsibility in any particular case, such as the offender's character, the seriousness of the offence, and the motive for the offence.

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[250] Supra note 171

[251] Sylvine, Medical Negligence and Law in India – An Analysis, ipleders (July 18, 2016), https://blog.ipleaders.in/medical-negligence-law-india-analysis/. (Last Visited on May 22, 2025)

[252] Satvik N. Pai et al**.,** The New Bharatiya Nyaya Sanhita Laws: Progress or Pitfall for Doctors?, 16 Cureus (Sept. 22, 2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11495828/. (Last Visited on May 22, 2025)

[253] State of Haryana v. Smt Santra, AIR 2000 5 SCC 182 .

In the Poonam Verma v. Ashwin Patel[254] the Supreme Court distinguished between recklessness, rashness, and carelessness. A person who inadvertently violates a positive responsibility by neglecting to perform an action that is expected of them is considered negligent. A reckless person is aware of the consequences of their acts, but they are misguided in thinking that they won't happen because of their actions. Criminal prosecution should not be applied to any behaviour that does not fit into the categories of intentional misconduct and recklessness.

Therefore, unless it can be demonstrated that a doctor was careless or incompetent and that their actions were so reprehensible for their patient's life and safety that they constituted a crime against the state, they cannot be held responsible for the patient's death.[255]

3.5.1 DEFENCES AVAILABLE TO DOCTORS

Under section 80 and 88 of the Indian Penal Code, doctors who have been accused of criminal culpability may raise a number of defence. Under section 80, anything done by accident or misfortune, without any criminal purpose or knowledge, in the course of carrying out a lawful act in a lawful way by lawful means, with appropriate care and caution, is not considered an offence. According to section 88, if someone acts in good faith for the benefit of another and the patient's verbal or tacit consent, and does not intend to do harm even when there is a risk of doing so, they cannot be charged with an offence.[256]

3.5.2 THE BURDEN OF EVIDENCE

The person filing the complaint often bears the burden of demonstrating the carelessness and the liability of doctors. When a doctor is accused of medical misconduct, the burden of proof is higher than it would be required under normal circumstances. In the cases of medical malpractice, it is the patient's responsibility to prove that the claim against the practitioner is legitimate.

It was decided that the complaint had a direct burden of proving carelessness and the ensuring service defect in the Calcutta Medical Research Institute v. Bimalesh

[254] Supra note 14
[255] R v. Adomako, (1994) 3 All ER 79.
[256] Agrawal, Amit, Medical Negligence: Indian Legal Perspective, 1 Ann. Indian Acad. Neurol. S9, S9–S14 (2016)

Chatterjee case.[257]It was decided that negligence had to be demonstrated rather than presumed in the Kanhaiya Kumar Singh v. Park Medical & Research Centre Case.[258] Even with meticulous adherence to all medical regulations, a skilled practitioner may nevertheless make a mistake. When something goes wrong during treatment or diagnosis a doctor is not held responsible for malpractice or medical deficiency if she/ he has acted in accordance practice accepted as proper by a reasonable body of medical professionals skilled in that particular art, even if she/he has not followed the practice accepted as proper by the reasonable body of medical professionals skilled in that particular art, according to a number of recent rulings by the Supreme Court and the National Consumer Dispute Redressal Commission. The chance of an accident leading to death during various medical and surgical treatments and procedures cannot be completely ruled out. It is assumed that a patient is willing to assume such a risk because of the doctor-patient relationship and the mutual trust that results.

Both the plaintiff and the defendant frequently seek the opinion of medical experts while handling medical malpractice cases. The Indian Evidence Act, 1872, Section 45, specifically provides that when a court is required to render a decision on a scientific matter, the opinion of an individual with specialised expertise in that subject is considered relevant. It is important to note that a relevant opinion does not necessarily mean that the viewpoint is conclusive and there are several instances of expert opinions that were disregarded for a number of reasons in law reports. In order for the court, which is not an expert, to make its own observations of the pertinent evidence and arguments, the expert's actual role is to present to the court all pertinent evidence along with the reasoning behind his particular conclusion.[259] Experts just offer their opinions, and when weighed against the rest of the evidence, those that are intelligible, persuasive and tested[260] become important factors in deciding the case's outcome.

The person who has been harmed will submit a first complaint with the local police authority against the guilty party or individuals. The Criminal Procedure Code of 1973, allows the individual who was wronged to make a criminal complaint when a fair period of time has gone by without any action.

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[257] Calcutta Med. Research Inst. v. Bimalesh Chatterjee, I (1999) CPJ 13 (NCDRC).
[258] Kanhaiya Kumar Singh v. Park Medicare & Research Centre, III (1999) CPJ 9 (NCDRC).
[259] Titli v. Alfred Robert Jones, AIR 1934 All 273.
[260] Ramesh Chandra v. Regency Hospital Limited, (2009) 9 SCC 709.

Many criticisms have been made against India's medical litigation laws, some of which are specifically directed at the law. The first and most crucial idea is the burden of proof. The burden of proof rests with the plaintiff. As a result, the law will require additional evidence to substantiate a patient's charge of medical malpractice. In this case, it becomes extremely difficult for the average person or patient to determine the exact type of harm and the link between the injury and the doctor's conduct. The burden of proof in this case transfers to the plaintiff, and as medicine is an unpredictable field where anything can happen in a human body at any time, the patient cannot prove the doctor's carelessness beyond a reasonable doubt.

3.5.3 CRIMINAL MEDICAL LIABILITY UNDER SECTION 304A OF IPC

In regards to charging registered medical professionals with gross negligence in the course of their practice under section 304A of the Indian Penal Code, the Supreme Court has given four conflicting rulings since 1998.

A panel of Supreme Court decided in Mohanan v. Prabha G. Nair[261] that the high court erred in dismissing a civil action at an early stage when the plaintiff's expert testimony was necessary to establish guilt. Additionally, it concluded that the appellant was not given a fair opportunity to disclose facts to the magistrate and that the only way to assess a healthcare professional's carelessness was to look at the expert testimony and any available evidence.

As a result, the Supreme Court issued a new order in Dr. Suresh Gupta v. Government of NCT of Delhi overturning its earlier ruling in Mohanan's case. According to an appellate court, a doctor or surgeon must demonstrate gross negligence or recklessness, rather than just a lack of the required care, attention and skill, in order for section 304A of the Indian Penal Code to establish criminal liability against them. After this ruling, a judge declared on September 9,2004, that the Suresh Gupta case's verdict was unconstitutionally severe. According to their findings, the adjectives "gross, reckless, competent, and indifference did not fit the definition of medical liability under section 304A of IPC. They thus sent the case back to the lower court so that a larger group of judges could give it more consideration. A panel of judges consisting of five members is still considering this referral.

[261] Mohanan v. Prabha G Nair, 8 (2004) 3 SCC 391.

Meanwhile, a three-member Supreme Court panel rendered a decision in August, 2005 in the case of Jacob Mathew v. State of Punjab.[262]

The Supreme Court upheld the legal precepts established in the Suresh Gupta Case in this instance. The Supreme Court elaborated the standards for establishing culpability in this decision, which addressed the criminal liability of a medical professional. The previously disregarded distinction between the concept of carelessness in civil law and criminal law was also emphasized.

In summarizing its findings, the Supreme Court stated that:

- According to criminal law, it must be proven that the accused did or failed to do anything that no reasonable medical professional in his or her usual senses and wisdom would have done or failed to do under the circumstances in order to prosecute a medical professional for carelessness. According to the standard of care, the accused doctor's risk should have been sufficient that the injury that transpired was most likely imminent.
- Res ipsa loquitur is a rule of evidence that is helpful in determining the burden of proof in cases involving carelessness and operates in the field of civil law, especially in the context of torts. It isn't a legal theory. In the domain of criminal law alone, the theory cannot be applied to assign the blame for carelessness.
- Section 304A of the Indian Penal Code does not mention the word gross, although it is widely known that in criminal law, negligence or recklessness must be so severe as to qualify as gross in order to be so deemed. Section 304A of the Indian Penal Code uses the phrase rash or negligent conduct, which must be understood as qualifying the statement with the word grossly.
- The criteria for evaluating carelessness and negligence set down in Bolam's case[263] is still applicable in India.
- Criminal and Civil law have varied definitions of what constitutes carelessness. What is deemed carelessness in criminal law may not be the same as what is deemed careless in civil law. For neglect to be regarded as an offence, the element of mens rea must be present. A very high level of carelessness, or flagrant or extremely is required for an act to constitute a criminal medical liability.

[262] Supra note 5.
[263] Supra note 30

- Either a professional does not the required skill that he claims to possess, or he does not execute the skill with reasonable competence in the specific situation, are the two grounds on which a professional may be judged negligent. No matter what the circumstances, the standard that would be applied to determine whether the person accused of carelessness would be that of an ordinary competent person utilizing ordinary competence in that profession. For a professional to practice at the highest level, he must possess the highest level of skill or talents in his discipline.

After the Supreme Court's ruling in the Jacob Mathew Case, it was believed that doctors could not be sued for carelessness or negligence. In State of Punjab v. Shiv Ram, the Supreme Court stated that the burden of proof is always on the side of the prosecution or the claimant, regardless of whether the case is criminal prosecution or tort claim. This was a postscript to Jacob Mathew case. In a specific case, a doctor might undoubtedly be asked to justify their actions based on the evidence presented by the claimant or the prosecution. The caution that was advised in Jacob Mathew case regarding holding future doctors accountable for medical misconduct does not change the position.

3.6 THE THREE NEW CRIMINAL LAWS

Amit Shah, the Home Minister, presented bills in the Lok Sabha on August 11,2023. The bill was a suggestion to replace the Indian Penal Code, 1860, Indian Evidence Act, 1872, Code of Criminal Procedure,1973 and to name as Bharatiya Nyaya Sanhita, Bharatiya Sakshya Adhiniyam, Bharatiya Nagarik Suraksha Sanhita. A Parliamentary standing committee has been recommended to consider the proposed legislation for further discussion.[264] On December 20th and 21st, 2023 the parliament ratified the proposal and on December 25th, 2023 the president endorsed it.

The Indian Parliament has passed new criminal laws to address the inadequacies in the previous legislation and to adapt to the evolving demands of the criminal justice system. Making these laws more pertinent to the demands of contemporary society and providing appropriate mechanisms for impending issues were the two main objectives. Through improved legal definitions, these statutes represent current knowledge and concerns. In order to create a more effective and accessible legal

[264] Manoj Kumar Singh, A Comparative Study of Bhartiya Nyaya Sanhita 2023 with Indian Penal Code 1860: Modernization or Mere Replacement?, J. Indian Legal Stud. 45, 112-34 (2023).

process, they have also shortened the procedures. The other goal is strengthening provisions for the protection and assistance of crime victims. In contrast to the British Raj's excessive focus on upholding law and order, safeguarding properties as key installations of the then government and preventing sedition, these laws also provided the necessary measures for addressing crime related to technology and digital age. The President of India Hon. Draupadi Murmu, stated during a speech to the joint session of parliament on June 27, 2024, that "Bharatiya Nyaya Sanhita 2023, Bharatiya Nagarik Suraksha Sanhita, 2023, Bharatiya Sakshya Adhiniyam, 2023 will speed up the judicial process. The three new criminal laws came into force on 1st July, 2024 which is granting justice instead of punishment, which was the mindset during the British regime.[265] The fact that the Indian prisons house the greatest number of under trials in the world proves the inadequacy of the old criminal laws. The National Crime Records Bureau (NCRB) reports that 67.2% of prisoners in Indian prisons are classified as under trials. The new criminal laws seek to illustrate the shift from punitive to restorative justice. The new criminal laws were a clear need and necessity for the nation in all of these ways.[266]

3.7 A COMPARATIVE ANALYSIS OF INDIAN PENAL CODE AND BHARTIYA NYAYA SANHITA 2023

The IPC comprises of 511 sections and only 358 sections in BNS. Furthermore, while 19 IPC sections eliminated, 31 new offenses are implemented by the BNS. The maximum sentence for 33 offenses has raised up and fines for 83 offenses increased. In addition, the minimum necessary punishment was applied to 23 offenses and community service was introduced as a substitute form of punishment for six minor offenses. Additionally, the BNS fills the gaps in the IPC by emphasizing victim's rights and rehabilitation. Its goal is to increase sensitivity in order to protect the rights and freedoms of women and other gender minorities. BNS plans to provide a fair approach to punishments, making sure that they are appropriate for the offence and incorporate corrective actions. In order to reduce the strain on the legal system, the BNS also emphasizes other conflict resolution procedures, including conciliation and

[265] Rahul K. Gawadei & Sarika K. Karanjule, Replacement of Old Criminal Laws by New: A Reformative Step to Boost Criminal Justice System of India, Int'l J. Law Mgmt. & Humanities, vol. 7, iss. 6, 2105-13 (2024).
[266] Vijeta Shrivastava, Independence from Colonial Vestige and Overhaul of Indian Criminal Justice System through Three New Laws, 33 Contemp. Soc. Sci. 174 (2024).

mediation.[267]The BNS addresses another significant area where the IPC has been judged to be deficient: it is in accordance with international human rights norms, guaranteeing the preservation of both individual and universal rights.[268]

3.8 MEDICAL LIABILITY UNDER SECTION 106, BNS

One of the most significant recent events in Indian legal history is the reform of the country's criminal code through the passage of the Bharatiya Nyaya Sanhita, 2023 (BNS). Section 106 is one of the many new laws that has generated debate, particularly in the medical community. This section discusses criminal responsibility for culpable homicide that results from careless or reckless actions but does not qualify as murder. It also makes a distinction for registered medical professionals. While the earlier legal scheme under Section 304A of the Indian Penal Code, 1860 (IPC) had uniform punishment for negligent homicide, Section 106 of the BNS reserves a distinct, reduced punishment for doctors conducting medical interventions. The relevance of this exception is not just in its immediate legal implications, but also in its symbolic recognition of the intricacy and risk-intensive nature of medicine. The integration of Section 106 in the BNS accordingly directly affects the criminal liability system for medical negligence, and this requires an exhaustive analysis of its form, interpretation, and effects on the provision of healthcare. Two distinct situations are addressed by Section 106 of the BNS: general carelessness and conduct by licensed medical professionals. It reads as follows: Anyone who kills another person by a careless or reckless act that does not qualify as culpable homicide faces up to five years in prison and a fine. If a registered medical professional commits such an act while performing medical treatment, they face up to two years in various forms of imprisonment and a fine. Two distinct situations are addressed by Section 106 of the BNS: general carelessness and conduct by licensed medical professionals. It reads as follows: Anyone who kills another person by a careless or reckless act that does not qualify as culpable homicide faces up to five years in prison and a fine. If a registered medical professional commits such an act while performing medical treatment, they face up to two years in various forms of imprisonment and a fine. [269]According to the explanation provided in this section a "registered medical practitioner" is a

[267] Aayush Pareek, A Comparative Evaluation: Bhartiya Nyaya Sanhita 2023 in Opposition to Indian Penal Code 1860, Int'l J. L. Mgmt. & Humanities, 1123, 1122-34 (2024)
[268] Shreya Gupta, Legal Reforms in the Indian Penal Code: An Analysis of the Bhartiya Nyaya Sanhita 2023, Indian L.J. 40, 87-101 (2024).
[269] Bharatiya Nyaya Sanhitha, 2023, Sec 106

person whose name is included in either the National Medical Register or a State Medical Register and who possesses medical credentials recognized by the National Medical Commission Act, 2019.

3.9 COMPARISON BETWEEN SECTION 304 A IPC AND SECTION 106 BNS

Under the previous legal system, Section 304A IPC stipulated that anyone who caused death through a careless or reckless act that did not amount to culpable homicide faced a two-year prison sentence, a fine, or both.[270] Such a clause failed to differentiate between general negligence and that which occurs in the specialized field of medicine. This approach changes as a result of BNS passing. A specific clause for doctors restricts punishment to two years if the crime occurs during a medical procedure, even if Section 106 has increased the default penalty for negligent homicide to a maximum of five years.

The following comparative table illustrates the key differences:

Aspect	Section 304 A IPC, (1860)	Section 106, BNS (2023)
Scope	Rash or negligent act causing death	Same
General Punishment	Up to two years imprisonment, or fine, or both	Up to five years imprisonment and fine
Registered Medical Practitioners	No distinction	Up to two years imprisonment and fine

3.10 CONCLUSION

In this chapter, the Indian legislative framework that oversees medico-legal litigation has been thoroughly examined. The analysis has been divided into two main areas: criminal and civil responsibility. Medical negligence remedies are primarily sought under the Consumer Protection Act of 2019 and tort law principles. Because of the aforementioned Act's definition of patients as "consumers," there is now a robust system in place to handle complaints against healthcare organizations and medical personnel, giving aggrieved patients access to justice on a larger scale. However, there has also been a rise in lawsuits against doctors, which has caused defensive

[270] Indian Penal Code, Sec 304 A

medicine to spread. Although professional accountability, deterrent, and compensation are at the core of the civil liability framework, it typically lacks procedural uniformity and specialized forums for resolving technically complex medical disputes.

The chapter covered the change from Section 304A of the Indian Penal Code to Section 106 of the Bharatiya Nyaya Sanhita, 2023, with regard to criminal cases. With the creation of a distinct provision for registered medical practitioners, the change constitutes a substantial legal revision. A maximum term of five years is imposed for general acts of reckless or careless behavior that result in death under Section 106, while doctors performing medical procedures may get a lower sentence of up to two years. The unique and often dangerous character of medical profession is acknowledged by this distinction.

Despite the existence of such statutory provisions, judicial interpretation has largely shaped the substantive evolution of Indian medical law rather than legislative action. In order to shield medical professionals from overzealous prosecution, seminal rulings like Jacob Mathew v. State of Punjab established the threshold of "gross negligence" for criminal liability, while Indian Medical Association v. V.P. Shantha expanded the definition of "service" to include medical treatment under consumer law. These decisions have bridged essential legislative lacunae, created doctrinal certainty, and given direction to civil as well as criminal liability in medical situations. Finally, although statutory law gives the fundamental structural framework to medico-legal litigation, it is the Indian judiciary that has contributed most towards creating, interpreting, and evolving the principles of medical law in India.

CHAPTER 4

JUDICIAL TREND WITH RESPECT TO MEDICO LEGAL LITIGATION

4.1 INTRODUCTION

The common law regime, which was established in England, is followed by the Indian Legal System, which consists of statutes and court rulings or precedents, that are incorporated into the nation's law. The Indian court system is highly involved in covering the delicate subject of medical malpractices. The judiciary has attempted to protect patients and physicians from defamatory allegations by establishing laws to handle such matters over the years. The judiciary has attempted to address all of the legislative deficiencies, starting with its attempts to bring medical services under the purview of consumer protection Act and provide guidance on doctor's liability and compensation amounts.

Every Indian citizen must get complete justice, according to the Indian judiciary and the constitution. Under section 142 of the Indian constitution, the Supreme court has the authority to issue any decree in order to carry out full justice. In recent years, the aforementioned Article 142 has grown to be a significant component of the Supreme Court, which is frequently used to decide cases and administer complete justice. The law doesn't specify any rules or standards that would explain when, where or under what conditions the Apex court can use the Article 142 to provide complete justice.

After considering the aforementioned, we realize that the Apex court has been empowered by our constitution with a very strong sword for ensuring complete Justice in every case or matter. Examining the rulings rendered by the Apex Court under Art 142, we discovered that the Supreme Court considers that it must step in to address some of the intricate situations pertaining to the environment, health and legislation that were insufficient for the current situation. We must have to squash the childish fiction that the judiciary does not create laws. In C. Ravichandran Iyer v. Justice A. M. Bhattacharjee[271], Sabyasachi Mukherji C. J said that in order to give the principles embodied in the constitution and to make them a reality, judges are not only responsible for interpreting the law; they are also responsible for establishing new legal standards and modifying it to fit the evolving social and economic landscape. Active judicial functions, which were once regarded as extra ordinary but

[271] Ravichandran Iyer v. Justice A.M. Bhattacharjee, (1995) 5 S.C.C. 457

now normal, and are demanded by the society. In S. P. Gupta v. President of India[272] the court held that every statutory provision must be interpreted in accordance with the evolving concepts and values. It must, also to the extent that its language permits or does not forbid it, undergo judicial interpretation in order to meet the needs of the rapidly evolving society that is going through social and economic transformation. The court continued by stating that the law does not function in a vacuum. As a result, it is meant to fulfil a social function, and its interpretation is impossible without considering the social, political, and economic context in which is to function. In this situation, the judge is asked to exercise creativity. Through a process of dynamic interpretation, he must give the legislature's dry skeleton flesh and blood through dynamic interpretation. This will give the law a meaning that aligns it with the dominant ideas and values.

A Supreme Court case has brought attention to the prospect that court rulings could supersede or alter laws passed by parliament once more. The case has significant implications for how the judiciary interprets the law as it currently exists. Presumably, the case's final verdict would have significant ramifications. Supporting the higher judiciary's interpretation of the law, which some claim equates to the judiciary legislating instead of interpreting the law. The Supreme court actually established the legislation dealing to sexual discrimination at workplaces in the lack of a statute governing the same in judgments like Vishaka, which has frequently been used to support this claim. In many other instances, courts have given administrative directives to government agencies and established policy standards.

4.2 CASES UNDER CONSUMER PROTECTION

4.2.1 INDIAN MEDICAL ASSOCIATION V. V. P. SHANTHA[273]

In 1995 the case of Indian Medical Association v. V. P. Shantha, one of the most significant rulings pertaining to medical litigation in India was rendered. In 1986 the Consumer Protection Act was passed, which lead to the case. The main purpose of the Act to give consumer relief when they receive subpar products or inadequate services. The Act did not address the question of whether the services rendered by medical professionals to patient qualified as services under the Act's definition. The Supreme Court addressed the issues at hand after considering many special leave petitions on

[272] S.P. Gupta v. President of India, A.I.R. 1982 S.C. 149
[273] Supra note 4

the matter and deciding to consider all of the petitions as part of the same procedures. If a doctor or hospital may be considered to be giving service under the Act, and under what conditions, that was the primary question in the case. If a doctor or hospital may be considered to be giving service under the Act, and under what conditions, that was the primary question in the case. Since medical services were professional services provided by professionals rather than occupational services, which the Act was supposed to address, the Indian Medical Association said that they did not fit under the heading of services as defined by the Act. The Supreme Court adopted the standard set forth in Bolam v. Friern Hospital Management Committee[274] Which establishes the requirement for medical malpractices to evaluate this issue. After applying the Criteria, the court came to the conclusion that careless behaviour might occur in the delivery of both professional and occupational services, and that there was no distinction between the two in terms of malpractice or negligence. Consequently, the court dismissed the IMA's argument. The court also rejected the respondent's claim that the medical profession would not be covered by the strict and restrictive definition of deficit, which was used to construct it.

The Supreme Court also examined at the issue of when medical services do not qualify as services under the Act. The court ruled that medical services would not be considered services if they were offered to everyone for free by a hospital or doctor. However, a service would be considered service under the Act if a doctor usually charges his or her patients for services performed but does not charge a certain class of patients. Additionally, free medical care provided by hospitals does not qualify as a service. Consequently, the case of V. P. Shantha provides precise criteria about when a medical professional can be considered to be offering services under the Consumer Protection Act. The case gave thousands of people who were harmed by medical malpractice the chance to pursue prompt and effective justice.

4.2.2 POONAM VERMA V. ASHWIN PATEL[275]

In this case the respondent no.1, a homeopathic physician, diagnosed the appellant's husband with fever. He administered allopathic medication and viral fever, and later on for typhoid. On the instruction of the first respondent, the appellant's husband was promptly sent to the respondent no. 2 hospital after his health worsened. He was taken

[274] Supra note 30.
[275] Supra note 14

to Hinduja hospital in an unconscious state two days later, and he passed away at there.

The appellant accused the defendants of carelessness and demanded damages for her husband's death in a lawsuit she filed with the Consumer Dispute Redressal Forum. However, the appellant's plea was denied by the forum. The forum's judgment was contested before the Supreme Court. The Court discussed the issue of carelessness and its expression in its evaluation of the case facts. The court ruled out that there are several forms of negligence such as active, passive, deliberate, reckless, criminal, negligence per Se and gross negligence.[276]

The court ruled that no more evidence is required to prove that a person is guilty of negligent per Se. The court's ruling stated that the practice and prescription of allopathic medicine by respondent no.1, a qualified homeopathic physician, amounted to negligent per Se. This meant that the appellant did not need to provide any additional evidence to prove the respondent's negligence.

4.2.3 DR. JANAK KANTIMATHI NATHAN V. MURLIDHAR EKNATH MASANED[277]

This case concerns the death of a 13-year-old kid. The facts of the case is that the respondent's son had epilepsy when he was 13-year-old. His doctor was Dr. Pawar. But the respondent sought a second opinion from the appellant a neuro physician, who gave the respondent's son some medications in place of the ones the prior doctor had recommended. Soon after, the respondent's son developed a number of rashes. The appellant suggested a different tablet and modified the prescription. However, the respondent's son experienced severe convulsions because his body did not tolerate the change in tablets.

The appellant instituted proceedings against the respondent doctor and hospital for negligence, and both the District and State forums found the respondents liable for negligence and fined them. The state Forum's decision was appealed to the National Forum, which noted that the case's facts clearly showed that nothing had gone wrong that caused the boy's death, and that the principle of res ipsa loquitur applied because the death of an otherwise healthy boy with a curable disease spoke for itself. The

[276] Id para 40
[277] Dr.Janak Kantimathi Nathan v Murlidhar Eknath Masane,(2002) 2 CPR.138

burden of demonstrating negligence is therefore not solely on the complaint in situations where the res ipsa loquitur principle applies; rather, the court can determine whether or not there was genuine negligence based on the case's circumstances.

4.2.4 SAMIRA KOHLI V. DR. PRABHA MANCHAND & ORS[278]

In this case the appellant went to the respondent's clinic because she was experiencing heavy menstrual flow. After doing an ultrasound, a laparoscopic test was recommended. The following documents were signed by the appellant:

- Card of admission and release.
- Consent for doing surgery.

The appellant fainted out during the laparoscopic test. The respondent's assistant then hurried out of the operating room and requested to the mother of the appellant for signing a consent form for a hysterectomy under general anaesthesia, which resulted in the removal of her reproductive organs.

The Supreme Court ruled that consent for a total hysterectomy with bilateral salpingo opherectomy does not equate to consent for diagnostic and surgical laparoscopy and, if necessary, laparotomy. The appellant was not an unsound person or a minor. Since the patient was an adult with the capacity to give consent, it was not necessary for someone else to do so. And there was no emergency, the appellant was momentarily unconscious while under anaesthesia. Until the appellant regained consciousness and provided the required consent, the respondent ought to have wait. Without an emergency, the issue of obtaining the patient's mother's approval does not come up. Her mother's consent is nether genuine nor valid. Because doing surgery without obtaining the consent of appellant amounts to an unauthorized invasion and interference with the appellant's body.

The court held that protecting the right to life of the person's is the responsibility of State. India lacks a common law for consent, so Indian courts must rely on the Indian Contract Act. The patient should be duly informed about the treatment before making a decision. The court's rule aligns with the reasoning of US and UK courts as well as Indian precedents. Although the courts had a valid cause to prevent taking advantage

[278]Supra note 121

of India's impoverished and uneducated citizens, they should have instituted the idea of proxy consent.[279]

4.2.5 BALRAM PRASAD V. KUNAL SAHA & ORS[280]

The Balram Prasad v. Kunal Saha & Ors case produced one of the seminal rulings in India's medical litigation sector. The facts of the case was on a visit to their home state, the respondent and his wife, Anuradha Saha, departed the United States and arrived in Calcutta. The respondent, who works as a doctor, observed that his wife had a temperature and sore throat. Her health quickly deteriorated, leading to a high-grade fever, infection and skin rashes. She was taken by the respondent to receive treatment from the opposing party's physician. After the first course of treatment, it appeared to be effective. Anuradha's condition quickly deteriorated, and she kept getting high fevers. Anuradha was diagnosed with Angio – neurotic oedema with allergic vasculitis after seeing the opposing party physician once more. To treat the same, depomedrol was given to her. However, this did not appear to be effective, and Anuradha was admitted to the Advanced Medical Research Institute (AMRI) for additional care under the appellant's supervision. She was diagnosed with toxic epidermal necrosis by a dermatologist who was also called in for the procedure. Anuradha was sent to Breach Candy Hospital in Mumbai because the medications and treatment provided to Anuradha had failed to work.

The respondent demanded more than Rs. 77,00,00,000 in compensation and filed consumer and criminal complaints against the physicians who treated Anuradha. He said that the physicians had given Anuradha an excessive amount of medication without any reason. Additionally, he said that the hospitals and physicians treated Anuradha carelessly. In evaluating the allegations put out by each party, the National Commission evaluated whether the actions of a reasonable and competent medical professional had been violated.[281] According to its conclusion the commission ultimately found that the hospitals and doctors have been negligent in their treatment of the patient and ordered them to provide the sum of Rs.1, 300,000 as compensation

[279] Id
[280] Balram Prasad v. Kunal Saha, (2014) 1 SCC 384
[281] Dr.KunalSaha v Dr.Sukumar Mukherjee, (2006) 3 CPJ 142

to the complainant. The parties filed an appeal to the Supreme Court by hearing the order.[282]

After hearing arguments from both sides, the Supreme Court granted the respondent an enhanced compensation of Rs.6,08,00550, payable jointly by the hospitals and doctors, plus 6% interest bringing the total amount to Rs. 11,00,00,000. The court made the crucial point that there was a rise in medical litigation due to doctor's carelessness, which indicates the necessity of stringent guidelines for the conduct of physicians and suitable sanctions for careless treatment. According to the court granting a large sum of amount as compensation will always create a warning and a deterrent to medical professionals and institutions who failed to take their duty to patients seriously.[283] The case is significant because it was the first time the court had granted huge sum as compensation to serve as a warning to other medical professionals. In this case, the prospective income of the deceased was also calculated for the fist time up to 30 years, rather than customary 10- 18 years, when determining compensation. As a result, the Kunal Saha case remains a seminal case in the medical litigation field since it establishes new guidelines for determining medical negligence compensation.

4.2.6 M. A. BIVJI V. SUNITA[284]

This case began when Mrs. Sunita complained to the National Consumer Disputes Redressal Commission (NCDRC) about medical malpractice under Sections 12 and 21 of the Consumer Protection Act, 1986. She was first treated at Gondia Hospital after suffering several fractures in a catastrophic traffic accident on May 5, 2004. To make breathing easier, a tracheostomy was done. She was subsequently sent to Suretech Hospital in Nagpur, where she continued to get care under the direction of Dr. Nirmal Jaiswal, the ICU in-charge, with help from Dr. M.A. Biviji, a radiologist, and Dr. Madhusudan Shendre, an ENT specialist. A nasotracheal intubation (NI) was carried out after the tracheostomy tube (TT) was withdrawn on May 13, 2004, even though a bronchoscopy report showed normal airways. The complainant claimed that this needless treatment caused septicemia, subglottic stenosis, aspiration of food into the respiratory tract, and eventually irreversible voice loss.

[282] Supra note 281
[283] Id para 149
[284] M.A. Bivji v. Suntia AIR 2023 SC 5527

Mrs. Sunita also alleged that a subsequent Barium Swallow Test—used to investigate the abnormal passage of food—was forcefully conducted without her consent or the presence of a radiologist, causing further respiratory distress. She underwent several additional procedures in Mumbai and Nagpur, including a tracheoplasty, and lived with a shortened windpipe and permanent voice loss. She sought ₹3.58 crore in compensation. The NCDRC held that the forced NI constituted negligence but concluded that the other complications, including thrombocytopenia, vision loss, and the Barium Swallow Test, were not directly caused by the doctors' actions. Accordingly, the NCDRC awarded ₹6,11,638 with 9% interest as compensation and ₹50,000 for litigation expenses.

The Supreme Court rejected Mrs. Sunita's appeal but granted the appeals of Dr. M.A. Biviji, Dr. Nirmal Jaiswal, Dr. Madhusudan Shendre, and Suretech Hospital. The Court noted that the NCDRC had erred in blaming the replacement of the tracheostomy tube with NI alone for negligence. After a failed decannulation, the Court determined that the NI technique was a medically recognized substitute to strengthen the tracheal wall, particularly in light of the tracheal injuries and stridor that were discovered after the accident and previous surgeries.

According to the court, the complainant was unable to demonstrate that the NI procedure was carried out carelessly or that it was not a recognized practice. The Court did not find any proof from later medical facilities or physicians that the NI was directly responsible for the difficulties. The NI technique was not blamed by the RML expert medical board. The Court determined that causation could not be solely linked to the alleged negligent act because of the numerous treatments carried out in different hospitals, the length of time between the NI and subsequent difficulties, and periods of home care.

The Supreme Court came to the conclusion that neither the doctors nor the hospital had violated their duties. It rejected Mrs. Sunita's appeal for improvement and overturned the NCDRC's decision, granting the doctors' and hospital's appeals. All parties were instructed to cover their own expenses.

4.2.7 JYOTI DEVI V. SUKET HOSPITAL[285]

On June 28, 2005, Dr. Anil Chauhan performed a regular appendectomy on the appellant, Jyoti Devi, at Suket Hospital in Himachal Pradesh. She was released on June 30, 2005, but she still had chronic discomfort close to the surgical site. She repeatedly sought therapy during the following four years, including from Mandav Hospital's Dr. L.D. Vaidya, but to no effect. She finally went to the Post Graduate Institute of Medical Science (PGI), Chandigarh, where a 2.5 cm surgical needle was found stuck close to her abdominal wall and had to be removed through additional surgery. Jyoti Devi filed a consumer complaint alleging severe medical negligence and a lack of service, requesting ₹19.8 lakh to cover her costs and suffering.

The appellant suffered for a long time as a result of the respondent hospital's and its surgeon's careless post-operative treatment, according to the District Consumer Disputes Redressal Forum, Mandi. It granted compensation of ₹5 lakh. Following an appeal, the Himachal Pradesh State Consumer Disputes Redressal Commission agreed that the appellant's chronic discomfort was caused by the surgery at Suket Hospital, however they only awarded ₹1 lakh in compensation. The National Consumer Disputes Redressal Commission (NCDRC) raised the compensation to ₹2 lakh in recognition of the hospital's poor post-surgery treatment and careless attitude.

The Supreme Court granted the appeal and reinstated the District Forum's first award of ₹5 lakh, along with ₹50,000 in litigation expenses and 9% simple interest from the original award date. The Court underlined that the State Commission and NCDRC's lowering of compensation was incompatible with the appellant's long-term suffering and negligent findings.

4.2.8 KALYANI RAJAN V. INDRAPRASTHA APOLLO HOSPITAL & OTHERS[286]

Indraprastha Apollo Hospital and its physicians were accused for medical negligence by the appellant, Kalyani Rajan, in a complaint she filed under Section 2(c)(iii) of the Consumer Protection Act, 1986, after her husband, Sankar Rajan, passed away. Under the supervision of Dr. Ravi Bhatia, a renowned was referred the appellant's husband for surgery due to Chiari Malformation (Type II) with Hydrocephalus. The

[285] Jyoti Devi v. Suket Hospital (2024) 8 SCC 655
[286] Kalyani Rajan v. Indraprastha Apollo Hospital & Others (2024) 3 SCC 37

patient was moved from the intensive care unit to a private room following the surgery on 29.10.1998. He started having neck ache shortly after, but it was written off as a side effect of the surgery. Although medications were given and phone consultations were conducted, no senior doctor physically attended to him until 11 p.m., when he experienced a heart arrest and was pronounced brain dead on 31.10.1998. The pain worsened and was accompanied by perspiration and dizziness. On life support, he passed away on November 6, 1998. The appellant claimed that this series of events amounted to gross medical negligence, including the failure to transfer the patient to the intensive care unit after surgery and the lack of prompt medical supervision.

The Supreme Court affirmed the National Consumer Disputes Redressal Commission's (NCDRC) decision to reject the complaint, ruling that there was no evidence of medical negligence against the respondents. After carefully considering the claims and supporting documentation, the Court came to the conclusion that the post-operative treatment given was in line with the hospital's regular operating procedure. It concluded that the patient's transfer to a private room was appropriate because there were no post-operative problems and no indication of a previous cardiac condition. The Court also cited the evidence of top neurosurgeon Prof. Gulshan Kumar Ahuja, who examined the case files and said that symptoms such as nausea, sweating, and neck pain did not signify a cardiac arrest and that the complications that resulted in death had nothing to do with the surgery. The Court stressed that there was no direct or indirect evidence connecting the patient's death to any medical staff negligence, making the res ipsa loquitur (the thing speaks for itself) theory inapplicable.

The court dismissed the appeal, stating that the doctors and hospital had complied with standard procedure and that they could not be held liable for medical negligence because there was no proof that the surgery or its aftermath caused the cardiac arrest.

4.3 CASE LAWS ON TORT LAW

4.3.1 JOSEPH V. DR GEORGE MOONJERLY[287]

"Those who run hospitals have the same responsibilities as the humblest doctor; when they accept a patient to be treated, they must take the necessary care and skills to

[287] Joseph v. Dr. George Moonjerly, 1994 (1) K.L.J. 782 (Ker. H.C.)

alleviate the patient," the Kerala High Court declared. The hospital management, of course, is unable to accomplish it alone; they do not have the hands to touch the surgeon's knife or the ears to listen to the stethoscope. They are just as guilty as anyone else who hires people to perform their duties for them if they treat the personnel they hire carelessly.

4.3.2 ACHUTRAO & OTHERS V. STATE OF MAHARASHTRA OTHERS[288]

"The hospital administration is a welfare activity carried out by the government, it is not an exclusive duty or activity of the government such that it may be regarded as exercising sovereign power," the Honourable Supreme Court said. Consequently, the State would be held vicariously liable for any damages brought about by the negligence of its physicians or other staff.

4.3.3 RAJMAL V. STATE OF RAJASTHAN[289]

A Committee of Inquiry appointed by the Supreme Court concluded that the doctor was not negligent during the procedure and that there were no concerns regarding its competence, integrity, or efforts in the case of the patient who died of neurogenic shock after a laparoscopic tubal binding at a primary health centre. The State Government was found liable vicariously and ordered to compensate the deceased's husband for the death, because the death was attributed due to lack of competent personnel.

4.3.4 APARNA DUTT V. APOLLO HOSPITAL ENTERPRISES LTD.[290]

A complainant's relative was experiencing lower abdominal pain in this case. She was recommended to have surgery to remove the cysts in her uterus after consulting with the physician in the hospital. Despite the good outcome of the procedure, the complainant's relative passed away after experiencing further lower abdominal pain. It was initially thought that she passed away naturally, but after her cremation, it was discovered that a pair of scissors had been discovered in the ashes. Therefore, the plaintiff realized that the surgeons had left the scissors behind during the procedure.

The complaint filed a suit against the hospital, claiming damages for her relative's death. The hospital was the provider of medical services, the Madras High Court

[288] Achutrao v. State of Maharashtra, JT 1996 (2) SC 664
[289] Rajmal v. State of Rajasthan, A.I.R. 1996 Raj. 80
[290] Aparna Dutt v. Apollo Hospital Enterprises Ltd, (2002) ACJ 954

concluded in this case. It is up to the hospital and its doctors and surgeons to decide how to hire them, but the hospital cannot avoid responsibility when it comes to patients who are not its own. Such medical services should be provided by the hospital, and if the service is subpar or the surgery is done negligently, the hospital should be held accountable. The hospital cannot avoid responsibility by arguing that there is no master-servant relationship between the hospital and the survivor. When negligence is shown, the hospital is liable, and the fact that the surgeon is no longer employed by the hospital, etc., is not an excuse.

4.3.5 DEVENRA MADAN AND OTHERS V. SHAKUNTALA DEVI[291]

The courts have imposed stringent guidelines on physicians' liability and the duty of care they owe to their patients, they have also created protections for physicians that shield them from unwarranted harassment or discrimination. The respondent's spouse was experiencing nausea and vomiting in this case. The appellants treated him for his pain after he was brought to the hospital. Three days after being admitted to the hospital, showed that he had a gall bladder stone in it. The patient was released from the hospital after receiving standard medical care. But the pain persisted, so he sought treatment at another hospital. He then passed away within hours after receiving treatment.

The owner of the hospital's Diagnostic and X-ray Division was among the appellants that the respondent filed a complaint against him also. She claimed that she was not given access to the sonography report's contents and that she was not made aware about her gall bladder had stones in it. However, the appellants contended that the respondent and other family members of the patient were the ones who disregarded the doctor's advice and that they were not negligent. The court noted that the respondent made contradictory comments at various points during the hearing. The Court ultimately decided that, in order for the complainant to succeed, it would be necessary to demonstrate that the doctor had violated his or her duty and that the patient's sufferings was caused by the violation. As a result, this judgment raises the bar for doctors to be found negligent by demonstrating a breach of duty. The Court also referenced this ruling in Mrs. Savitri Devi v. Union of India.[292]

[291] Devendra Madan v. Shakuntala Devi, (2003) 1 CPJ 57
[292] Mrs Savitri Devi v Union of India, (2003) 4 CPJ 164

4.3.6 PASCHIM BANGAL KHET MAZDOOR SAMITY & OTHERS V. STATE OF BENGAL[293]

One essential component of the government's responsibility under the welfare state was to provide people with adequate medical services. "The right to life guaranteed by Article 21 of the Indian Constitution is violated when government hospitals fail to provide timely medical treatment to those in need of it."

4.3.7 STATE OF PUNJAB V. SURINDER KAUR[294]

In this case the court held a doctor employed by a state hospital performs their obligations while they are employed by the State, and under these circumstances, the master bears vicarious responsibility for the employee's acts while on the job. The state is in charge of determining whether or not negligent physicians are at fault. Although it is their personal matter, the patient may be able to get the money back from the state government. The primary responsibility of the hospital authorities is to ensure that the hospital or its officers are not irresponsible; the absence of a doctor, anaesthetist, or assistant is essentially a loss of responsibility on the part of the hospital authorities. The State authorities are responsible for making sure that their personnel are available in the hospital on time; if a doctor or expert is unavailable for any reason, the hospital authorities should have been informed beforehand.

4.3.8 DR. M. K. GOURIKUTTY V. M. K. MADHAVAN AND ORS[295]

In this case a patient died due to postpartum sterilization the court deemed the defendants negligent and held the State Government, anesthesiologist, and other staff members vicariously accountable rather than the State alone.

4.3.9 R. P. SHARMA V. STATE OF RAJASTHAN[296]

In the case of R. P. Sharma v. the State of Rajasthan, the State was held vicariously liable for the negligence of the blood bank staff and the transfusion physician when a woman died "as a result of a mismatched blood transfusion."

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[293] Supra note 114
[294] State of Punjab v. Surinder Kaur, 2001 ACJ 1266
[295] Dr. M. K. Gourikutty v. M. K. Madhavan, AIR 2001 Ker. 398
[296] R. P. Sharma v. State of Rajasthan, AIR 2002 Raj. 1.

4.3.10 REKHA GUPTA V. BOMBAY HOSPITAL TRUST &ANOTHER[297]

Regardless of the rules, the hospital that hired them all was accountable for their acts which was held by the National Consumer Redressal Commission. By arguing that it could not perform or recommend any operation or amputation on its own and that it only supplied infrastructure, nursing staff, support workers, and technicians, it cannot escape responsibility. "The hospital charges the patient for all services, including consultation costs with the consultant doctor, and takes 20% of the money when sending it to the consultant. The hospital cannot use these tenuous grounds to escape accountability, regardless of how the lawsuit turns up.

The management of the hospital accounts for "anesthesiologist and surgeons, who practice independently but admit/operate a case," in addition to their own staff, other staff, doctors, and other professionals. Whether they are full-time or part-time, permanent or temporary, or visiting consultants, it makes no difference. Any negligence on the part of such employees is typically attributed to the hospital's administration. It has been established that the hospital was offering medical services when a consultant surgeon who is not a hospital employee operates on patients while they are there and negligence occurs.[298] Although the defendant hospital and its physicians and surgeons have different hiring practices, this does not absolve the hospital of responsibility for patients who are third parties. After being admitted, patients depend on the hospital to provide them with expensive medical care. In the event that the hospital fails to provide these medical services, or in situations like those where the operation was performed "carelessly and without caution," the hospital will be held accountable and will not be exempt from liability because there is no master-servant relationship between the hospital and the patient. Often, a senior or super-specialist carries out surgery in a centre where the expertise is not locally available. After surgery, a competent local doctor is tasked with postoperative care. The failure of the senior/super-specialist to follow postoperative therapy personally may not be regarded reckless if the postoperative care doctor is competent; this can also be stated of a visiting doctor.

[297] Rekha Gupta v. Bombay Hosp. Tr. & Another, 2003 (2) CPJ 160 (NCDRC)
[298] Frank A., Experiencing Illness Through Storytelling, in Handbook of Phenomenology and Medicine 361 (S.K. Toombs ed., Springer 2001).

Surgery is frequently performed by a senior or super-specialist in a facility without local experience. Postoperative care is the responsibility of a qualified local physician following surgery. If the postoperative care physician is competent, the senior/super-specialist's failure to personally adhere to postoperative therapy may not be considered reckless; this also applies to visiting physicians.

If the surgery is performed in a hospital, the NCDRC is in charge of the postoperative care and therapy for the patients there. Surgery is frequently performed in India by foreign physicians, and it is impossible to guarantee that a foreign physician who may no longer be in the nation will give postoperative care and therapy. But, "the patient may die if the visiting surgeon never inquiries about the patient's condition and entrusts the patient's postoperative and follow-up care to another physician who is unable to treat the patient appropriately." The State has been held accountable for the carelessness of its physicians or personnel in a number of cases involving negligence against state hospitals, especially where there is a shortage of staff or equipment. In a few instances, the court rendered rulings to get damages from state physicians whose negligence was demonstrated.

4.3.11 DR. PREM LUTHRA V. IFTEKHAR[299]

In this case the court restated the idea established in Devendra Madan. The case concerned a situation in which the patient received treatment for his ailment from the physician. Nevertheless, the patient was not fully cured despite the doctor's ongoing care. The complainant claimed that because of the doctor's careless treatment, his sickness had not been treated and that he was still in pain as a result of the doctor's improper treatment.

The Court ruled that a doctor cannot be considered negligent if a patient continues to experience pain and disease as long as the doctor followed the right medical procedures, gave the right treatment, and used skills to the best of his or her abilities. Although the doctor is an expert in the field of medicine, they cannot promise that all illnesses will be cured.

[299] Dr.Prem Luthra v. Ifthekar, (2004) 11 CLD 37

4.3.12 V. KISHAN RAO V. NIKHIL SUPER SPECIALITY HOSPITAL & ANOTHER[300]

Due to a fever, the appellant in this particular case had his wife admitted with the respondent. The appellant's wife was subjected to multiple tests by the respondent, but none of them revealed that she had malaria. The respondent treated her by giving her saline, but her body did not react. She was then given oxygen support after she began to have respiratory issues. The appellant's wife passed away within hours after he moved her to a different hospital. The appellant, who filed the complaint in the District Forum, claimed that the respondent had been negligent. Despite the District Forum's order for the respondents to compensate the appellant, the State and National Forums found no evidence of the respondent's fault. The patient was transferred from the respondent hospital to another hospital in a clinically dead state, this fact was identified by the Supreme Court on appeal. The Supreme Court took note of the fact that the District Forum asked a senior physician for expert testimony. Nonetheless, the Supreme Court held that medical malpractice might be proven without the necessity for expert testimony. When the 'res' (thing) establishes carelessness, the plaintiff will not need to provide evidence of it because the res ipsa loquitur principle will be in effect. To refute the claim of carelessness, the respondent must instead demonstrate that they acted sensibly and with adequate caution.[301] The burden of proof is transferred in situations where the principle of res ipsa loquitur is relevant since the courts have repeatedly supported its applicability in medico-legal issues.

4.3.13 NEERAJ SUD V. JASWINDER SINGH[302]

The complainants, a father and his young son (Jaswinder Singh), filed a Complaint with the State Consumer Disputes Redressal Commission, seeking ₹15,00,000 for medical malpractice and ₹4,55,000 for treatment and related costs. Congenital ptosis, or drooping of the left eyelid, was diagnosed in the six-year-old son and treated by Dr. Neeraj Sud at the Post Graduate Institute of Medical Education and Research (PGI), Chandigarh. On June 26, 1996, the procedure was carried out. According to the complainants, the operation was performed carelessly, and rather

[300] V. Kishan Rao v. Nikhil Super Speciality Hosp., (2010) 5 SCC 513
[301] Devendra Madan v. Shakuntala Devi, (2003) 1 CPJ 57
[302] Neeraj Sud v. Jaswinder Singh AIR 2024 SC 5625

than making the situation better, it made it worse. The ptosis increased from mild to severe, the eyesight deteriorated from 6/9 to 6/18, and double vision developed.

Dr. Neeraj Sud and PGI argued in defense that a skilled and knowledgeable ophthalmologist used conventional methods to do the surgery. Between 1994 and 1996, Dr. Sud's residency included 74 ptosis operations that he either performed or assisted with. They further argued that repeat treatments may be necessary in situations of congenital ptosis due to known recurrence or complications. The patient was transferred to other hospitals after January 1997, ending ongoing medical surveillance, and did not return to PGI.

Since there was no proof of carelessness or departure from recognized medical procedures, the State Commission first rejected the complaint. On appeal, however, the National Consumer Disputes Redressal Commission (NCDRC) partially granted the complaint after reevaluating the PGI medical documents. It decided that Dr. Sud and PGI were negligent, citing the worsening in vision and formation of double vision following surgery, and ordered ₹3,00,000 in compensation, ₹50,000 in costs, and 6% interest from the date of the complaint.

The Supreme Court reinstated the State Commission's dismissal after accepting the appeal submitted by Dr. Neeraj Sud and PGI and overturning the NCDRC's ruling. The Court underlined that a patient's condition worsening after surgery does not, by itself, amount to actionable negligence. It decided that a failed or unsuccessful surgical outcome does not always result in liability unless there is clear proof of a professional duty violation.

The Court further underlined that there was no evidence that the treatment varied from accepted medical standards, nor did the complainants present any expert testimony indicating that the doctor did not exercise due care or skill. It was also mentioned that repeated surgeries are a recognized medical response in cases of congenital ptosis, and the reason PGI did not do this follow-up was because the patient had stopped receiving care there.

The Court further ruled that a failed surgery cannot be considered prima facie proof of carelessness without proving particular lapses, rejecting any automatic application of the res ipsa loquitur doctrine. Because there was no medical expert testimony to back up the claims, the complainants were unable to meet their burden of proof. The

NCDRC erred in overturning the State Commission's well-reasoned finding, the Supreme Court ruled, concluding that no actionable fault had been proven. As a result, PGI and Dr. Neeraj Sud's appeal was granted, the compensation award was revoked,

4.4 CASES UNDER IPC

4.4.1 DR. LAXMAN BALKRISHNA JOSHI V. DR. TRIMBAK BAPU GODBOLE[303]

In this case, the respondent's son sustained injuries to his left leg after falling. He consequently suffered a fracture to one of his bones, and the respondent took him to the hospital of the appellant. After diagnosing the respondent's son, the appellant determined that the fracture required treatment, and plaster splints were applied to the wounded leg using morphia and hyoscine hydro bromide. The boy then started having breathing issues, and even though the appellant's hospital was providing emergency care, his health rapidly deteriorated and he died. Fat embolism was determined to be the cause of death. Being a medical professional himself, the respondent realized that if the treating physician had taken better care of his son's injury, his condition might have been under control.

The respondent's only choice, given that the incident happened prior to the Consumer Protection Act's passage, was to file a tortuous damage lawsuit against the appellant in the trial court, claiming that the appellant ought to have given general anesthesia before applying plaster splints to the boy's fractured leg. The appellant was penalized when the trial court and Bombay High Court determined that the respondent's allegations were legitimate. The Supreme Court upheld the lower courts' conclusions after receiving an appeal from the appellant. The Court ruled that when someone says he is willing to offer medical advice and treatment, it is assumed that he has the necessary expertise and understanding to do so. A duty of care is owed to the patient when they arrive for treatment before such a person. Choosing whether to take on the case, what kind of treatment to provide, and how to provide it are all covered by the duty of care. The Court ruled that a patient may initiate medico-legal procedures against a medical professional if any one of the aforementioned responsibilities is broken. The court decision is based on Halsbury's Laws of England and held that,

[303] Supra note 171

depending on the specifics of each case, a reasonable level of skill and understanding is required for the medical practitioner.[304]

This case gave rise to a landmark decision that established the idea that doctors had a duty of care to their patients. It created a sense of accountability for healthcare professionals and emphasized patients' rights to file lawsuits against care providers who fail to uphold their duty of care. The case enabled courts to reach well-reasoned conclusions and set the standard for a number of subsequent medico-legal trials.

4.4.2 A.S. MITTAL & OTHERS V. STATE OF U.P.& OTHERS[305]

The facts of the case is for offering ophthalmic surgery services to the residents of Khurja village in Uttar Pradesh, an organization organized an eye camp. The organization invited Dr. R.M. Sahay from Jaipur and his team of medical professionals to conduct the surgical service at the camp after securing the required approvals and clearances. The team of doctors lead by Dr. R.M. Sahay treated around 108 of the 122 individuals that were diagnosed, primarily doing cataract procedures. However, the patients experienced excruciating eye discomfort a few hours following the surgery, to the point where the eyes were irreparably and totally ruined. After being informed of this, Dr. R.M. Sahay and his medical staff continued to treat the afflicted areas. The patients' symptoms, however, did not improve, and there was no improvement.

The petitioners brought a public interest lawsuit, claiming the state had failed to ensure proper procedures were established for the organization of eye camps. The Supreme Court took up the issue and looked into whether the government had failed to establish guidelines and requirements for the operation of eye camps. The Court cited the ruling in Dr. Laxman Balakrishna Joshi v. Dr. Trimbark Babu Godbole in considering the case's merits and reiterated the strict duty of care that physicians have to their patients.

[304] CF. Halsbury's Law of England 233–42 (3d ed. 2019)
[305] A.S. Mittal v. State of U.P., (1992) 2 SCR 815 (India).

4.4.3 CALCUTTA MEDICAL RESEARCH INSTITUTE V. BIMALESH CHATTERJEE[306]

According to a basic legal concept, the party presenting the matter before the court often bears the burden of proving negligence. This guarantees that the complainant has a legitimate claim against the other party and that the person against whom the lawsuit is brought is not harassed by the complainant. This idea was reaffirmed in this case, where Calcutta Medical Research Institute and other opposing parties appealed the lower court's ruling requiring the opposing parties to reimburse the complainant for damages incurred as a result of the opposing parties' negligence. In the aforementioned appeal, the court determined that the complainant had failed to discharge the burden of proof, holding that "the onus of proving negligence and resultant deficiency in service was clearly on the complainant".[307] As a result, the lower court's order was partially overturned and the appeal was granted.

4.4.4 KANHAIYA KUMAR SINGH V. PARK MEDICARE & RESEARCH CENTRE[308]

In this case the petitioner's youngest son was admitted to the hospital of the opposing party because he had upper abdominal pain, fever, and vomiting. The opposing party notified the petitioner a day later that the son would need surgery to treat severe appendicitis. When the petitioner is not present, his elder son, who is also a minor, granted permission to carry out the operation from the opposing party. The patient continued to complain of upper abdominal pain, fever, and vomiting after the procedure was finished. When the pain got intolerable two days later, the opposing party told the petitioner that his younger son would need to have a second operation. The patient was operated on by the opposing party before the petitioner could consent. Even the second procedure, though, was unable to relieve the patient's suffering. The patient's suffering persisted, but ten days later he was released and sent home. For additional care, the patient was referred by the opposing party to Christian Medical Hospital in Vellore. But the petitioner took his son to a new physician, who gave him different treatment, and the boy soon recovered his entire health.

[306] Calcutta Medical Research Institute v. Bimalesh Chatterjee, CPJ 1999 N.C 13
[307] Id, para 3
[308] Supra note 259

In his complaint, the petitioner claimed that the other party had engaged in completely needless activities and that their improper handling and actions amounted to negligence. According to the Court's analysis of the facts and evidence, in situations involving medical professionals' negligence, the complainant must prove and substantiate the negligence; it cannot be assumed otherwise. This ruling protects the interests of medical professionals who treat patients to the best of their knowledge and competence, free from malice, but who are unable to completely cure their condition. It acknowledges that medical professionals can make mistakes and defends those who do so without being careless. Surgery in particular is a dangerous medical procedure, and mishaps are inevitable. It is assumed that the patient is conscious of the dangers associated with the course of treatment. The aforementioned stance has also been adopted by UK courts. In R v. Adomako, the House of Lords ruled that a doctor cannot be held accountable for a patient's death unless it can be demonstrated that the doctor was incompetent or negligent, disregarding life and safety to the point where his actions constituted a crime against the State.[309]

4.4.5 BHALCHANDRA ALIAS BAPU & ANOTHER V. STATE OF MAHARASHTRA[310]

carelessness is punishable under criminal law; it became unclear whether the action should be civil or criminal in nature once it was determined that it was necessary and sufficient for patients to file a lawsuit against doctors. It is crucial in these situations to comprehend the distinction between criminal and civil carelessness, as established by the court in this case. In this case, the Court made the following observations:

"Criminal negligence is the egregious and culpable neglect or failure to exercise that reasonable and proper care and precaution to guard against injury either to the public generally or to an individual in particular, which, given all the circumstances surrounding the charge, the accused person had an imperative duty to have adopted. While negligence is defined as the failure to do something that a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs, would do."[311]

[309] Supra note 256
[310] Bhalchandra Alias Bapu v State of Maharashtra,(1968) SCR 766
[311] Id

In light of this, the ruling makes it clear that not all instances of carelessness would be categorized as criminal negligence. More than just a simple violation of the duty of care is required for criminal negligence; there must be some element of gross neglect for the obligation a medical professional has to a patient to ensure that the patient is not harmed.

4.4.6 SYAD AKBAR V. STATE OF KARNATAKA[312]

In this case elucidated the criteria for criminal negligence. The Supreme Court ruled in the aforementioned case that, although negligence is a necessary component of the crime, the prosecution must prove that the negligence was culpable or gross.

It was therefore firmly established that a mere act of carelessness did not qualify as criminal negligence; rather, it had to meet a higher level of gross carelessness on the part of the accused in order to qualify as such.

4.4.7 SURESH GUPTA V. GOVERNMENT OF NCT & ANOTHER[313]

In this case the appellant was charged with culpable homicide by the magistrate's court for causing his patient's death during surgery, the bar for proving criminal negligence was further lifted. The appellant claimed that his activities were not criminal in character and petitioned the High Court to have the allegations against him quashed. The High Court chose not to dismiss the case while noting that the charge sheet and complaint submitted to the trial court included inconsistencies. Consequently, the appellant petitioned the Supreme Court to have the charges quashed.

The appellant's bona fide intentions were observed, and the Court held that the appellant's act should have been one of "gross negligence" or "recklessness" rather than merely lack of necessary care. The proof presented before the trial court explained that the appellant's negligence caused the death by asphyxia, but it was also noted that even after the patient started experiencing asphyxia, the appellant did his best to treat the patient and stop the patient's condition from getting worse. As a result, the court determined that the appellant could not be criminally liable for the patient's death since his acts did not demonstrate recklessness to the point where they

[312] Syad Akbar v. State of Karnataka, A.I.R. 1979 SC 1848
[313] Suresh Gupta v Government of NCT, (2004) 6 SCC 422

constituted a crime against the State due to his total disdain for the patient's life and safety.

4.4.8 JACOB MATHEW V. STATAE OF PUNJAB & ANOTHER[314]

This case not only upheld but also reinforced the high bar of criminal negligence. In this instance, the complainant's elderly father was admitted as a patient in the private hospital ward. After being admitted, the patient had trouble breathing and called the doctor to get a diagnosis. The doctor, who is the appellant in this case, took over twenty-five minutes to show up to see the plaintiff. An oxygen mask was put over the patient's lips and nose per the doctor's instructions to administer oxygen to the patient through it. However, the patient's suffering persisted, and when he attempted to get out of bed, the medical team restrained him. The oxygen cylinder was quickly discovered to be empty and not supplying the patient with oxygen. The patient passed away from his incapacity to breathe before another oxygen cylinder could be brought into the room.

The complainant accused the doctor for criminal negligence that resulted in his father's death and filed a formal complaint against him. The doctor petitioned the High Court to have the FIR against him to getting quashed. However, because the appellants failed to provide adequate grounds for quashing, the High Court dismissed the appeal and did not quash the FIR. The appellant then requested special leave to address the Supreme Court. The appellant contended that there was no evidence of criminal negligence on his part in treating the patient and that his detention was arbitrary. The Court pointed out that physicians do not guarantee that their patients would recover from their illnesses. They simply claim to possess the necessary abilities to provide treatment with a decent level of competence. Therefore, it would be inappropriate for a doctor to treat patients while constantly fearing criminal prosecution. The Supreme Court noted in its final ruling that:

"A private complaint cannot be considered unless the complainant has presented the court with prima facie evidence—a reliable opinion from another qualified physician—to substantiate the allegation of haste or carelessness on the part of the accused physician. An independent and qualified medical opinion should be obtained

[314]Supra note 5

by the investigating officer, ideally from a government-employed physician who is typically required to provide an unbiased and objective judgment."[315]

In light of the aforementioned observations, the Court determined that no medical professional may be arrested unless it is absolutely required to gather evidence or conduct additional investigation, or unless the investigating officer believes the professional will not turn himself in for prosecution. The Court then dismissed the allegations against the appellant and granted the appeal. As a result, this case illustrates the process that must be followed when medical personnel are charged with criminal negligence.

4.5 JUDICIAL ACTIVISM IN MEDICO - LEGAL MATTERS

Medical personnel hold significant positions in society, and the medical field is a noble one. Nonetheless, medical personnel are not exempt from carelessness or from failing to fulfil their obligations to their patients. Medical personnel who behave carelessly may face both civil and criminal legal action. The aforementioned cases rank among the most significant and frequently referenced cases in India's medico-legal system. Their landmark rulings have established the norms that physicians, patients, hospitals, attorneys, and courts must adhere to while hearing medico-legal disputes. To create a suitable legal framework that tackles medico-legal matters, it is vital to examine the rulings and pinpoint the elements that are genuinely innovative and progressive. A review of the rulings yields some significant guidelines, which are outlined below:

- Every doctor has a responsibility to take good care of their patients. As a result, physicians who violate their duty of care will be held negligently accountable. It must also be demonstrated that the patient's suffering was brought on by the doctor's negligence.
- The standard of care in the medical field is typically higher due to its skill and high level of risk, and this should be taken into account in medico-legal matters.
- In addition to positive acts like giving patients the wrong care, negligence can also arise from negative acts like failing to keep track of a patient's case file,

[315] Id

failing to warn them of the risks involved in risky medical procedures, and failing to assist them in getting a second opinion.[316]

- A lawsuit for deficiency cannot be filed against a doctor who offers free medical care to all of their patients since the treatment cannot be categorized as a service under the Consumer Protection Act. However, the treatment given by such doctors will be categorized as service under the act if they charge certain people for their services while offering a particular class of patient's free care.
- In order to serve as a reminder or deterrent to medical practitioners to take their responsibilities seriously, compensation granted in medico-legal situations might be both standard and exemplary. The courts have established the aforementioned concepts.
- In addition to other criminal charges, doctors who make false statements about their qualification in the medical field may also be charged with negligence.
- Regardless of the treatment's outcome, a medical professional cannot be held accountable if they carried out their duties with the highest care and took all required precautions.
- In medico-legal matters, medical professionals must meet a higher threshold of negligence in order to be found guilty of criminal negligence. The medical practitioner ought to have behaved so grossly or recklessly that his actions could be viewed as a danger to the public.

Indian courts have established the aforementioned principles, which are still used in medico-legal issues. The examination of the rulings rendered by India's numerous courts demonstrates that the judiciary has played a significant role in the development of the medico-legal system of laws. This has primarily resulted from the legislature's disregard for the medico-legal regime. When it comes to medico-legal cases, the courts have frequently been compelled to create laws.

4.6 ISSUES WHICH HAVE TO BE ADDRESSED BY THE LEGISLATURE OR COURT

Even while the Indian judiciary has made a number of significant contributions to the evaluation of medico-legal matters, there are still many problems that the courts have

[316] Malay Kumar Ganguly v Sukumar Mukherjee, (2009) 9 SCC 219

either ignored or have not sufficiently clarified. In India, there are many gaps in medical law, and the judiciary has frequently helped to widen some of these. Therefore, the following issues are identified in this chapter as needing the attention of the legislature or the courts.

- The judiciary has not put in place a suitable system to determine the damages that negligent medical professionals should be subjected to. Courts have recently been known to award damages in crore of rupees, but up until the early 2000s, the maximum damages granted to victims of medical negligence was between 1 and 10 lakh rupees. The obvious problem is that compensation in medico-legal situations in India is frequently awarded inconsistently. In recent rulings, the multiplier method which courts most frequently employ to award compensation has come under scrutiny.[317]
- The highest amount of damages that courts can impose on medical providers is unlimited. The Supreme Court and the National Consumer Disputes Redressal Commission have the authority to award medical professionals any quantity of money for medical malpractice. This encourages inconsistent damage awards even more. In order to prevent medical professionals from becoming targets of consumer activism, courts must set a maximum amount of damages that can be awarded in medico-legal disputes. In many affluent nations, restrictions on doctors' maximum liability have been put in place.[318]
- Many legal and medical experts have questioned the courts' lack of knowledge about medical procedures and treatments. In medico-legal cases, the courts typically rely on the advice of other medical professionals or the Medical Council of India, both of which have been charged with showing bias in favor of the medical practitioners. Medical practitioners almost seldom oppose members of their own fraternity. Courts can address this matter by proposing the creation of a unique medico-legal tribunal or by assembling an unbiased panel of medico-legal experts from the medical community.
- Although courts have frequently addressed the problem of medical professionals' carelessness and patients' rights, they have not given much

[317] Nizam Institute of Medical Sciences, Hyderabad v Prasanth S. Dhananka (2009) 6 SCC 1
[318] David Goguen, State-by-State Medical Malpractice Damages Caps, NOLO,https://www.nolo.com/legal-encyclopedia/state-state-medical-malpractice-damages-caps.html.(Last visited on May 25 2025)

thought to defining the relationship between doctors and as well as patients. For the purposes of the Consumer Protection Act, patients are regarded as consumers, while doctors are recognized to play the role of service providers. This does not, however, address the ambiguity surrounding the relationship that arises when patients receive free medical care during medical camps, when medical students treat patients as part of their internship, or when untrained individuals administer medical care. Reaffirming the doctor-patient relationship is a crucial issue that courts should focus on more.

As a result, even if the courts have made a substantial contribution to the growth of India's medico-legal system, they have also left numerous problems with wide-open gaps. These and other matters should be addressed by courts in medico-legal cases in the future in order to help the legal and medical community ensure that the medico-legal case proceedings are clear.

4.7 CONCLUSION

The study of judicial interpretation in medico-legal matters in India demonstrates the shifting character of the legal landscape involving medical malpractice. In the absence of special statutory provisions, Indian courts in particular, the Supreme Court and the National Consumer Disputes Redressal Commission (NCDRC) have been essential in forming the jurisprudence on this issue. Courts have repeatedly emphasized the significance of patient rights, medical professionals' accountability, and the need for informed consent through seminal rulings. The cases included, such as V.P. Shantha[319] and Kunal Saha[320] are significant because they establish high standards for medical care and acknowledge that medical services are covered by the Consumer Protection Act. These rulings demonstrate that physicians have a duty of care to their patients, and depending on the extent of the carelessness, a breach of this duty may result in either civil or criminal culpability. In order to promote justice in complicated instances, the concepts of res ipsa loquitur and negligence per Se have been adopted. However, courts have been careful not to excessively demonize the medical field and have shielded physicians from pointless lawsuits by demanding a high standard of proof, particularly in criminal cases.

[319]Supra note 4
[320]Supra note 281

The uneven distribution of compensation in medico-legal conflicts is among the most obvious problems. Without a set procedure, the damages granted have varied widely, from a few millions to many crore, creating uncertainty and what is thought to be judicial arbitrariness. Despite being widely utilized, the multiplier approach is inconsistent, and the lack of a statutory cap makes matters worse. Because courts have not established a set method or cap for determining compensation, victims and healthcare providers are left in the dark. Furthermore, there are questions about impartiality and possible bias in favor of the medical professionals raised by the use of medical expert panels, which are frequently selected from within the medical community.

The vague and unclear character of the doctor-patient relationship in specific situations, including medical camps, internship-based therapies, or unlicensed care, is another major cause for concern. Despite the fact that courts have construed physicians as service providers and patients as consumers under the Consumer Protection Act, these interpretations fall short when medical care is provided informally or for free. This grey area necessitates a more sophisticated view of medical responsibility beyond financial transactions and complicates the legal status of such situations. Furthermore, the establishment of impartial expert panels or specialized medico-legal tribunals, which could give court rulings in this intricate field more technical credibility, has not been methodically handled by the courts.

In conclusion, by filling in legislative gaps and bolstering medical practitioners' accountability, the judiciary has unquestionably helped to establish medico-legal jurisprudence in India. Nevertheless, a number of systemic problems still exist in spite of these contributions. Establishing independent medico-legal tribunals, defining doctor-patient relationships more precisely, and imposing set compensation criteria are all urgently needed ways for the government and court to work together to address these problems. Even while the current regime is changing, it can still lack consistency, predictability, and fairness in the absence of such reforms. In order to guarantee justice for victims and clarity for medical professionals, the future calls for a more organized, uniform, and comprehensive strategy, even though the courts have established important principles and judicial precedents. In addition to protecting patient rights, the Indian medico-legal framework must strike a balance between the safety and sanctity of the medical field under an equitable legal system.

CHAPTER 5

CONCLUSION AND SUGGESTIONS

5.1 INTRODUCTION

Throughout the past fifty years, the medical field has seen tremendous growth and change. The state and professional organizations have advanced their regulation and management of the medical profession as a result of its evolving terrain. Setting high standards for patient care and holding those who deliver subpar care accountable are the goals of the profession's control. However, there is still much work to be done before the medical profession is regulated to the extraordinary standards that are expected of it, particularly with regard to medico-legal legislation in India.

In accordance with its objectives, the dissertation examined medico-legal cases in India, concentrating on a few of their most important facets, such as the patients' rights, doctor-patient relationship, the judiciary's function, and persistent problems in the nation. Investigating India's legal framework pertaining to the medical profession was the first step in the research process. The research is followed by a thorough examination of the judiciary's function in India in constructing and interpreting laws and regulations in a harmonious manner, determining the verdicts in significant medico-legal cases, and creating perfect precedents.

5.2 CONCLUSION

The study contents are summed up in the first chapter, "Introduction." Introduction, scope of study, statement of problem, research objectives, research questions, hypothesis, research methodology, chapterization, and literature review were the eight subheadings that made up the chapter. A preview of what lies ahead is provided in this chapter. The study's primary goals and objectives are described in the first chapter. It begins by providing a brief overview of the topic i.e, explaining the medico legal field and the main factors that leads to medico legal litigation. The main two factors which leads to medico legal litigation is the occurrence of negligence and the breach of patient rights. In the scope of the study it examines patient rights, healthcare practitioners' culpability in the event that they are found liable for medical negligence, and the regulatory system that oversees medico-legal disputes in India generally. By examining statutory laws like as the Consumer Protection Act of 2019, the Law of Torts, and the Bharatiya Nyaya Sanhita (BNS), 2023, it explores the multifaceted

nature of medico-legal issues. The study also looks at how court rulings influence the medico-legal field, especially in light of the absence of comprehensive codified laws. Additionally, it covers the responsibilities of medical professionals under the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulation, 2023, as well as the Charter of Patients' Rights issued by the Ministry of Health and Family Welfare. The statement of problem sets the stage for the study by highlighting the context in which it is being conducted. The research objectives identify the three main focus areas and the same is framed into research problems. The research methodology outlines how the study had to have been conducted. The study was purely doctrinal used books, articles and other materials to form the conjecture. The study was divided into five chapters including the conclusion and suggestions that together form the core of the research. The literature review provides an overview of the books and materials referenced during the study.

The second chapter discusses the doctor-patient relationship and its legal and ethical obligations. Historically, the relationship was paternalistic, with doctors making decisions without consulting patients; however, as medical science has advanced and awareness has grown, the model has been shifting towards patient-centeredness, emphasizing patient autonomy, informed consent, and trust between the two parties. The relationship is both contractual and fiduciary, meaning that the doctor is legally and morally obligated to act in the patient's best interests. Several models of doctor-patient relationship are defined in the chapter, including the Principal-Agent Model, in which the doctor makes decisions on behalf of the patient; the Paternalism Model, in which the doctor makes decisions without consulting the patient; the Shared Decision-Making Model, in which the patient and doctor jointly decide on the course of treatment; and the Informed Decision-Making Model, in which the patient chooses the course of treatment after the doctor has made all the required disclosures.The chapter's discussion on the 2018 Ministry of Health and Family Welfare adoption of the Charter of Patient Rights is one of its main highlights. It lists seventeen rights, including the right to knowledge, informed consent, emergency care, access to medical records, secrecy and privacy, nondiscrimination, second opinions, and high-quality care. Laws like the Clinical Establishments Act and the Consumer Protection Act, as well as constitutional provisions like Article 21 (right to life), uphold these rights.The Indian Medical Council (professional conduct, etiquette, and ethics)

Regulations, 2002, The National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulation, 2023, and its obligations for doctors are also explained in this chapter. Doctors must prescribe generic medications, maintain confidentiality, maintain a minimum of three years of medical records, and disclose charges before treatment. Additionally, doctors have a duty to act morally, especially in emergency situations, and refrain from promoting themselves in the media. Prior to treatment, informed consent must be obtained, and doctors must ensure equitable referral practices and prevent commercial influences on patient care. The chapter highlights the twin duties i.e, of safeguarding patients' rights and ensuring that medical professionals follow ethical and professional guidelines.

In chapter three an extensive overview of the Indian medico-legal framework with regard to medico-legal litigation is covered. It begins by discussing how commercialization, inadequate communication, and growing patient awareness have tarnished the doctor-patient relationship, which was formerly characterized by trust and respect. Legal complaints against doctors have increased as a result of these developments, with most patients attributing unfavorable outcomes to medical malpractice. The chapter highlights the fact that both criminal and civil remedies are used to address such disputes in the legal system. The main options for redress on the civil law are the Consumer Protection Act (CPA), 1986, and its modification in 2019. By seeing patients as consumers and healthcare services as a "service," the CPA holds hospitals and physicians accountable for care deficiencies. The chapter also covers the application of tort law, which allows for civil action for negligence-related damages. The burden of proving that the doctor's negligence resulted in the harm is on the complainant under tort law. Inaccurate diagnosis, surgical errors, and lack of informed consent are typical examples. Additionally, the chapter examines criminal culpability, which was previously addressed in Section 304A of the Indian Penal Code (IPC), 1860, which made it illegal to commit careless or reckless acts that resulted in death. But with the introduction of the Bharatiya Nyaya Sanhita (BNS), 2023, Section 106 was included expressly to address medical malpractice. This section distinguishes between carelessness in general and negligence committed by licensed medical practitioners during the course of performing medical operations. Given the risks and complexities involved in medical care, it imposes a less severe punishment on doctors, up to two years in prison. The chapter ends by noting that

while the structural basis of medico-legal litigation is provided by provisions in laws like the CPA and the BNS, the Indian judiciary has made the greatest contributions to the interpretation and development of medical law principles in order to strike a balance between safeguarding patient rights and protecting honorable physicians from harassment.

Chapter four highlights that the Indian judiciary, with major judgments and judicial activism, has sculpted the medico-legal landscape. It begins by describing how the Indian legal system based on the common law has evolved to address medical negligence by integrating statutory law and court judgments. Through the establishment of liability standards, compensation standards, and the scope of consumer rights in the medical field, the courts have played a pivotal role in protecting both patients and doctors. Indian Medical Association v. V.P. Shantha[321] is a notable case that was discussed. In this ruling, the Supreme Court held that medical services are within the purview of the Consumer Protection Act, allowing those who have been injured to recover compensation. The chapter also includes the cases of Kunal Saha[322], where the largest award for medical negligence was given in India, and Poonam Verma v. Ashwin Patel[323], where the concept of "negligence per se" was established with a focus on the deterrent value of such rulings. Other cases, like Samira Kohli,[324] and Dr. Laxman Joshi,[325] bring to the fore the importance of duty of care, informed consent, and the res ipsa loquitur doctrine. The chapter further examines criminal culpability in the Indian Penal Code and the Bharatiya Nyaya Sanhita, 2023, with special reference to gross negligence as a qualification for criminal prosecution, as discussed in Jacob Mathew v. State of Punjab. The chapter recognizes the judiciary's affirmative role in medico-legal jurisprudence development, but it also highlights certain deficiencies, such as the absence of proper guidelines for ascertaining compensation, uneven application of legal principles, and lack of unmistakable legislative framework for physician-patient relationships more so in the case of unpaid medical care.

The fifth chapter, titled "Conclusions and Suggestions," begins with an introduction that sets the context for the culmination of the research study. A couple of

[321] Supra note 4
[322] Supra note 281
[323] Supra note 14
[324] Supra note 121
[325] Supra note 171

introductory paragraphs provide insight into the overall scope and objectives of the study, giving the reader a clear understanding of the journey undertaken. A comprehensive paragraph summarizing the main findings from each of the earlier chapters follows this introduction. The different facets of the study are condensed into a coherent whole in this section's succinct but perceptive analysis. This paragraph provides the reader with a comprehensive understanding of the research findings by emphasizing the key points from each chapter, enabling them to quickly understand the study.The chapter then moves into a section devoted to recommendations, in which the researchers offer recommendations derived from the thorough knowledge the study has provided. Since it summarizes the main points of the study and offers a plan for further action, the "Conclusions and Suggestions" chapter can, therefore, be regarded as the most significant and well-organized portion of the research project.

5.3 SUGGESTIONS

The research has offered a substantial amount of information about the current situation of India's medico-legal system. It has, above all, highlighted the problems with the nation's medico legal system that require urgent attention consideration and correction. This section of the dissertation, which will address suggestions for improving India's medico-legal system, is based on the research and observations from each chapter. In order to enforce the suggestions, further authority will be introduced together with modifications to existing laws, policies, and regulations.

- First, new legislation should be created from the ground up, taking into account the prior experiences of all parties involved as well as scientific and technological developments in medicine. In the absence of a clear legal framework, courts have established a number of doctrines; consequently, these doctrines ought to be sanctioned by the law, and a specific law pertaining to "medico legal field" ought to be passed, outlining doctors' obligations and guaranteeing that patients receive the barest minimum of equitable treatment throughout trials.
- **Medico - Legal Tribunal** - There are issues with judges and attorneys in civil, criminal, and consumer courts not knowing enough about medical law. However, the party who has been injured typically starts actions with the District, State, or National Consumer Disputes Redressal Commission because there are no specialized institutions to hear medico-legal issues. The members of these commissions have a sufficient comprehension of the law but lack specialized

expertise of medical law. There are two possible outcomes from this. First of all, a lack of knowledge causes the courts to make incorrect rulings in medico-legal situations, which can seriously affect the rights of the party who was injured. Second, courts may choose to consult with specialists designated as amicus curiae, which can cause significant delays in the resolution of medico-legal disputes. Either way, the victim in this case is not given prompt and effective justice. In the field of medical law, several countries have established special tribunals. For example, the UK has established the Medical Practitioners Tribunal Service to hold hearings that make independent decisions about whether doctors are fit to practice medicine.[326] It is suggested that the establishment of a medico-legal tribunal can prove to be beneficial to the fast, accurate, and effective disposal of medico-legal cases. Such a tribunal will consist of adjudicating members who possess expertise in the field of medico-legal litigation and will be able to act in the best interest of the parties to a case.

- Compensating egregious medical misconduct should be distinguished from compensating regular medical malpractice. A fair standard of care ought to be established based on the expectations of patients who are receiving treatment from doctors and placing their complete trust in them, taking into account the doctor's experience, competence, and expectations. No amount can be deemed absolutely reasonable and appropriate, as the Supreme Court of India has previously determined. In order for the decisions to be fair, reasonable, prudent, and just in the long run, the courts must be prepared to evaluate each case on its own merits, regardless of the background and circumstances. A medical practitioner's suspension of only a few months or years is insufficient punishment in cases of great carelessness when the patient suffers from a chronic illness. The NMC need to quickly and without prior warning cancel their license.
- **Regulatory control towards the hospital** - The Quality Council of India's National Accreditation Board for Hospitals & Healthcare Providers was established to create and run an accreditation program for healthcare organizations with the goal of optimizing a hospital's overall operations. However, not all hospitals are required to have this NABH accreditation because it is not a regulatory necessity. Only a small number of large corporate hospitals take pride

[326] Medical Practitioners Tribunal Service., https://www.mpts-uk.org/ (last visited on May 25 2025).

in obtaining NABH accreditation in order to draw in patients. On the down side, NABH inspections only happen once every four years. The majority of hospitals will solely adhere to NABH rules when conducting inspections. All hospitals in India must be required to be accredited by a robust accrediting organization and undergo an annual surveillance audit. Without certification, new hospitals won't be allowed to open. This will undoubtedly reduce medico legal litigation in India.

- **Educating patients'** - The establishment of a medical law patient education clinic by the government in collaboration with the National Medical Commission, akin to a legal aid clinic. In order for the general people to absorb pertinent information regarding medical law, governments must regularly facilitate or give patient education. There are several direct and indirect ways to accomplish this. For the advantage of the general public, regular seminars and pop-up camps might be held where professionals from the legal and medical domains offer fundamental knowledge on medical legislation. Furthermore, hospitals and medical professionals may be required to prominently publish on the premises the legal remedies and patient rights in medico-legal cases.
- **Legal Assistance** - laws pertaining to providing of legal services should be modified by the state governments. The modifications must ensure that each district's legal services authority has at least one medico-legal specialist on staff, whose services are open to anybody in need of help with medico-legal matters. In addition to this, lawyers must have adequate medico-legal training by attending workshops and attending specialized lectures on the topic. A knowledgeable legal community can quickly and effectively help judges and parties reach the right decisions in medico-legal disputes. To guarantee that law students are prepared in accordance with medical legislation and are capable of offering counsel in medico-legal cases, the Bar Council of India and medical colleges throughout the nation might also implement medico-legal instruction at the basic level.

BIBLIOGRAPHY

ARTICLES

1. A Conversation With Florence Nightingale, AM. ASS'N OF CRITICAL-CARE NURSES (Apr. 24, 2019), https://www.aacn.org/nursing-excellence/nurse-stories/a-conversation-with-florence-nightingale
2. A. Goic, It Is Time to Think About Patient's Rights, 128 REV. MED. CHIL 371, 371–73 (2000)
3. Aayush Pareek, A Comparative Evaluation: Bhartiya Nyaya Sanhita 2023 in Opposition to Indian Penal Code 1860, Int'l J. L. Mgmt. & Humanities, 1123, 1122-34 (2024)
4. Agrawal, Amit, Medical Negligence: Indian Legal Perspective, 1 Ann. Indian Acad. Neurol. S9, S9–S14 (2016)
5. Anmol Mahani & Rudranath Zadu, Ensuring the safety of healthcare professionals: A review of current challenges and legal frameworks in India, IJFCM, 152-158 (2024)
6. C. Charles, Decision making in the physician-patient encounter: revisiting the shared treatment decision-making model, 49 Social Science and Medicine 651-661 (1999).
7. Cecilia Nardini, The Ethics of Clinical Trial, https://pmc.ncbi.nlm.nih.gov/articles/PMC3894239/ (last visited on May 20, 2025).
8. Chin, J J, "Doctor-patient Relationship: From Medical Paternalism to Enhanced Autonomy", 43 Singapore Med J 152 (2002).
9. Daniel Wechter & Donna Harrison, A Second Opinion: Response to 100 Professors, 29 Issues L. & Med. 147 (2014).
10. David Goguen, State-by-State Medical Malpractice Damages Caps, NOLO,https://www.nolo.com/legal-encyclopedia/state-state-medical-malpractice-damages-caps.html (Last visited on May 25 2025)
11. Don Malcolmson, The Patient's Right to Know, 101 J. Med. Regul. 32 (2015).
12. Dya Eldin M. Elsayed & Rabaa Elamin M. Ahmed, Medical Ethics: What Is It? Why Is It Important?, 4 Sudanese J. Pub. Health 234,(2009).
13. Emanuel E.J.et al. Four models of physician patient relationship, 11 (3) JAMA, 208-211 (2010).

14. Furkhan Ali et al., Consent in Current Psychiatric Practice and Research: An Indian Perspective, 6 Indian J. Psych. 667 (2019).
15. Hayley Rosenman, Patients' Rights to Access Their Medical Records: An Argument for Uniform Recognition of a Right of Access in the United States and Australia, 21 Fordham Int'l L.J. 1500, 1503 (1997).
16. Hui Zhang et al., Patient Privacy and Autonomy: A Comparative Analysis of Cases of Ethical Dilemmas in China and the United States, 22 BMC Med. Ethics 1, 8 (2021).
17. Ian kennedy, Treat me right: Essays in Medical law and Ethics 387 (Clarendon Press 1991).
18. Inder Maurya, Medical 2nd Opinion – Trends & Challenges, BW Healthcare World,https://bwhealthcareworld.com/article/medical-2nd-opinion-%E2%80%93-trends-challenges-179592 (last visited May 22, 2025).
19. James L. Rigelhaupt, What Constitutes Physician-Patient Relationship for Malpractice Purposes, 17 A.L.R. 132 (2001).
20. Joshua G. Rivenbark & Mathieu Ichou, Discrimination in Healthcare as a Barrier to Care: Experiences of Socially Disadvantaged Populations in France from a Nationally Representative Survey, Discrimination in healthcare as a barrier to care: experiences of socially disadvantaged populations in France from a nationally representative survey | BMC Public Health | Full Text (Last visited on May 22 2025).
21. Jyoti Dogra Sood, Responsibility of Doctors for Rash or Negligent Act, 46 J. Indian L. Inst. 588 (2004).
22. L. Prinsen, The Leading Causes of Medicolegal Claims and Possible Solutions, 113 S. Afr. Med. J.,1140, 1140-42 (2023).
23. M.S. Pandit & Shobha Pandit, Medical negligence: Criminal prosecution of medical professionals,importance of medical evidence: Some guidelines for medical practitioners, 25(3) Indian Journal of Urology. 381, 379-383 (2009)
24. Manoj Kumar Singh, A Comparative Study of Bhartiya Nyaya Sanhita 2023 with Indian Penal Code 1860: Modernization or Mere Replacement?, J. Indian Legal Stud. 45, 112-34 (2023).
25. Marwan A Habiba, Examining the consent within the Patient- Doctor Relationship, Journal of Medical Ethics, 186 (2000)

26. Mohammad Mohammadi et al., Do Patients Know That Physicians Should Be Confidential? Study on Patients' Awareness of Privacy and Confidentiality, 11 J. Med. Ethics & Hist. Med. 1 (2018).
27. Moore, P. et al., A study of hospital complaints and the role of the doctor-patient communication, 139 Rev. Med. Chil. 880 (2011).
28. Mukesh Yadav & Pooja Rastogi, Patient Safety Due to Administrative Negligence: Neglected Area in India?, 1 Annals of Int'l Med. & Dental Res. 72 (2015).
29. Neda Milevska, Patients' Rights as a Policy Issue in SEE - the Transition Context, at 2, IPF Fellow, Open Society Inst.-Budapest (2005)
30. Nomal Chandra Borah, Doctors' Dilemma and Patients' Right to Second Medical Opinion, econ. times: health Doctors' dilemma and patients' right to second medical opinion - Health Files by Dr. Nomal Chandra Borah | ET HealthWorld (Last visited on May 22, 2025)
31. Omprakash Nandimath, Consent and Medical Treatment: The Legal Paradigm in India, 25 Indian J. Urol. 343 (2009).
32. Rahul K. Gawadei & Sarika K. Karanjule, Replacement of Old Criminal Laws by New: A Reformative Step to Boost Criminal Justice System of India, Int'l J. Law Mgmt. & Humanities, vol. 7, iss. 6, 2105-13 (2024).
33. Rituparna Maiti et al., Essential Medicines: An Indian Perspective, 40 Indian J. Cmty. Med. 223 (2015).
34. Satvik N. Pai et al**.,** The New Bharatiya Nyaya Sanhita Laws: Progress or Pitfall for Doctors?, 16 Cureus (Sept. 22, 2024).
35. Seabury, Seth et al., Malpractice Risk According to Physician Specialty, 365 N.E. J. Med. 629 (2011).
36. Shreya Gupta, Legal Reforms in the Indian Penal Code: An Analysis of the Bhartiya Nyaya Sanhita 2023, Indian L.J. 40, 87-101 (2024).
37. Simon, R.I. & Shuman, D.W., The Doctor-Patient Relationship, 5 J. Lifelong Learning Psychiatry 423 (2007)
38. Singh, S. et al., Knowledge of consumer protection act among doctors from government and private sectors of union territory, Chandigarh, 68 Indian J. Med. Sci. 5 (2016).

39. Smreeti Prakash, A Comparative Analysis of Various Indian Legal Systems Regarding Medical Negligence, Legal Services India, https://www.legalserviceindia.com/medicolegal/mlegal.htm (Last Visited on May 22, 2025)
40. Suncica Ivanovic et al., Medical Law and Ethics, 52 AMM 67, 67-73 (2013)
41. Susan Dorr Goold, The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies, 14 J. Gen. Internal Med. 26 (1999).
42. Susan Sherwin, A Relational Approach to Autonomy in Healthcare, in The Politics of Women's Health: Exploring Agency and Autonomy 21 (Francoise Baylis et al. eds., Temple Univ. Press 1998)
43. Swaranjali Gajbhiye & Swapnil Patond, Medico-Legal Aspects of Medical Negligence Amongst Medical Students, 10 J. Res. Med. Dent. Sci., 226-30 (2022).
44. Talha Abdul Rahman, Medical Negligence and Doctor's Liability, 2 IND. J. MED. ETHICS 60, 60-61 (2005).
45. Thomas Joseph, Medical records and issues in negligence, 25 Ind. J. Urol. 384 (2009)
46. Vijeta Shrivastava, Independence from Colonial Vestige and Overhaul of Indian Criminal Justice System through Three New Laws, 33 Contemp. Soc. Sci. 174 (2024).

BOOKS

1. Andrew Grubb, The Law of Tort 858 (Lexis Nexis, 2d ed. 2007).
2. Apurba Nandy, Principles of Forensic Medicine Including Toxicology 88 (3d ed. 2010).
3. Barry R. Furrow et al., Health Law 260 (2d ed. 2000).
4. Cecil Helman, Introduction: The Healing Bond, in Doctors and Patients: An Anthology 1 (1 st ed 2003).
5. Dogra & Abhijit Rudra, Lyon's Medical Jurisprudence and Toxicology, 171, (The Delhi Law House,11 th Edn 2022)
6. Edward Premdas Pinto, Health Justice in India 89 (1st ed.2021)

7. Frank A., Experiencing Illness Through Storytelling, in Handbook of Phenomenology and Medicine 361 (S.K. Toombs ed., Springer 2001).
8. H.M.V. Cox, Medical Jurisprudence and Toxicology 77 (6th ed. 1990).
9. John Salmond, Charlesworth on Negligence 21 (6th ed. 2013).
10. K Kannan, A textbook of Medical Jurisprudence and Toxicology, 117, (Lexis Nexis 26th ed 2019)
11. M.N. Shukla, The Law of Torts 122(13th ed. 1990).
12. P.V.Rama Raju - The Consumer Protection Act, 1986,Latest Edition 2003, S.Gogia & Company Section 2(l)(d) of The Consumer Protection Act.
13. Ratan Lal & Dhiraj Lal, The Law of Torts 458 (2nd ed. 2005)
14. Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics 57 (5th ed. 2001).
15. W. Wyatt-Paine, The Law of Torts 140 (7th ed. 1921).
16. Y.V. Rao, Law Relating to Medical Negligence 4 (2d ed. Asia L. House 2010).
17. Yogesh V. Nayyar & Laxman, Medical Negligence and Medical Evidence 49 (1st ed. 2024).

WEBSITES

1. Clinical Establishments (Central Government) Rules, 2012, Rule 9**,** https://clinicalestablishments.gov.in/WriteReadData/386.pdf. (Last visited on May 22, 2025)
2. Clinical Establishments (Registration and Regulation) Act Standards for Hospital Level 1, Annexure 8**,** https://clinicalestablishments.gov.in/WriteReadData/147.pdf. (Last visited on May 22, 2025)
3. Clinical Establishments (Registration and Regulation) Act, 2010, Sec. 18, https://www.indiacode.nic.in/bitstream/123456789/7798/1/201023_clinical_establishments_%28registration_and_regulation%29_act%2C_2010.pdf. (Last Visited on May 22, 2025)

4. https://indiankanoon.org
5. Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 https://www.nmc.org.in/wp-content/uploads/2017/10/Ethics-Regulations-2002.pdf (Last visited on May 23, 2025)
6. Ministry of Health & Family Welfare, Charter of Patients' Rights (2018), https://nhrc.nic.in/sites/default/files/charter_patient_rights_by_NHRC_2019.pdf. (Last visited on May 22, 2025)
7. National Accreditation Board for Hospitals & Healthcare Providers (NABH), Charter of Patients' Rights (2018), https://nabh.co/Images/pdf/Patient_Charter-DMAI_NABH-new.pdf. (Last visited on May 22, 2025)
8. National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulation,2023 https://www.nmc.org.in/rules-regulations/national-medical-commission-registered-medical-practitioner-professional-conduct-regulations-2023-reg/ (Last visited on May 23, 2025)
9. www.jstor.com
10. www.lawctopus.com
11. www.ssconline.com

STATUTES, RULES, REGULATIONS

1. Bharathiya Nyaya Sanhitha, 2023
2. Clinical Establishments (Central Government) Rules, 2012
3. Clinical Establishments (Registration and Regulation) Act, 2010
4. Consumer Protection Act, 1986
5. Consumer Protection Act, 2019
6. Indian Constitution, 1950
7. Indian Evidence Act, 1872
8. Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002
9. Indian Penal Code, 1860
10. Ministry of Health & Family Welfare, Charter of Patients' Rights (2018),
11. National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulation, 2023

INTERNATIONAL DECLARATIONS , REPORTS

1. European Declaration on the Promotion of Patients' Rights art. 7 (1994),
2. Kan.Stat.Ann.60-427(a)(1)(2023), https://www.ksrevisor.org/statutes/chapters/ch60/060_004_0027.html (last Visited on May 20, 2025)
3. Law on the Rights of Patients and Damage Done to Patients art. 1(1) (1996),https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/TAIS.42491 (last Visited on May 20, 2025)
4. Medical Practitioners Tribunal Service., https://www.mpts-uk.org/ (last visited on May 25, 2025).
5. WHO Expert Comm. on the Selection & Use of Essential Medicines, The Selection and Use of Essential Medicines, WHO Tech. Rep. Series No. 914 (2002).
6. World Health Organization, Declaration on the Promotion of Patients' Rights in Europe, (1994).

LEGAL DICTIONARY, ENCYCLOPEDIA

1. CF. HALSBURY'S LAW OF ENGLAND 233–42 (3d ed. 2019)
2. Henry Campbell Black, Black's Law Dictionary 1126 (6th ed. 1993).

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