205HA26

by Anu Cde

Submission date: 16-Feb-2026 04:14PM (UTC+0530)
Submission ID: 2880581467
File name: 205HA26_total.pdf (3.21M)
Word count: 146279
Character count: 848148

HEALTHCARE LAWS, ETHICS AND COUNSELLING SKILLS

MASTER OF BUSINESS ADMINISTRATION (HOSPITAL ADMINISTRATION)

FIRST YEAR, SEMESTER-I, PAPER-V

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MBA (HA): Healthcare Laws, Ethics and Counselling Skills

First Edition : 2025

No. of Copies :

This book is exclusively prepared for the use of students of MASTER OF BUSINESS ADMINISTRATION (Hospital Administration) Centre for Distance Education, Acharya Nagarjuna University and this book is meant for limited circulation only.

Published by:

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Centre for Distance Education,
Acharya Nagarjuna University

Printed at:

FOREWORD

Since its establishment in 1976, Acharya Nagarjuna University has been forging ahead in the path of progress and dynamism, offering a variety of courses and research contributions. I am extremely happy that by gaining 'A+' grade from the NAAC in the year 2024, Acharya Nagarjuna University is offering educational opportunities at the UG, PG levels apart from research degrees to students from over 221 affiliated colleges spread over the two districts of Guntur and Prakasam.

The University has also started the Centre for Distance Education in 2003-04 with the aim of taking higher education to the door step of all the sectors of the society. The centre will be a great help to those who cannot join in colleges, those who cannot afford the exorbitant fees as regular students, and even to housewives desirous of pursuing higher studies. Acharya Nagarjuna University has started offering B.Sc., B.A., B.B.A., and B.Com courses at the Degree level and M.A., M.Com., M.Sc., M.B.A., and L.L.M., courses at the PG level from the academic year 2003-2004 onwards.

To facilitate easier understanding by students studying through the distance mode, these self-instruction materials have been prepared by eminent and experienced teachers. The lessons have been drafted with great care and expertise in the stipulated time by these teachers. Constructive ideas and scholarly suggestions are welcome from students and teachers involved respectively. Such ideas will be incorporated for the greater efficacy of this distance mode of education. For clarification of doubts and feedback, weekly classes and contact classes will be arranged at the UG and PG levels respectively.

It is my aim that students getting higher education through the Centre for Distance Education should improve their qualification, have better employment opportunities and in turn be part of country's progress. It is my fond desire that in the years to come, the Centre for Distance Education will go from strength to strength in the form of new courses and by catering to larger number of people. My congratulations to all the Directors, Academic Coordinators, Editors and Lesson-writers of the Centre who have helped in these endeavors.

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MASTER OF BUSINESS ADMINISTRATION
(HOSPITAL ADMINISTRATION)
Programme Code: 197
PROGRAMME SYLLABUS
1st YEAR – 2nd SEMESTER SYLLABUS
205HA26: HEALTH CARE LAWS, ETHICS & COUNSELING SKILLS

Unit - I Establishment: Andhra Pradesh Private Medical Care Establishment Act 2002; Formation of a Health care Organization under Partnerships and Corporate basis (private and public); Public Private Partnerships in health care; National Medical Council; Physician Patient relationship; Duties towards patients by medical and Para-medical staff; Medical ethics & Oaths; Code of conduct.

Unit - II Hospital Services and Law: Contractual obligations in Hospital Services; Requisites of a valid contract; Contractual liability and damages; Criminal liability and defenses available to hospitals and medical staff; tortuous and vicarious liability; Legal remedies available to patients, Hospital as a bailee; CP Act, RTI.

Unit – III Hospitals and Labour Enactments: Hospital as an Industry; Unrest in Hospitals; Dispute Settlement Mechanisms; Role of Trade Unions; Unfair Labour Practices and Victimization; Disciplinary Actions– Requisitions of a valid disciplinary enquiry; Service Conditions; Retiral benefits; Social Security and Insurance

Unit - IV Legal frame work: Patient right's and responsibility; Medical malpractice; Medico legal aspects of: impotence, sterility, sterilization and artificial insemination; Medico legal aspects of psychiatric &mental health; Toxicology - laws related to toxicology; Giving evidence in police investigation; Organ transplantation; Euthanasia (mercy killing); Diagnosis, prescriptions and administration of drugs; Anesthesia and Surgery.

Unit - V Counseling skills: Introduction, growth of Counseling Services; Approaches to counseling; Process of Counseling; Attitudes of Counselors; Skill of Counseling; Problems in Counseling; Assessing and diagnosing clients' problems; Selecting counselling strategies & interventions; Changing behavior through counseling; Application of Counseling to Hospital Situations with a Focus on Performance Improvement.

Reference Books:

1. S.L. Goel, Healthcare Management and Administration, Deep & Deep Publications Pvt. Ltd. New Delhi, 2010
2. Harris, D. (2014). Contemporary Issues in Healthcare Law and Ethics. Chicago: Health Administration Press
3. Kapoor, N. D. (1983). Elements of mercantile law: Including company law and industrial law. New Delhi: Sultan Chand & Sons.
4. Kavita Singh, Counseling skills for Managers' PHI Publishing House.

CONTENTS

LESSON-1

HEALTHCARE ESTABLISHMENTS AND REGULATORY FRAMEWORK

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Comprehend the constitutional basis of right to health under Article 21
2. Analyse the AP Private Medical Care Establishments Act, 2002's registration and infrastructure norms
3. Evaluate the penalty structure for non-compliance under the Act
4. Assess the role of hospital administrator in ensuring statutory compliance
5. Apply the principles of emergency care to prevent regulatory liability

STRUCTURE OF THE LESSON

1.1 INTRODUCTION

Healthcare law operates at the intersection of scientific knowledge, ethics, and individual rights. The rapid expansion of private healthcare in India brought challenges of unregulated growth and commercialisation. This lesson examines the constitutional mandate for emergency care and the Andhra Pradesh Private Medical Care Establishments Act, 2002 – a pioneering legislation that transformed private healthcare regulation. For the hospital administrator, this knowledge is a practical compliance toolkit essential for delivering safe, dignified care.

1.2 INTRODUCTORY CASE STUDY: THE SAHAJANAND HOSPITAL TRAGEDY

On February 15, 2019, Mr. K. Srinivasa Rao, a 38-year-old factory worker, suffered a massive heart attack and was rushed to Sahajanand Multi-Speciality Hospital, Visakhapatnam – a 75-

bed facility registered under the AP Act. The security guard at the casualty entrance refused entry, insisting that the patient be taken to the main admission counter on the first floor. At the admission counter, the attendant demanded a ₹25,000 advance deposit for emergency critical care and required completion of a four-page admission form. The patient's colleagues pleaded, offering their own money and identity proofs, but were told to complete the formalities. Meanwhile, the on-duty nurse attempted to contact the sole cardiologist on the hospital roster, who resided 40 minutes away. By the time the administrative formalities were completed – a delay of approximately thirty minutes – the patient was wheeled into casualty. The defibrillator in the casualty ward was non-functional, and one had to be brought from the Operation Theatre, taking an additional eight minutes. The cardiologist arrived at 10:58 PM. Despite resuscitation efforts, Mr. Rao was declared dead at 11:25 PM.

The subsequent investigation by the District Medical and Health Officer revealed shocking non-compliance. The hospital's registration certificate had expired eleven months prior to the incident, and the renewal application was pending due to non-submission of updated infrastructure audit reports. The hospital mandated five per cent of total beds for casualty – approximately four beds – but only two beds were functional. The Act mandated ten per cent of beds for ICCU with specific equipment including defibrillators, oxygen concentrators and cardiac monitors. The hospital had only four ICCU beds instead of the required seven to eight and lacked a dedicated defibrillator in the unit. The central oxygen pipeline was non-functional in the casualty bay; only portable cylinders were available, one of which was found empty. The roster showed a qualified emergency physician was to be present twenty-four by seven, but at the time of the incident only a first-year intern was present, who was not authorised to handle critical cardiac emergencies independently.

The District Level Advisory Committee recommended immediate suspension of the hospital's registration. The State Registering Authority imposed a penalty of ₹5 lakhs for operating without valid registration and an additional ₹2 lakhs for failing to maintain minimum required standards. The Medical Superintendent was charge-sheeted, and the hospital's name was publicly listed as non-compliant, severely damaging its reputation. This case illustrates the gap between statutory requirements and operational reality, demonstrating how failures in registration management, infrastructure maintenance, and administrative protocol can culminate in catastrophic outcomes leading to criminal, civil, and regulatory liability.

1.3 RIGHT TO HEALTH AND EMERGENCY CARE UNDER ARTICLE 21

Article 21 of the Constitution of India states that no person shall be deprived of his life or personal liberty except according to procedure established by law. For decades, this was interpreted narrowly as merely a protection against arbitrary state action. However, the Supreme Court revolutionised Indian jurisprudence by expanding the interpretation of life to include the right to health and emergency medical care.

The single most important judgment regarding emergency care in India is Parmanand Katara v. Union of India decided in 1989. In this case, a scooterist hit by a car was taken to multiple hospitals in Delhi, but private hospitals refused admission citing police formalities and lack of bed. He died. The Supreme Court laid down the absolute law that every doctor, whether in public or private service, has a professional obligation to extend his services to protect life. The Court held that the preservation of life is paramount. A doctor cannot wait for legal formalities like filing an FIR to be completed. There can be no demand for payment or police clearance

before commencing emergency treatment. This principle applies to all hospitals – government, private, charitable, or trust.

In Paschim Banga Khet Mazdoor Samity v. State of West Bengal decided in 1996, a landless labourer fell from a train and suffered severe head injuries. He was refused treatment at several government and private hospitals due to lack of beds or CT scan facilities and died. The Supreme Court held that the State is liable for failure to provide timely medical treatment to a citizen in need. It is the constitutional obligation of the State to provide adequate medical facilities. The Court awarded compensation of ₹25,000 to the family.

The AP Act operationalises Article 21. While Article 21 provides a broad, philosophical right, the AP Act provides the specific machinery to enforce it. When the AP Act mandates a twenty-four by seven casualty with specific equipment, it is translating the Supreme Court's directive in Parmanand Katara into a tangible, auditable requirement. If a hospital violates the AP Act by having a non-functional casualty, it is not just a violation of a state law; it is an infringement of the patient's fundamental right to life.

It is important to note that the right to emergency care is absolute for stabilising the patient. However, once the patient is stabilised and out of immediate danger, the hospital is not constitutionally bound to provide free long-term care. At that stage, the commercial contract involving payment, insurance, or transfer comes into play. The line between emergency stabilisation and elective care is often a point of litigation.

1.4 THE ANDHRA PRADESH PRIVATE MEDICAL CARE ESTABLISHMENTS ACT, 2002 – CONDENSED PROVISIONS

The Andhra Pradesh Allopathic Private Medical Care Establishments (Registration and Regulation) Act, 2002 extends to the whole of the State of Andhra Pradesh and applies to allopathic establishments. After the bifurcation of the state in 2014, this Act continues to apply to both Andhra Pradesh and Telangana unless specifically repealed or amended by the respective states.

Prohibition of Unregistered Establishments under Section 3

This is the core penal provision of the Act. It states that no person shall, on or after the commencement of this Act, establish or run a private medical care establishment unless it is duly registered under this Act. Operating without registration is a continuing offence. Even a hospital established in 1980, prior to the Act, was required to apply and get registered within a specified grace period of usually three months from the commencement of the Act. Failure to do so renders them illegal entities.

Registration Process under Sections 4, 5 and 6

An application for registration must be made in the prescribed form, known as Form A, to the District Level Registering Authority. The application requires details of the applicant, whether individual, partnership, trust or company, the location and premises plan, details of infrastructure, equipment and personnel, and payment of prescribed fees. Upon receipt, the Registering Authority verifies the application and usually conducts a physical inspection of the premises to verify claims of equipment and staffing. If satisfied, a Certificate of Registration

is granted. This certificate is valid for a specific period ranging from one to five years and must be displayed prominently at the establishment.

Registration is not perpetual. An application for renewal must be submitted before the expiry of the current certificate. Failure to renew on time results in the establishment being treated as unregistered. The Sahajanand Hospital case failed precisely on this ground as they were operating on an expired license. If the Authority refuses registration due to inadequate space or staffing, the applicant has the right to appeal to the State Level Authority, being the Commissioner of Health, within thirty days.

Infrastructure and Minimum Standards under the Schedule and Rules

The Act itself provides broad principles, but the detailed minimum standards are prescribed in the Schedule to the Act or the Rules framed subsequently. For a hospital with inpatient facility, the site must be located in a sanitary and safe environment. The building should have adequate ventilation, lighting and floor space. There must be continuous and potable water supply. Scientific bio-medical waste management must be carried out as per the Bio-Medical Waste Management and Handling Rules.

For the Casualty or Emergency department, a minimum of five per cent of total beds must be reserved. The department should have its own designated entrance, preferably accessible by ambulance. Required equipment includes a resuscitation trolley, defibrillator with battery backup, oxygen cylinders with flow meters, suction apparatus, ventilators as per bed strength, and cardiac monitors.

For the Intensive Care Unit or Intensive Coronary Care Unit, a minimum of ten per cent of total beds must be reserved. There must be centralised oxygen and suction lines, multi-para monitors per bed, and a crash cart with emergency drugs.

For the Operation Theatre, there must be a separate OT complex with sterile and non-sterile zones, anaesthesia equipment, OT tables, lights, and autoclave.

For diagnostic services, the hospital must have X-ray, ECG, and basic laboratory facilities or a tie-up with a certified diagnostic centre.

Regarding staffing norms, the establishment must be under the charge of a qualified allopathic doctor. The ratio of doctors to beds is prescribed. There must be a minimum requirement of qualified nurses per shift.

Duties of the Establishment under Section 7

The Act explicitly lists duties, making them statutory obligations. The establishment must maintain the premises in a clean and hygienic condition. It must maintain equipment in good working order. It must maintain records and registers as prescribed for admission, discharge, operation, and death. It must display rates and charges for various services prominently. It must dispose of bio-medical waste as per rules. Crucially, it must provide medical care to all patients without discrimination on grounds of religion, caste, or creed, and must provide emergency care irrespective of the patient's ability to pay.

Maintenance of Records under Section 8

Proper documentation is a key defence in any medico-legal case. The Act mandates the maintenance of a register of in-patients, a register of operations, a register of births and deaths, case sheets and medical records for each patient, and registers for drugs, particularly narcotics.

These records must be preserved for a minimum period of three years and must be made available to the Authorised Officer for inspection upon demand.

1.5 ENFORCEMENT, PENALTIES AND CONTEMPORARY RELEVANCE

Authorities under the Act

The Act establishes a three-tier structure for effective enforcement. The State Level Registering Authority is headed by the Director of Health and is responsible for overall policy, appeals, and registration of highly specialised institutions. The District Level Registering Authority is headed by the District Medical and Health Officer and is responsible for registration and inspection of establishments within the district. The District Level Advisory Committee comprises the DMHO, a Professor from a medical college, and a representative of private hospitals. This committee advises the Registering Authority and hears grievances.

Penalties for Non-Compliance under Sections 9 and 10

If an establishment operates without a valid registration certificate, it is liable for a fine. The original Act prescribed fines which have been increased via amendments. Currently, this can be a significant sum ranging from ₹50,000 to ₹5,00,000. For continuing offences, there is an additional daily fine. For violations of infrastructure norms, hygiene standards, or failure to provide records, the Registering Authority can levy fines and also issue directions to rectify the defects within a specified time. While rare, the Act does provide for imprisonment in cases of repeat or severe offences, underscoring the seriousness with which the state views non-compliance. The most severe penalty is suspension or cancellation of registration. If an establishment fails to comply with the standards or is convicted of an offence, the Registering Authority can suspend or cancel the registration certificate. Once cancelled, the establishment must cease operations immediately.

Implementation Challenges

Despite its robust framework, the AP Act faces implementation challenges. The DMHO is responsible for registration, inspection and monitoring of hundreds of establishments with limited staff. Powerful hospital lobbies can sometimes influence enforcement actions. While the Act provides a framework, the specific minimum standards schedules are sometimes outdated and not revised frequently enough to keep pace with changing medical technology. There have been allegations of rent-seeking behaviour in the renewal process, though this has decreased with the introduction of online portals.

Contemporary Relevance in 2025

The AP Act is more relevant today than ever. The principles of this Act – registration, minimum standards, patient safety – are mirrored in national schemes like the National Medical Commission guidelines and voluntary accreditation standards like NABH. Compliance with the AP Act is the first step towards national accreditation. Empanelment under the Ayushman Bharat PM-JAY national health insurance scheme requires the hospital to be legally registered under the relevant state Clinical Establishments Act or AP Act. Non-compliance means losing access to this massive patient pool. Under the Consumer Protection Act 2019, if a hospital violates the infrastructure norms of the AP Act and a patient is harmed, this violation serves as conclusive evidence of deficiency in service, making the hospital liable for heavy compensation.

Role of the MBA Hospital Administration Graduate

As a future Hospital Administrator, your role regarding this legislation is proactive, not reactive. You must function as a Compliance Officer ensuring that the hospital's registration certificate is always valid and prominently displayed, maintaining a calendar for renewal applications. You must act as an Auditor conducting internal audits to ensure that the Casualty and ICU meet the mandated equipment and staffing norms, never waiting for the DMHO inspection to fix a broken defibrillator. You must serve as a Liaison Officer acting as the point of contact with the District Registering Authority, building a professional, transparent relationship. You must be a Trainer educating the medical and paramedical staff, particularly those at the admission counter and casualty, about their statutory duty to never deny emergency care, and conducting mock drills. You must be a Policy Drafter drafting hospital policies such as the Financial Clearance Policy for Emergency Admissions that are explicitly aligned with the AP Act and the Parmanand Katara judgment to protect the hospital from legal liability.

STUDENT LEARNING ACTIVITIES

Activity 1: Compliance Audit Simulation

Visit the website of the Andhra Pradesh State Health Department and locate the list of registered and non-registered hospitals in your district. Select any one registered hospital. Based on the infrastructure norms discussed in this lesson for Casualty, ICU, Operation Theatre, and bio-medical waste management, draft a mock Internal Compliance Audit Checklist of twenty points. If you were the Hospital Administrator, what would be your top three concerns regarding compliance with the AP Act, 2002? Justify each concern with specific reference to the provisions of the Act and the lessons from the Sahajanand Hospital case study.

Activity 2: Case Law Analysis

Read the full text of the Supreme Court judgment in Parmanand Katara v. Union of India, available on indiankanoon.org. Write a one-page critique focusing on three aspects: first, why did the private hospitals refuse treatment and what were the justifications offered; second, what was the main legal principle established by the Court regarding the duty of doctors and hospitals in emergency care; and third, how can a hospital administrator implement the Parmanand Katara principle in the hospital's admission and financial clearance policy without incurring massive financial losses from non-paying emergency patients. Propose a practical policy framework that balances constitutional obligations with financial sustainability.

Activity 3: Gap Analysis and Procurement Planning

Imagine you are the Administrator of a new fifty-bed multi-speciality hospital being set up in Vijayawada, Andhra Pradesh. The promoters have allocated a ten thousand square feet area. Based on the Schedule of the AP Act, 2002 and the infrastructure norms discussed in this lesson, calculate the minimum required area and bed allocation for Casualty being five per cent of total beds, ICU being ten per cent of total beds, and Operation Theatre complex. Prepare a detailed equipment procurement priority list for the ICU indicating which equipment must be compulsorily available as per the norms, which equipment is recommended for quality care, and the timeline for procurement before the first patient admission. Also identify three infrastructure deficiencies that would lead to immediate rejection of registration application during the DMHO inspection.

8. SUMMARY

Healthcare laws are specialised regulations designed to balance the autonomy of medical professionals with the state's duty to protect citizens' right to health. They convert ethical obligations into enforceable legal duties. The Right to Health is not explicitly stated in the Constitution but has been read into Article 21, the Right to Life, by the Supreme Court through landmark judgments like Parmanand Katara and Paschim Banga Khet Mazdoor Samity. These judgments establish an absolute, non-negotiable duty on hospitals to provide emergency medical care without pre-conditions of payment or police formalities. The Andhra Pradesh Private Medical Care Establishments Act, 2002 is a pioneering state legislation enacted to regulate the booming private healthcare sector. Its primary objectives are mandatory registration, prescription of minimum infrastructure and staffing standards, and creation of a statutory grievance mechanism. Registration under the Act is not a one-time event but a continuous process requiring timely renewal. Operating without valid registration is a criminal offence. The Act prescribes detailed infrastructure norms for casualty, ICCU, operation theatres, and waste disposal. These are not merely recommendations but legally binding standards. Penalties range from substantial fines to suspension or cancellation of registration and, in extreme cases, imprisonment. Beyond statutory penalties, non-compliance exposes hospitals to civil liability in consumer courts and criminal prosecution. For the Hospital Administrator, this Act is an operational manual. Ensuring compliance with the AP Act is the foundational step towards risk management, quality assurance, and building public trust.

1.7 KEY WORDS WITH EXPLANATIONS

Article 21 is the fundamental right guaranteeing protection of life and personal liberty, which the Supreme Court has interpreted to include the right to dignity and emergency healthcare.

Casualty refers to the emergency department of a hospital and is legally defined under the AP Act with specific bed strength and equipment requirements.

Deficiency in Service is a term under the Consumer Protection Act, 2019, and violation of AP Act standards automatically constitutes deficiency, entitling the patient to compensation.

DLAC or District Level Advisory Committee advises the Registering Authority and hears grievances under the AP Act.

DMHO or District Medical and Health Officer is the chief district health officer and ex-officio Registering Authority under the AP Act.

ICCU or Intensive Coronary Care Unit is a specialised ICU for cardiac patients with mandated equipment under the AP Act.

Parmanand Katara is the landmark Supreme Court case establishing the absolute duty of doctors to provide emergency care without waiting for police or financial formalities.

Registering Authority is the government official, usually the DMHO, empowered to grant, renew, suspend or cancel registration under the AP Act.

1.8 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What is the main objective of the AP Private Medical Care Establishments Act, 2002?

Ans. The main objective is to mandate the compulsory registration of all private allopathic medical establishments in Andhra Pradesh and to regulate them by prescribing minimum standards of infrastructure, equipment, and manpower to ensure quality healthcare delivery.

Q2. Under which Article of the Constitution has the Supreme Court recognised the Right to Health?

Ans. The Supreme Court has recognised the Right to Health as an integral part of the Right to Life under Article 21 of the Constitution of India.

Q3. Can a private hospital in AP refuse to admit an unconscious accident victim if the victim's family cannot pay the advance deposit?

Ans. No. As per the principle laid down in Parmanand Katara v. Union of India and reinforced by the AP Act, emergency medical care must be provided immediately. Demanding advance payment as a precondition for emergency treatment is illegal and constitutes a violation of the patient's fundamental rights.

Q4. What is the penalty for operating a private medical establishment without valid registration under the AP Act?

Ans. Operating without registration is a punishable offence. The establishment is liable for a significant monetary fine, which can be recurring on a daily basis for continuing the offence. In severe or repeat cases, the registration can be cancelled and the owner or operator may face imprisonment.

Q5. What is the minimum percentage of beds required to be reserved for Casualty and ICCU under the standard norms of the AP Act?

Ans. Under the standard infrastructure norms derived from the Act, a hospital must reserve approximately five per cent of its total beds for the Casualty or Emergency department and approximately ten per cent of its beds for the Intensive Care Unit or Intensive Coronary Care Unit.

B. Analytical Multiple Choice Questions

1. Which of the following judgments first established that every doctor, whether in government service or private practice, has a professional obligation to extend services for protecting life without waiting for police formalities?

a) Paschim Banga Khet Mazdoor Samity v. State of West Bengal
b) Indian Medical Association v. V.P. Shantha
c) Parmanand Katara v. Union of India
d) S. Rajaseekaran v. Union of India

Correct Answer: c) Parmanand Katara v. Union of India

2. Under the Andhra Pradesh Private Medical Care Establishments Act, 2002, what is the minimum percentage of total hospital beds that must be reserved for the Intensive Care Unit or Intensive Coronary Care Unit?

a) Five per cent
b) Ten per cent
c) Fifteen per cent
d) Twenty per cent

Correct Answer: b) Ten per cent

3. A private hospital in Andhra Pradesh is operating with a registration certificate that expired forty-five days ago. The management has filed a renewal application but continues to admit patients. Under the AP Act, 2002, this hospital is:

a) Lawfully operating because renewal application is pending
b) Operating without registration and liable for penalty
c) Exempt from penalty if renewal application was filed within thirty days of expiry
d) Required only to pay a nominal late fee

Correct Answer: b) Operating without registration and liable for penalty

4. The District Level Advisory Committee under the AP Act, 2002, is comprised of which of the following members?

a) District Medical and Health Officer, a Professor from a Medical College, and a representative of private medical establishments
b) District Collector, Superintendent of Police, and Chief Planning Officer
c) Director of Health, Commissioner of Food Safety, and Municipal Commissioner
d) Three senior doctors nominated by the Indian Medical Association

Correct Answer: a) District Medical and Health Officer, a Professor from a Medical College, and a representative of private medical establishments

5. Which constitutional provision serves as the legislative basis for the Andhra Pradesh Private Medical Care Establishments Act, 2002?

a) Entry 25 of the Concurrent List – Medical education
b) Entry 6 of the State List – Public health and hospitals
c) Article 246 of the Constitution – Distribution of legislative power
d) Article 252 – Power of Parliament to legislate for two or more States
Correct Answer: b) Entry 6 of the State List – Public health and hospitals

1.9 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

Code Blue at Midnight: Regulatory Failure and Constitutional Violation at Lakshmi Private Hospital
Lakshmi Private Hospital is a 150-bed multi-speciality allopathic hospital located in Krishna District, Andhra Pradesh. It is registered under the Andhra Pradesh Private Medical Care Establishments Act, 2002, bearing Registration Certificate No. AP/DMH/KRI/045/2020 valid

up to 31 December 2024. The hospital is empanelled under the Dr. NTR Vaidya Seva health insurance scheme and also treats private paying patients. The Medical Superintendent is Dr. S. Narasimha Rao. The hospital has a stated bed complement of 150 distributed as General Wards with ninety beds, Semi-private with thirty beds, ICU with twelve beds constituting eight per cent of total, Casualty with six beds constituting four per cent of total, and Post-operative ward with twelve beds.

On the night of 15 February 2025 at approximately 11:45 PM, Mr. Venkata Subbaiah, a fifty-two-year-old farmer, was brought to the casualty department of Lakshmi Private Hospital by his son and two neighbours. He had suddenly complained of severe crushing chest pain radiating to his left shoulder and jaw, accompanied by profuse sweating, nausea, and shortness of breath. Upon arrival, the patient was conscious but in visible distress. His son rushed to the casualty reception counter. The on-duty receptionist informed the son that admission to the casualty requires a minimum advance deposit of ₹15,000. The son had only ₹4,500 in cash and offered to pay the remaining amount the next morning. He also offered to leave his Aadhaar card and gold ring as security. The receptionist refused and insisted on the full cash deposit, citing hospital policy for all emergency admissions. At this point, the patient's condition visibly deteriorated. A staff nurse passed by the reception area and observed the patient, recognising the urgency. She requested the receptionist to admit the patient immediately and complete formalities later. The receptionist refused, stating that he was only following the Medical Superintendent's written instructions that no patient shall be admitted without financial clearance from the front office. Approximately fifteen minutes elapsed in this exchange. At 12:05 AM, the patient suffered a cardiac arrest in the waiting area. The casualty medical officer was immediately alerted. The resuscitation trolley was brought, but the defibrillator was found to be non-functional with the battery completely drained and the spare battery missing from the storage cupboard. Manual CPR was initiated, but the ambulance to transfer the patient to another hospital could not be arranged for another twenty minutes. The patient was declared brought dead at 12:45 AM at a nearby government hospital.

The incident was reported in the local newspaper on 17 February 2025. Taking suo motu cognisance, the District Medical and Health Officer, Krishna District, conducted an inspection of Lakshmi Private Hospital on 20 February 2025. The inspection revealed that the hospital's registration certificate had expired on 31 December 2024 and an application for renewal was filed only on 10 February 2025, forty-one days after expiry. The hospital continued to operate and admit patients during this period without valid registration. The hospital had six casualty beds against a requirement of seven point five beds, being five per cent of one hundred fifty. The management had not increased casualty bed strength despite increasing total beds from one hundred twenty to one hundred fifty. The only defibrillator in the casualty department was non-functional. The maintenance log showed last preventive maintenance check was August 2024. There was no contract with a biomedical equipment maintenance vendor. The emergency crash cart was missing Adrenaline and Atropine, both drugs having expired in January 2025 and not replenished. Central oxygen pressure in casualty bay was recorded at two point five bar against the minimum requirement of four bar. The portable oxygen cylinder was found empty. The hospital had twelve ICU beds against the requirement of fifteen beds, being ten per cent of one hundred fifty. There were only eight multi-para monitors for twelve beds, and four beds were being monitored using portable monitors brought from the general ward. There were two ventilators for twelve beds, and one ventilator was under repair since January 2025. Regarding staffing, the night shift from 10 PM to 8 AM had only one staff nurse for casualty against the requirement of two as per nurse to bed ratio of one to three for critical areas. The hospital roster claimed twenty-four by seven emergency physician coverage, but at the time of

incident, only the casualty medical officer was present and no qualified emergency physician with MD, MS or DNB was on call. The hospital did not maintain a separate Medico-legal Case Register. Entry for Mr. Subbaiah was made in the general admission register without any reference to the cardiac arrest. There was no daily log of equipment functionality for defibrillator, ventilator, or oxygen pressure. The hospital produced a written policy titled Financial Clearance for Admissions dated 1 January 2024, signed by the Medical Superintendent, which stated that no patient, whether emergency or elective, shall be admitted to the hospital unless a minimum advance deposit as per the schedule is collected at the front office and exceptions require prior written approval of the Medical Superintendent.

The DMHO issued a show-cause notice on 21 February 2025 to Lakshmi Private Hospital proposing prosecution under Section 3 read with Section 10 of the AP Act for operating without valid registration, penalty for violation of infrastructure norms, and suspension of registration pending inquiry. The son of the deceased filed a consumer complaint before the District Consumer Disputes Redressal Commission claiming compensation of ₹25,00,000 for deficiency in service and medical negligence. An FIR was lodged at the local police station under Sections 336, 337, 338, and 304A of the Indian Penal Code against the hospital, the Medical Superintendent, the receptionist, and the on-duty nurse.

Questions for Analysis with Hints

Q1. Identify and categorise the violations of the Andhra Pradesh Private Medical Care Establishments Act, 2002 committed by Lakshmi Private Hospital covering registration violations, infrastructure violations, staffing violations, and policy violations.

Hints: Registration violations include expired certificate and forty-one days of unregistered operation under Section 3 read with Section 10. Infrastructure violations include casualty bed shortfall, ICU bed shortfall, non-functional defibrillator with no maintenance since August 2024, expired emergency drugs, low oxygen pressure, empty portable cylinder, inadequate ICU monitors, and ventilator under repair. Staffing violations include single staff nurse for casualty against requirement of two and absence of qualified emergency physician on call. Policy violations include written admission policy demanding advance deposit before emergency treatment in direct violation of Section 7 duty. Records violations include no separate MLC register and no daily equipment log under Section 8.

Q2. Applying Section 12 of the AP Act regarding Offences by Companies, analyse the personal liability of Dr. S. Narasimha Rao as Medical Superintendent, Ms. Lakshmi Devi as Staff Nurse, and Mr. Ravi Kumar as Receptionist. What defences, if any, are available to each individual?

Hints: Dr. Narasimha Rao is the person in charge and responsible for conduct of business and deemed guilty under Section 12. Defences of lack of knowledge are weak as renewal is administrative duty, and due diligence requires evidence of delegated responsibility and supervision. His personal signing of illegal admission policy demonstrates direct involvement. Ms. Lakshmi Devi as employee can be prosecuted for acts in course of employment. Defence includes acting under instructions of superior and professional judgment overridden by administrative policy. Weakness is failure to escalate to duty doctor or Medical Superintendent. Mr. Ravi Kumar as employee acted strictly per written policy. Defence includes lack of knowledge regarding illegality of policy, which is stronger, and acted in obedience to employer's instructions. Weakness is that ignorance of law is no excuse, though prosecution may be disproportionate and compounding of offence may be appropriate.

Q3. Examine the hospital's Financial Clearance for Admissions policy in light of the constitutional principles established in Parmanand Katara v. Union of India and the duties prescribed under Section 7 of the AP Act. Is this policy lawful? Provide reasoned justification.
Hints: The policy is illegal and void. Constitutionally, Parmanand Katara establishes that preservation of life is paramount and financial clearance cannot be precondition for emergency treatment. No law or procedure can delay this absolute obligation. Statutorily, Section 7 of AP Act imposes duty to provide medical care without discrimination. Denial of emergency care violates statutory duty. The hospital policy directly contradicts constitutional mandate, violates Section 7 duty to provide care irrespective of ability to pay, was applied mechanically with no exception exercised even when patient critically deteriorated, and nurse's request to override policy was refused demonstrating rigid, unlawful application. Remedial action requires immediate withdrawal of illegal policy, issuance of new emergency admission policy of stabilise first, formalities later, mandatory training for all front office staff on Parmanand Katara principles, and financial counselling only after stabilisation.

Q4. The DMHO has proposed suspension of the hospital's registration. Discuss the legal procedure that must be followed before suspension can be validly ordered. What are the grounds for suspension under the AP Act?
Hints: Procedure under Section 9 requires show-cause notice specifying grounds clearly, reasonable opportunity of hearing through personal hearing or written representation, consideration of representation where authority must consider defence, speaking order which is a reasoned order addressing each ground, and communication of order to establishment. Grounds for suspension under Section 9 include violation of conditions of registration regarding infrastructure norms for Casualty and ICU, staffing norms, equipment maintenance, failure to comply with minimum standards prescribed under Schedule 170 Rules, and conviction of offence under Section 10. Suspension cannot be arbitrary and must follow principles of natural justice.

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The preservation of human life is of paramount importance. Once life is lost, the status quo ante cannot be restored.
— Supreme Court of India, Parmanand Katara v. Union of India, 1989.

LESSON-2

FORMATION OF HEALTHCARE ORGANISATIONS

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Distinguish between partnership firms, corporate entities and public-private partnerships as legal structures for healthcare organisations
2. Explain the essential elements of partnership formation under the Indian Partnership Act, 1932 and their application to nursing homes
3. Analyse the regulatory framework for corporate hospitals under the Companies Act, 2013 including private and public limited structures
4. Evaluate the Public-Private Partnership model in healthcare through the Manipal-Wenlock case study
5. Apply the principles of legal entity selection to real-world healthcare administration scenarios

STRUCTURE OF THE LESSON

2.1 INTRODUCTION: THE LEGAL ARCHITECTURE OF HEALTHCARE ORGANISATIONS

Healthcare delivery in India is a heterogeneous ecosystem comprising solo practitioners, partnership-run nursing homes, corporate hospital chains, government institutions, and public-private hybrid models. Each organisational form represents a distinct legal architecture—a framework of rights, duties, liabilities and governance structures defined by statute. For the Hospital Administrator, the choice of legal structure is a strategic decision with profound implications for liability, capital raising, governance, perpetuity, regulatory burden and taxation. This lesson provides a comprehensive examination of the three primary legal

structures through which healthcare organisations are formed in India: Partnership Firms under the Indian Partnership Act, 1932; Corporate Hospitals under the Companies Act, 2013; and Public-Private Partnerships, which represent a contractual hybrid between public ownership and private operation.

2.2 INTRODUCTORY CASE STUDY: PREETI NURSING HOME v. REGIONAL PROVIDENT FUND COMMISSIONER

M/s Preeti Nursing Home was established in September 1979 at Allahabad as a registered partnership firm under Section 69 of the Indian Partnership Act, 1932 with three partners: Dr. Preeti Gupta, Sri Amit Gupta and Dr. P.C. Gupta. The nursing home employed approximately ten persons. In 1990, a separate establishment, M/s Preeti Hospital, was founded as another registered partnership firm with a different constellation of partners: Sri Anuj Gupta, Amit Gupta, Smt. Sushila Gupta and Dr. Preeti Gupta. Two partners—Amit Gupta and Dr. Preeti Gupta—were common to both firms, while the remaining partners were distinct. A third entity, M/s Preeti Medical Research and Charitable Trust, was also established at a different location. On 9 May 1991, an Enforcement Officer from the Employees' Provident Fund Organisation inspected M/s Preeti Nursing Home and reported finding twenty-two employees working at the establishment. Based on this report, the Regional Provident Fund Commissioner issued a notice on 31 March 1992 directing M/s Preeti Nursing Home to comply with the Employees' Provident Funds and Miscellaneous Provisions Act, 1952 from 28 February 1987 onwards and to pay all accrued contributions and dues. The petitioner firm contested the notice on the grounds that M/s Preeti Nursing Home, M/s Preeti Hospital and M/s Preeti Medical Research and Charitable Trust were distinct legal entities with separate partnership deeds, separate registrations, separate premises and separate sets of employees. The Enforcement Officer had erroneously clubbed the employees of all three establishments to arrive at the figure of twenty-two, whereas the Nursing Home independently employed only ten persons—below the statutory threshold of twenty required for applicability of the PF Act.

The Allahabad High Court acknowledged that despite common partners, the firms were different entities in the eyes of law for all purposes. This case affirms the contractual basis of partnership—each partnership deed creates a distinct relationship. Registration under Section 69 provided the firms standing to challenge the PF Commissioner's order. The case implicitly demonstrates why growing healthcare enterprises often transition from partnership to corporate structure. A company under the Companies Act enjoys perpetual succession and separate legal personality in a manner more robust than a partnership, and a single corporate entity with multiple divisions would have avoided the clubbing controversy altogether.

Partnership Firms in Healthcare – Relevant Provisions Only

Registration under Section 69 is Optional but Essential for Healthcare Firms

An unregistered nursing home partnership cannot file a suit against any partner or third party to enforce contractual rights. In Preeti Nursing Home v. Regional Provident Fund Commissioner, the Allahabad High Court held that registration under Section 69 gave the firm legal standing to challenge statutory notices issued by the Employees' Provident Fund Organisation. Without registration, the writ petition would not have been maintainable. Every healthcare partnership, irrespective of size, must register immediately upon formation to preserve legal remedies and enforce contracts with suppliers, insurers and patients.

Joint and Several Liability under Section 25 – Critical Risk for Doctors

Every partner is personally liable, jointly with all other partners and also severally, for all acts of the firm done while he is a partner. This is the most significant disadvantage of the partnership structure for healthcare organisations. A patient who suffers negligence can sue all partners jointly or can select any one partner and recover the entire compensation amount from that partner's personal assets. In a twenty-five bed nursing home, a single catastrophic malpractice claim of one crore rupees can attach the personal residence, bank savings and other investments of a partner who was not even the treating doctor and had no involvement in the alleged negligence. This unlimited personal liability makes the partnership structure unsuitable beyond twenty to thirty beds or when the nature of medical practice involves high-risk specialties such as neurosurgery, cardiothoracic surgery or obstetrics. The only mitigation is comprehensive professional indemnity insurance of at least one crore rupees per partner and transition to private limited company when the enterprise reaches a scale where personal assets are no longer insurable at reasonable cost.

Implied Authority under Section 19 – Operational Flexibility and Risk

A partner has implied authority to bind the firm by acts done to carry on, in the usual way, business of the kind carried on by the firm. In healthcare partnerships, this means a single partner can admit emergency patients, purchase medical equipment up to reasonable value, order diagnostic tests, hire temporary nursing staff during emergencies, and incur expenditure for protecting the firm from loss. However, a partner's implied authority does not extend to submitting patient disputes to arbitration, compromising or relinquishing claims against defaulting patients, acquiring or transferring immovable property such as hospital building, or admitting new partners without the consent of all existing partners. In healthcare partnerships, the managing partner's authority should be expressly defined in the partnership deed. Where restrictions are imposed on a partner's authority under Section 20, such restrictions must be communicated to frequent creditors including pharmaceutical suppliers, medical equipment vendors and insurance companies to be binding on third parties who deal with the partner without knowledge of the restriction.

Partnership at Will under Section 7 – Creates Instability

Where the partnership deed does not specify a fixed duration for the partnership or a method for its determination, the partnership is deemed to be partnership at will. Such a partnership can be dissolved by any partner giving notice in writing to all other partners of their intention to dissolve the firm. Two cardiologists running a clinic as partnership at will face automatic dissolution if one partner retires, becomes insolvent, dies or simply serves a notice of dissolution. This causes sudden interruption in patient care, automatic termination of employee contracts, disruption of ongoing treatment for admitted patients, and the need to renegotiate all vendor agreements, insurance empanelment and government registrations. Every healthcare partnership deed must contain an express continuation clause providing that the retirement, death or insolvency of a partner shall not dissolve the firm and that the legal heirs or representatives of the deceased partner shall be entitled to receive the value of their share as determined in the deed but shall not become partners.

Particular Partnership under Section 8 – Single Venture Only

Persons may partner for a single adventure or undertaking. Three surgeons may form a partnership exclusively to conduct a specific three-month medical camp in a rural area or to establish a single-speciality day-care centre for cataract surgeries for a limited period. Upon completion of the venture, the partnership dissolves automatically. This structure is not suitable for permanent healthcare establishments and offers no continuity for ongoing patient care.

Section 6 – Written Deed Essential to Avoid Disputes

In determining whether a partnership exists, regard shall be had to the real relation between the parties as shown by all relevant facts taken together. In the absence of a written partnership deed, courts may infer partnership from the conduct of the parties. Two doctors sharing clinic expenses equally but treating their own patients separately and retaining their own consultation fees may not be partners. Conversely, doctors who present themselves as Dr. X and Dr. Y Clinic on a common signboard, employ common staff paid from pooled receipts, share consultation fees in an agreed ratio, and represent to patients that they are practicing together may be deemed partners even without written agreement, thereby attracting joint and several liability for each other's negligent acts. Every healthcare partnership must have a written partnership deed executed on adequate stamp paper and registered with the Registrar of Firms.

Partnership Deed – Mandatory Clauses for Healthcare Firms

The partnership deed is the constitutional document of the firm and must contain specific clauses relevant to healthcare practice. The nature of business clause must specify whether the partnership is for allopathic, ayurvedic, homoeopathic or multi-system practice, whether it includes inpatient facilities or is restricted to outpatient consultation, and the specific specialities offered. The duration clause should provide for a fixed term renewable by mutual consent to avoid the instability of partnership at will. The capital contribution clause must include valuation methodology for equipment brought in by partners and goodwill of any established practice being contributed. The profit and loss sharing ratio need not be equal and should reflect the capital contribution, working time, patient referral base and administrative responsibilities of each partner. The remuneration clause must specify salary payable to working partners as this is essential for tax deduction at source and for claiming deduction under the Income Tax Act. The retirement clause must contain a clear valuation methodology for determining the value of a retiring partner's share, the payment terms, and a non-compete clause provided that Section 36 of the Contract Act permits reasonable restraint on practicing within a specified geographical area for a specified period. The dissolution clause must specify the grounds for dissolution and the mode of settlement of accounts. The dispute resolution clause must provide for arbitration to avoid prolonged and public litigation that damages the reputation of the healthcare establishment.

Maximum Partners Limitation – Section 11 of Companies Act, 2013

No association or partnership consisting of more than fifty persons shall be formed for the purpose of carrying on any business that has for its object the acquisition of gain by the association or partnership or by the individual members thereof, unless it is registered as a company under the Companies Act, 2013 or is formed in pursuance of some other Indian law. Large medical practices employing more than fifty doctors, multi-speciality groups covering multiple departments, and hospital chains operating across multiple locations cannot operate as partnerships. Such enterprises must mandatorily incorporate as companies.

Transition Trigger Points – When to Exit Partnership

The partnership structure becomes unsustainable and transition to corporate structure becomes mandatory when the healthcare enterprise crosses certain thresholds. When bed capacity exceeds thirty beds, the unlimited personal liability exposure becomes unacceptable for most partners. When annual turnover exceeds five crore rupees, the inability to raise institutional debt and private equity becomes a significant constraint on growth. When personal liability exposure from a single catastrophic claim threatens personal assets, partners begin to seek limited liability protection. When banks refuse to lend beyond ten crore rupees against

partnership security and insist on corporate structure, transition becomes unavoidable. When private equity investors express interest in funding expansion, they invariably insist on corporate structure with clean cap table and ESOP capability. When succession planning requires that the hospital continue beyond the retirement or death of the founding partners, perpetual succession of a company becomes essential. When NABH accreditation process requires the healthcare establishment to be a legal entity with perpetual succession and clear ownership records, partnership structure becomes a barrier. When insurance empanelment and government scheme enrolment require corporate structure, the partnership firm loses business opportunities. Every hospital administrator must recognise these trigger points and initiate transition well before the partnership structure becomes a liability.

Private Limited Company – Preferred Structure for Thirty to Five Hundred Bed Hospitals

The private limited company is the optimal legal structure for hospitals with bed capacity ranging from thirty to five hundred beds, operating in a single city or a single state, with annual turnover up to one hundred crore rupees. This structure offers the optimum balance between regulatory compliance burden and operational flexibility for medium-sized healthcare enterprises.

Registration Requirements under Section 7 of the Companies Act, 2013

A private limited company requires minimum two members and maximum two hundred members, with minimum two directors. The incorporation process requires filing of Memorandum of Association stating the name of the company, the state in which registered office is situated, the objects clause specifying the healthcare activities to be carried on, and the liability clause stating that members' liability is limited to the unpaid amount on shares. The Articles of Association prescribe the internal governance rules including restrictions on transfer of shares, conduct of board meetings, appointment and removal of directors, and declaration of dividends. The company must obtain Director Identification Number and Digital Signature Certificate for all proposed directors. The application must be filed with the Registrar of Companies in the prescribed Form SPICe plus and must be accompanied by declaration of compliance, proof of registered office, and particulars of directors. Registration is ordinarily completed within seven to fourteen working days.

Relevance to Healthcare Operations

Limited liability is the most significant advantage for healthcare entrepreneurs. The personal assets of promoter doctors, including their residences, personal investments and savings, are completely protected from malpractice claims against the hospital. A claimant can recover compensation only from the assets of the company, not from the personal wealth of shareholders or directors. This protection extends even if the promoter doctor is the Chairman and Managing Director and holds ninety-nine per cent shares in the company.

Perpetual succession means the hospital continues to exist irrespective of the death, retirement, insolvency or resignation of any shareholder or director. Patients need not fear that the hospital will suddenly close down because the founder doctor has retired or passed away. Employees continue in service, contracts with vendors remain valid, and registrations with statutory authorities remain operative. This is essential for building patient trust and institutional brand equity.

The ability to raise capital is fundamentally different from partnership structure. A private limited company can issue equity shares to private equity investors, venture capital funds, and angel investors. It can issue preference shares with differential rights as to dividend and

redemption. It can issue debentures and accept deposits from members. It can obtain institutional debt from banks and financial institutions without requiring personal guarantees from all promoters. This capital raising ability enables funding of major expansion including new hospital wings, high-end medical equipment, digital transformation and acquisition of competing healthcare facilities.

ESOP feasibility enables the company to grant employee stock options to senior consultants, department heads and key managerial personnel. Options to acquire equity shares at a predetermined price after a vesting period align the interests of medical professionals with the long-term success of the hospital. This is a powerful retention tool against poaching by competing corporate hospital chains.

Credibility with external stakeholders is significantly enhanced. Insurance companies prefer to empanel companies rather than partnership firms for cashless treatment arrangements. Government schemes including Ayushman Bharat PM-JAY and state health insurance schemes mandate corporate structure for empanelment. NABH accreditation process views corporate structure favourably as it indicates institutionalisation of governance and perpetual succession. Pharmaceutical and medical device companies offer better credit terms to corporate entities.

Mandatory Compliances for Corporate Hospitals

Every private limited company must hold a minimum of four board meetings every year with a gap of not more than one hundred twenty days between two consecutive meetings. The board of directors is responsible for the overall management of the company and must meet at least once in every calendar quarter. Meetings may be held through video conferencing subject to prescribed safeguards.

The company must hold an Annual General Meeting once every calendar year within six months of the close of the financial year. The gap between two annual general meetings shall not exceed fifteen months. Shareholders approve the annual financial statements, declaration of dividends, appointment and remuneration of auditors, and appointment or re-appointment of directors at the annual general meeting.

Financial statements must be prepared in Schedule III format prescribed under the Companies Act, 2013 and must be audited by a firm of chartered accountants appointed by the shareholders. The financial statements comprise the balance sheet, statement of profit and loss, cash flow statement, and statement of changes in equity. The directors' report must be attached to the financial statements and must contain disclosures on the state of the company's affairs, amount proposed to be carried to reserves, material changes and commitments affecting financial position, conservation of energy, technology absorption, foreign exchange earnings and outgo, and a declaration by the directors that the auditors' report with qualifications has been adequately explained.

ROC filings are mandatory and time-bound. Every company must file its financial statements in Form AOC-4 with the Registrar of Companies within thirty days of the annual general meeting. Every company must file its annual return in Form MGT-7 within sixty days of the annual general meeting. The annual return contains details of its registered office, principal business activities, particulars of its directors and key managerial personnel, meetings of members and board, remuneration of directors, and details of its shareholding pattern.

The directors' report is a statutory requirement under Section 134 of the Companies Act, 2013 and must be attached to the financial statements. The report must contain the extract of annual return, number of board meetings held, directors' responsibility statement, particulars of loans, guarantees and investments, particulars of contracts or arrangements with related parties, state of the company's affairs, amount proposed to be carried to reserves, and material changes and commitments affecting financial position.

Appointment of auditor is mandatory within thirty days of incorporation. The auditor holds office from the conclusion of one annual general meeting until the conclusion of the sixth annual general meeting. The auditor must be a firm of chartered accountants and must be independent of the management. The auditor's report on the financial statements must be placed before the shareholders at the annual general meeting.

Corporate Social Responsibility under Section 135 applies to companies having net worth of five hundred crore rupees or more, or turnover of one thousand crore rupees or more, or net profit of five crore rupees or more during any financial year. Such companies must constitute a Corporate Social Responsibility Committee of the board and must spend at least two per cent of the average net profits of the immediately preceding three financial years on CSR activities. Schedule VII of the Companies Act, 2013 includes promoting health care including preventive health care and sanitation as an eligible CSR activity. Corporate hospitals occupy a dual role as they are themselves required to spend on CSR activities if they meet the thresholds, and they are also eligible recipients of CSR funds from other companies for their community health initiatives, free surgeries and rural outreach programmes.

Transition from Partnership to Private Limited – When Mandatory

The transition from partnership to private limited company is not merely a matter of strategic choice but becomes mandatory when certain thresholds are crossed. When unlimited liability becomes unacceptable because the scale of operations exposes partners to catastrophic claims exceeding their personal insurance cover, the protection of limited liability becomes essential. When banks refuse to lend beyond ten crore rupees against partnership security and insist on corporate structure with clean title to assets, the partnership structure becomes a barrier to growth. When private equity investors express interest in funding expansion and insist on corporate structure with clear shareholding pattern and ESOP capability, the partnership structure cannot accommodate such investment. When succession planning requires that the hospital continue beyond the retirement or death of the founding partners, the perpetual succession of a company becomes essential. When NABH accreditation process requires the healthcare establishment to be a legal entity with perpetual succession and clear ownership records, partnership structure is viewed as less institutionalised. When employee retention requires ESOPs to be granted to senior consultants, the partnership structure offers no equivalent mechanism. When bed capacity exceeds fifty beds or annual turnover exceeds eight to ten crore rupees, the administrative burden and compliance complexity of partnership structure becomes comparable to that of a company, diminishing the advantage of simplicity.

2.3 PUBLIC SECTOR HOSPITALS AND GOVERNMENT HEALTHCARE ENTITIES

Constitutional Basis

Public sector hospitals in India are established under Entry 6 of the State List which covers public health and hospitals, sanitation, and related matters. This entry empowers State

Legislatures to enact laws for the establishment, maintenance and regulation of hospitals and dispensaries. Central government institutions such as the All India Institute of Medical Sciences, the Postgraduate Institute of Medical Education and Research, Chandigarh, and the Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry are established under Entry 24 of the Union List read with Entry 28 of the Concurrent List relating to medical education. Unlike partnership firms or corporate hospitals, public sector healthcare entities are not registered under the Indian Partnership Act, 1932 or the Companies Act, 2013. Their legal existence derives from specific legislation or executive orders.

Legal Forms of Public Sector Hospitals

The All India Institute of Medical Sciences, New Delhi was established under the AIIMS Act, 1956 as amended from time to time. It is an autonomous institution with separate legal personality, governed by a Governing Body with the President of India as Visitor. It has degree-granting powers and its own faculty recruitment rules. It is declared an Institute of National Importance and its employees are not government servants in the strict sense but are governed by the AIIMS regulations.

The Postgraduate Institute of Medical Education and Research, Chandigarh was established under the PGI Chandigarh Act, 1966 with the President of India as Visitor, an Institute Body, and a Director. It provides specialised super-speciality tertiary care and is also an Institute of National Importance. The Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry was established under the JIPMER Act, 2008 and functions under the Ministry of Health and Family Welfare. The National Institute of Mental Health and Neurosciences, Bengaluru was established under the NIMHANS Act, 2012 with Deemed University status and its own Governing Council, merging mental health and neurology specialties.

State government hospitals including State Medical Colleges and attached hospitals are established either by a specific State Act or by executive order of the State Health Department. They are attached to the State University for academic purposes but function as government departments under the administrative control of the State Health Directorate. They have no separate legal personality and are treated as departments of the government. District Hospitals are established by executive order of the State Health Department and are subordinate offices of the State Health Directorate with no separate legal personality. Community Health Centres and Primary Health Centres are established under National Health Mission guidelines and State Public Health Acts respectively and are subordinate field offices of the State Health Department.

Public Sector Undertaking hospitals include ESI Hospitals established under the Employees' State Insurance Act, 1948 and governed by the ESI Corporation with Regional Directors and Medical Superintendents. Railway Hospitals are established by administrative order of the Ministry of Railways with Chief Medical Directors and Divisional Medical Officers. Defence Hospitals are established under the Army Act, 1950, the Air Force Act, 1950 and the Navy Act, 1957 and function under the Armed Forces Medical Services. CGHS Wellness Centres are established by administrative order of the Ministry of Health and Family Welfare under the Additional Director, CGHS.

Liability of Government Hospitals – Erosion of Sovereign Immunity

The doctrine of sovereign immunity historically protected the State from tortious liability for acts done in the exercise of sovereign functions. This doctrine has been substantially eroded by

Judicial interpretation. Article 300 of the Constitution provides that the Government of India and the Government of a State may sue and be sued in the name of the Union of India or the State Government as the case may be. The extent of liability is the same as that of the Dominion of India and the Provinces before the Constitution.

In State of Rajasthan v. Vidyawati decided by the Supreme Court in 1962, a government vehicle maintained for official use caused an accident. The State raised the defence of sovereign immunity. The Supreme Court rejected this defence and held that the Government is liable for tortious acts of its employees committed in the course of employment to the same extent as a private employer. Running a government department with motor vehicles is not a sovereign function.

In Achutrao Haribhau Khodwa v. State of Maharashtra decided in 1996, a cotton mop was left inside a patient's abdomen during sterilisation surgery at a government hospital. The Supreme Court held the State vicariously liable for the negligence of its medical staff and observed that running a hospital is a welfare activity and not a sovereign function. The distinction between sovereign and non-sovereign functions was held to be irrelevant for tortious liability arising from medical negligence.

The current position is that government hospitals whether State or Central are vicariously liable for the negligence of their employees committed in the course of employment. Statutory corporations such as AIIMS and PGI Chandigarh are liable as separate legal entities and are entitled to be indemnified by the government under their respective establishing Acts. ESI hospitals are liable under Section 53 of the ESI Act, 1948 read with Section 146 of the Employees' State Insurance General Regulations. Defence hospitals have limited immunity for combat-related activities but are fully liable for routine medical care as held in Indian Military Nursing Services v. State of Punjab decided in 2006.

Limitations for Hospital Administrators in Public Sector

Public sector hospital administrators face significant constraints that do not apply to their private sector counterparts. Budgetary allocation is dependent on the fiscal capacity of the government and the political priority accorded to healthcare. Even after budget allocation, release of funds is often delayed, affecting procurement of essential drugs, maintenance of equipment and timely payment to vendors. Procurement procedures are governed by the General Financial Rules and Central Vigilance Commission guidelines which mandate multiple approvals, open tenders for even moderate value items, and adherence to strict timelines. These procedures cause significant delays in procurement of life-saving equipment and essential consumables.

Decision-making is through a hierarchical civil service structure where the Medical Superintendent reports to the Joint Director, who reports to the Additional Director, who reports to the Director of Health Services, who reports to the Secretary of Health, who reports to the Minister. Each level of hierarchy adds to decision-making time and diffuses accountability. Transfers of key personnel are frequent and often unrelated to performance. A skilled Medical Superintendent may be transferred to a non-clinical administrative post, and a newly transferred officer may take months to understand the local health profile and operational challenges.

The inability to raise equity capital means that all capital expenditure must be met from budgetary allocation or grants. There is no access to private equity, venture capital or public issue markets. The inability to incentivise staff through performance-linked payments means that motivation depends entirely on professional commitment and public service ethos, which can erode over time in the absence of recognition and reward. Infrastructure obsolescence is a chronic challenge as replacement cycles for medical equipment extend over many years and innovative procurement models such as equipment lease or build-operate-transfer are not readily available within the government financial framework. The administrator is subject to audit by the Comptroller and Auditor General of India and scrutiny by the Central Vigilance Commission for commercial decisions, creating a compliance-focused rather than performance-focused work culture.

2.4 PUBLIC-PRIVATE PARTNERSHIPS IN HEALTHCARE

Definition of Healthcare PPP

A Public-Private Partnership in healthcare is a contractual arrangement between a government entity and a private sector entity wherein the private party performs a public function which is the delivery of healthcare services, management of hospital operations, provision of diagnostic services or clinical services. The private party assumes substantial financial, technical and operational risks associated with the delivery of such services. The private party receives performance-linked payments which are contingent upon achievement of specified quality and quantity benchmarks. The public sector retains ownership of the facility and ultimate accountability to the citizen for the delivery of healthcare services. This is fundamentally different from privatisation where ownership is permanently transferred to the private sector. In PPP, the government retains ownership and regulatory control while specific functions are contracted out.

PPP Models in Indian Healthcare – Healthcare Applications Only

Contracting Out or Services model involves the government paying a private provider to deliver specific services to patients. The clinical risk is borne by the private party and the payment risk is borne by the government. This model is extensively used for diagnostic services under the National Health Mission and for dialysis PPPs where the government provides space and utilities while the private partner provides equipment, consumables and technical manpower and is paid on a per-procedure basis.

Management Contract model involves a private operator managing a public hospital facility for a management fee. The operational risk is borne by the private party while strategic risk remains with the government. The private party is responsible for day-to-day administration, staffing of non-clinical services, procurement of consumables and maintenance of equipment while the government continues to own the land and building and remains responsible for policy direction and funding. The Manipal-Wenlock arrangement in Mangalore and the Karuna Trust model in Karnataka are examples of long-term management contracts.

Build-Operate-Transfer or BOT model involves the private party building the facility, operating it for a specified concession period and transferring it to the government at the end of the concession period. Construction and operation risk is borne by the private party while ownership is retained by the government. This model is used for AIIMS-like projects funded through the Higher Education Financing Agency where the private partner constructs super-speciality blocks and operates them for a fixed period to recover investment.

Voucher Scheme model involves the government providing vouchers to the target population and patients choosing any empanelled private provider. The demand-side risk is borne by the patient in choosing the provider while the payment risk is borne by the government. The Chiranjeevi Yojana in Gujarat and the Rajiv Aarogyasri scheme in Andhra Pradesh are examples where the government paid private obstetricians a package rate for deliveries to Below Poverty Line women.

Chiranjeevi Yojana – Lessons for Healthcare Administrators

Launched in Gujarat in 2005, the Chiranjeevi Yojana was a pioneering demand-side PPP designed to reduce maternal and infant mortality among Below Poverty Line families in rural areas. The government empanelled private obstetricians practicing in rural and semi-urban areas and paid them a package rate of eight hundred rupees per normal delivery and one thousand eight hundred rupees per Caesarean section. The private providers agreed to provide free delivery care to BPL women including antenatal care, delivery services, postnatal care and management of complications. Patients received free transport, free medicines, free diagnostics and free food during hospital stay.

Over eight lakh deliveries were conducted under the scheme in the first decade of its operation. Out-of-pocket expenditure for BPL families was reduced by eighty-four per cent. Maternal mortality ratio in participating districts showed significant reduction. However, the scheme faced challenges including adverse selection where private providers retained low-risk cases and referred high-risk cases with complications to government hospitals, delayed reimbursement of claims leading to provider dropouts from the scheme, and variable quality across empanelled facilities with no effective mechanism to penalise poor quality or reward high quality. The lesson for healthcare administrators is that PPP contracts must include risk-adjusted payments that provide higher compensation for high-risk cases to prevent adverse selection, and robust quality assurance mechanisms including mandatory NABH accreditation, clinical audit and patient-reported outcome measures.

Key Legal and Contractual Issues in Healthcare PPPs

The Concession Agreement is the foundational document of any healthcare PPP. The scope of services clause must define exactly what the private partner will provide. This may include outpatient department services, inpatient department management, diagnostic services, dialysis services, radiology services, pharmacy services, cafeteria services, housekeeping services, security services, or full hospital management. Each service must be defined with sufficient precision to enable measurement of performance and identification of shortfall.

The performance standards clause must establish measurable, auditable benchmarks against which the private partner's performance will be evaluated. These standards should be derived from NABH accreditation standards, infection control rates, patient satisfaction scores measured through validated instruments, waiting times for outpatient consultation and elective surgery, and clinical outcome indicators including mortality rates, readmission rates and complication rates. The standards must be objectively verifiable and the verification mechanism must be specified in the agreement.

The payment mechanism clause specifies how and when the private partner is compensated. This may be through per-procedure payment where the private partner is paid a fixed amount for each diagnostic test or surgical procedure performed, management fee where the private partner is paid a fixed monthly or annual amount for managing the facility, annuity where the private partner is paid equal periodic instalments over the concession period, or viability gap funding where the government provides a capital grant to make the project commercially

viable. The payment must be linked to achievement of performance standards with deduction for non-performance.

The risk allocation clause identifies which party bears which risks. Demand risk is the risk that the volume of patients using the facility will be lower than projected, affecting revenue. This risk is typically borne by the private partner in management contracts and BOT projects, but may be shared in voucher schemes. Force majeure risk is the risk of unforeseen events beyond the control of either party such as natural disasters, epidemics, war or civil unrest. This risk is typically borne by the government as the private partner cannot insure against such events at reasonable cost. Regulatory change risk is the risk that government regulations affecting the project will change during the concession period, increasing costs or reducing revenue. This risk is typically shared with the government providing relief if the change is discriminatory or specifically targets the project.

The monitoring and audit clause establishes how the government ensures compliance with the concession agreement. This may include third-party audit by an independent engineer or auditor, an independent hospital committee with representation from government, private partner and civil society, and public disclosure of performance reports. The dispute resolution clause provides a multi-tiered mechanism for resolving conflicts beginning with negotiation between senior officials, escalating to mediation by a neutral third party, and finally to arbitration under the Arbitration and Conciliation Act, 1996. The term and termination clause specifies the concession period which for healthcare PPPs is typically ten to thirty years, grounds for early termination including persistent material breach, insolvency, force majeure, and public interest, and the compensation payable upon early termination calculated on the basis of un-depreciated capital investment or discounted future cash flows. The assets and staff clause addresses the treatment of assets and employees upon termination of the concession, including transfer of assets to the government at nil or nominal value, and absorption of employees by the government or the incoming private partner.

Statutory Clearances Required for Healthcare PPPs

Healthcare PPPs require multiple statutory clearances before commencement of operations. Establishment registration must be obtained under the applicable state Clinical Establishments Act or the Andhra Pradesh Private Medical Care Establishments Act, 2002 from the District Medical and Health Officer. Bio-medical waste authorisation must be obtained from the State Pollution Control Board under the Bio-Medical Waste Management Rules, 2016. Fire safety certificate must be obtained from the State Fire Department certifying compliance with the National Building Code and fire safety standards. Drug licence must be obtained from the State Drugs Control Authority under the Drugs and Cosmetics Act, 1940 if the PPP includes pharmacy services. PCPNDT registration must be obtained from the Appropriate Authority under the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 if the PPP includes ultrasound or imaging services. Medical Council registration of all medical practitioners must be verified and maintained. The concession agreement must allocate responsibility for obtaining and maintaining these clearances and the cost and time associated with the same.

2.5 THE MANIPAL EXPERIMENT: A SEVEN-DECADE PPP SUCCESS STORY

The Model from 1953 to 2024

The Government of Karnataka entered into an unprecedented arrangement with Kasturba Medical College, Mangalore in 1953. The government agreed to make Wenlock Government

Hospital, Mangalore which was one of the oldest district hospitals in Karnataka with bed capacity exceeding one thousand and serving a catchment population of over one crore, available to KMC as its teaching hospital. In return, KMC agreed to provide medical staff including faculty, residents and interns to manage clinical services at Wenlock Hospital. KMC agreed to upgrade and maintain hospital infrastructure. KMC agreed to provide super-speciality services through its faculty. KMC agreed to treat all patients, both government and private, without discrimination. This was not a registered partnership under the Indian Partnership Act, 1932 nor a corporate joint venture under the Companies Act. It was a contractual arrangement formalised through government orders and memoranda of understanding, periodically renewed over seven decades.

Resource Sharing – Healthcare Specific

The government contribution included land and buildings with ownership of the Wenlock Hospital campus retained by the government. It included clinical staff with salaries of permanent government doctors and nurses paid from the state budget. It included basic equipment procured through state budget allocations. It included drugs and supplies procured through the government procurement system at rates determined by the State Rate Contract. It included utilities such as electricity, water and sanitation charges. It included patient care with free treatment for all BPL patients funded by the government.

The private contribution from KMC included capital investment in new blocks, major renovation of existing wards, and upgradation of infrastructure. It included clinical staff with salaries of KMC faculty, residents and interns posted at Wenlock. It included high-end equipment such as CT scan, MRI, dialysis machines and ventilators which the government could not afford from its budgetary allocation. It included supplementary drugs and advanced surgical consumables beyond the scope of the government rate contract. It included generator backup and additional water storage to ensure uninterrupted services. It included paid services for paying patients with twenty per cent of beds allocated to private paying patients and the professional fees for KMC faculty and private ward charges accruing to KMC to cross-subsidise the free services.

Outcomes Relevant to Healthcare Administrators

Bed capacity increased from three hundred fifty beds in the nineteen fifties to one thousand one hundred fifty beds in two thousand twenty-four. Outpatient department attendance grew from less than five hundred patients per day to between three thousand and three thousand five hundred patients per day. Super-speciality departments expanded from nil to twelve departments including cardiology, nephrology, neurology, urology and gastroenterology. Medical postgraduate seats increased from nil to over one hundred twenty seats across fifteen specialities. The hospital achieved NABH and NABL accreditation. Maternal mortality rate in the hospital reduced from eight to ten per one thousand live births to less than zero point five per one thousand live births. Out-of-pocket expenditure for BPL patients was reduced to zero with regulated rates for paying patients.

Seven Success Factors for Healthcare PPPs

Continuity of commitment across seven decades of uninterrupted partnership across multiple governments of different political parties and successive KMC leadership demonstrates institutionalisation rather than personal relationships. The partnership survived changes in government, changes in health policy, fiscal constraints and even the bifurcation of the state. This was possible because the relationship was formalised in government orders and

memoranda of understanding and was not dependent on personal equations between individual ministers and the Pai family.

Complementary strengths are evident as the government provided land, building, patient trust and public funding while the private partner brought managerial efficiency, clinical expertise, investment capacity and innovation. Neither party could have achieved the outcomes individually. The government could not have afforded the capital investment and super-speciality faculty. The private partner could not have acquired land and building or gained the patient volume and trust.

Autonomy with accountability is maintained as KMC enjoys operational autonomy in staffing, procurement and clinical protocols while being subject to audit by the state health department and quality reviews by the National Medical Commission and the National Accreditation Board for Hospitals. The private partner does not have to seek government approval for every purchase or every recruitment, enabling speedy decision-making. At the same time, the government retains audit powers and can step in if quality standards are not met.

Risk sharing includes demand risk shared as government patients ensure volume and paying patients generate surplus. Financial risk is shared as capital investment is by KMC while operational expenditure is shared. Clinical risk is shared as vicarious liability is covered through insurance with both parties contributing to the premium cost.

Stakeholder alignment is critical. Government doctors and nurses initially resisted the arrangement fearing privatisation and loss of service benefits. Integration was achieved through joint training programmes, parity in professional recognition, and creation of a common identity as Wenlock-KMC team rather than government employees versus private employees. Patient trust is transferable. The government hospital brand of Wenlock signifying affordable, accessible care combined with the private clinical expertise of KMC signifying quality, technology and innovation created a hybrid trust. Patients perceived that they were getting the best of both worlds.

Long-term perspective is essential. Short-term contracts of three to five years discourage private investment because the private partner cannot recover capital investment over such a short period. Thirty-year concessions enable meaningful capital infusion and the private partner is willing to invest in major equipment and infrastructure.

Lessons for Healthcare Administrators

PPPs require long-term perspective. Short-term contracts of three to five years may be suitable for service contracts but are completely unsuitable for management contracts or BOT projects. Twenty to thirty year concessions enable the private partner to invest in capital infrastructure and recover the investment over the concession period. The Wenlock-KMC model succeeded because it was renewed every ten to fifteen years without interruption.

Performance standards must be explicit. Wenlock-KMC succeeded for several decades without formal service level agreements because of the professional commitment of the Pai family and the KMC faculty. However, later formalisation of performance standards improved accountability and enabled measurement of outcomes. New PPPs must codify standards upfront including infrastructure upkeeps, clinical quality indicators, patient satisfaction targets and financial performance metrics.

Autonomy is essential but not absolute. The private partner requires operational freedom to manage staff, procure supplies and determine clinical protocols. If every decision requires government approval, the private partner cannot bring its management efficiency to the project. However, government must retain audit and oversight powers to ensure that public funds are being utilised appropriately and that quality standards are being maintained.

Stakeholder alignment is critical. Government doctors and nurses will inevitably perceive PPP as a threat to their job security and service conditions. This resistance must be addressed through joint training, parity in professional recognition, creation of common identity, and transparent communication about the purpose and terms of the PPP. The Wenlock-KMC model succeeded because government doctors were integrated into the teaching faculty of KMC and received recognition for their teaching contributions.

Patient trust in the government brand can transfer to private clinical expertise. Patients who have relied on government hospitals for generations may be suspicious of private sector involvement. The Wenlock-KMC model demonstrates that when patients see that the same doctors are treating them, the same nurses are caring for them, and the same facilities are available, and that the only change is improved equipment and reduced waiting time, trust is maintained and enhanced.

2025 Update – Karnataka Model PPP for District Hospitals

In January 2025, the Government of Karnataka, drawing from the Wenlock-KMC success spanning seven decades, announced the Karnataka Model PPP for District Hospitals. Under this policy, ten district hospitals will be managed on PPP model by empanelled medical colleges. The concession period will be thirty years to enable meaningful capital investment by the private partner. The private partner will be required to invest one hundred to one hundred fifty crore rupees per hospital for upgradation of infrastructure, procurement of high-end equipment and establishment of super-speciality departments. The government will provide viability gap funding for the first five years to compensate for the low patient volume in the initial period.

Free treatment to Below Poverty Line families will continue as a non-negotiable condition of the concession agreement, with the government reimbursing the private partner at predetermined package rates. The private partner is permitted to operate paying wards comprising up to thirty per cent of total beds to cross-subsidise the free treatment provided to BPL patients. The policy explicitly mandates that the private partner shall not deny treatment to any patient on the ground of inability to pay and that all emergency care must be provided immediately without any pre-condition of deposit or insurance verification. This policy represents the scaling up of the seven-decade Wenlock-KMC experiment into a replicable state-wide framework and is being closely watched by other States as a model for revitalising distressed district hospitals without prohibitive budgetary outlay.

Background: Wenlock Hospital and Kasturba Medical College

Wenlock Hospital, Mangalore was established in 1848 as one of the oldest district hospitals in Karnataka, serving the undivided Dakshina Kannada district. It is a government hospital owned by the Karnataka State Health Department with bed capacity exceeding one thousand, providing tertiary care to a catchment population of over one crore. Kasturba Medical College, Mangalore was established in 1953 by Dr. T.M.A. Pai as the first private medical college in

India. It sought to provide modern medical education but lacked adequate clinical teaching facilities and hospital infrastructure.

The Partnership Conception in 1953

In 1953, the Government of Karnataka and KMC, Mangalore entered into a unique, unprecedented arrangement. The government agreed to make Wenlock Hospital available to KMC as its teaching hospital. In return, KMC agreed to provide medical staff including faculty, residents and interns to manage clinical services at Wenlock Hospital, upgrade and maintain hospital infrastructure, provide super-speciality services through its faculty, and treat all patients, both government and private, without discrimination. This was not a registered partnership under the Partnership Act, 1932 nor a corporate joint venture. It was a contractual arrangement formalised through government orders and memoranda of understanding, periodically renewed over seven decades.

Evolution and Expansion

From 1953 to 1970, KMC faculty managed clinical departments while government retained administrative control over nursing staff, supplies and budget. From 1971 to 1990, government transferred management of nursing staff to KMC and KMC undertook major capital upgrades including new operation theatres and intensive care units. From 1991 to 2000, super-speciality services in cardiology, nephrology and neurology were established through KMC faculty and government paid honorarium. From 2001 to 2015, Wenlock expanded to over one thousand beds, KMC established satellite diagnostic centres and performance standards were formalised. From 2016 to 2024, COVID-19 response was coordinated through PPP, telemedicine integration was achieved and NABH accreditation was obtained jointly.

Governance Structure

The Manipal-Wenlock PPP operates through a tripartite governance framework. The State-Level Steering Committee comprises the Principal Secretary, Health and Family Welfare as Chairperson, Director of Medical Education as Member, Dean, KMC Mangalore as Member, and Medical Superintendent, Wenlock Hospital as Member Secretary. Its functions include policy direction, annual budget approval and dispute resolution. The Hospital Management Committee comprises the District Surgeon or Medical Superintendent as Chairperson, Heads of clinical departments who are KMC faculty as Members, and Chief Nursing Officer as Member. Its functions include day-to-day administration, quality assurance and resource allocation. The Academic Council of KMC is responsible for undergraduate and postgraduate teaching, clinical postings and rotations within Wenlock, and research ethics and hospital-based studies.

Resource Sharing and Financial Arrangement

Government contribution includes land and buildings with ownership of Wenlock Hospital campus, clinical staff with salaries of permanent government doctors and nurses, basic equipment through state budget, drugs and supplies through government procurement, utilities including electricity, water and sanitation charges, and patient care through free treatment for BPL patients. Private contribution from KMC includes capital investment in new blocks and renovation, clinical staff with salaries

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continue for the remaining part of the lesson modification as per approved format , and avoid repetition or duplication of KMC faculty, residents and interns posted at Wenlock, high-end equipment such as CT scan, MRI, dialysis machines and ventilators, supplementary drugs and

advanced surgical consumables, generator backup and additional water storage, and paid services for paying patients with professional fees for KMC faculty and private ward charges. Performance Outcomes from 1953 to 2024.

Bed capacity increased from three hundred fifty beds to one thousand one hundred fifty beds. Outpatient department attendance grew from less than five hundred patients per day to between three thousand and three thousand five hundred patients per day. Super-speciality departments expanded from nil to twelve departments including cardiology, nephrology, neurology, urology and gastroenterology. Medical postgraduate seats increased from nil to over one hundred twenty seats across fifteen specialities. The hospital achieved NABH and NABL accreditation. Maternal mortality rate in the hospital reduced from eight to ten per one thousand live births to less than zero point five per one thousand live births. Out-of-pocket expenditure for BPL patients was reduced to zero with regulated rates for paying patients.

Key Success Factors

Continuity of commitment across seven decades of uninterrupted partnership across multiple governments and successive KMC leadership demonstrates institutionalisation rather than personal relationships. Complementary strengths are evident as government provides land, building, patient trust and public funding while private partner brings managerial efficiency, clinical expertise, investment capacity and innovation. Autonomy with accountability is maintained as KMC enjoys operational autonomy in staffing, procurement and clinical protocols while being subject to audit by state health department and quality reviews by NMC and NABH. Risk sharing includes demand risk shared through government patients ensuring volume and private patients generating surplus, financial risk with capital investment by KMC and operational expenditure shared, and clinical risk with vicarious liability shared through insurance. Political and bureaucratic support is sustained by recognition that Wenlock-KMC is not a privatisation but a public service delivery enhancement model.

Lessons for Healthcare Administrators

PPPs require long-term perspective as short-term contracts of three to five years discourage private investment; twenty to thirty year concessions enable meaningful capital infusion. Performance standards must be explicit as Wenlock-KMC succeeded without formal SLAs initially but later formalisation improved accountability; new PPPs must codify standards upfront. Autonomy is essential but not absolute as private partner requires operational freedom while government must retain audit and oversight powers. Stakeholder alignment is critical as government doctors and nurses initially resisted but integration was achieved through joint training and parity in professional recognition. Patient trust is transferable as government hospital brand of Wenlock combined with private clinical expertise of KMC created hybrid trust.

2025 Update: The PPP Expansion

In January 2025, the Government of Karnataka, drawing from the Wenlock-KMC success, announced the Karnataka Model PPP for District Hospitals. Under this policy, ten district hospitals will be managed on PPP model by empanelled medical colleges with a concession period of thirty years. The private partner will invest one hundred to one hundred fifty crore rupees per hospital for upgradation. The government will provide viability gap funding for the first five years. Free treatment to BPL families will continue while the private partner is permitted to operate paying wards up to thirty per cent of beds to cross-subsidise free care. This policy represents the scaling up of the seven-decade experiment into a replicable state-wide framework.

2.6 COMPARATIVE ANALYSIS AND DECISION FRAMEWORK

Decision Matrix for Healthcare Entrepreneurs

The partnership firm structure is recommended for small scale operations of one to fifty beds with low initial capital requirement from self or family. Promoters bear unlimited joint and several liability. Regulatory burden is low and fund raising ability is poor. Taxation is at individual slab with no dividend distribution tax. The firm dissolves on partner death. Profit distribution is through profit-sharing ratio. Decision-making is by majority or unanimous consent as per deed. Suitability for NABH accreditation is moderate.

The private limited company structure is recommended for medium scale operations of fifty to five hundred beds with moderate capital requirement through equity and debt. Promoters have limited liability to unpaid capital. Regulatory burden is moderate and fund raising ability is good through private equity, venture capital and debt. Taxation is at corporate tax rate of twenty-five point one seven per cent for domestic companies. The company has perpetual succession. Profit distribution is through dividends. Decision-making is by Board of Directors. Suitability for NABH accreditation is high.

The public limited company structure is recommended for large scale operations of over five hundred beds or chains with high capital requirement through public issue. Promoters have limited liability to unpaid capital. Regulatory burden is high and fund raising ability is excellent through equity and debt. Taxation is at corporate tax rate plus dividend distribution tax if applicable. The company has perpetual succession. Profit distribution is through dividends. Decision-making is by Board of Directors plus shareholder approval. Suitability for NABH accreditation is high.

The Section 8 Company structure is recommended for charitable hospitals with capital requirement through donations, CSR and grants. Promoters have limited liability. Regulatory burden is moderate and fund raising ability is through donations, CSR and grants. Taxation is exempt under Sections 11 and 12 of Income Tax Act. The company has perpetual succession. Profit distribution is not permitted; surplus is reinvested. Decision-making is by Board of Directors plus Charity Commissioner. Suitability for NABH accreditation is high.

The public sector structure is recommended for state-level tertiary institutions with capital requirement through budgetary allocation. State bears liability. Regulatory burden is not applicable under Companies Act. Fund raising ability is through government funding. Taxation is not applicable. Perpetuity is perpetual by operation of law. Profit surplus is credited to government treasury. Decision-making is through bureaucratic hierarchy. Suitability for NABH accreditation is variable.

The PPP structure is recommended for district and teaching hospitals with mixed capital requirement from public and private sources. Liability allocation is contractual. Regulatory burden is moderate to high. Fund raising ability is through public and private combination. Taxation is as per entity type. Perpetuity is for contractual term. Profit distribution is as per contract. Decision-making is through joint committee. Suitability for NABH accreditation is high.

Growth Trajectory: The Natural Transition

Successful healthcare enterprises in India typically follow a natural progression through legal forms. Phase one begins as solo practice or proprietorship. Phase two transitions to partnership firm with two to five doctors. Phase three converts to private limited company with five to one hundred crore rupees turnover. Phase four evolves to public limited company with over five hundred crore rupees turnover. Phase five may operate as PPP operator or manager at district or state level, culminating in public listing through IPO or FPO.

The transition from proprietorship to partnership is triggered when the practitioner is unable to handle patient volume alone and needs complementary skills. The legal change required is execution of partnership deed and registration under Partnership Act. The transition from partnership to private limited company is triggered when unlimited liability becomes unacceptable and institutional funding is needed. The legal change required is incorporation of company, transfer of assets and dissolution of partnership. The transition from private limited to public limited is triggered when large capital is needed for expansion and exit for early investors is required. The legal change required is conversion to public company and IPO. The transition from corporate to PPP operator is triggered when proven clinical and managerial capability is developed and government contracts become available. The legal change required is bid qualification and special purpose vehicle formation.

Selecting the Appropriate Structure: A Decision Framework

The first question is whether the primary motive is charitable or non-profit. If yes, a Section 8 Company under the Companies Act is appropriate. If no, the enterprise is profit-making and the next question is the scale of operations. For less than twenty beds with single location, partnership firm under Section 4 is suitable. For twenty to five hundred beds with single site, private limited company is appropriate. For over five hundred beds with single site, public limited company is suitable. For multiple sites or chain operations, public limited company listed on stock exchange is appropriate. The final question is whether the organisation has developed clinical excellence and managerial capability to bid for government hospital management contracts. If yes, PPP with State or Central Government should be considered. If no, the organisation should continue with its existing structure.

2.7 STUDENT LEARNING ACTIVITIES

Activity 1: Comparative Structure Analysis

You are a consultant advising three different healthcare ventures in Andhra Pradesh. For each venture described below, recommend the most appropriate legal structure from partnership, private limited company, Section 8 company or PPP and justify your recommendation with specific reference to the provisions of the Indian Partnership Act, 1932 or the Companies Act, 2013 as applicable.

Venture A: Two cardiologists with fifteen years of clinical experience each wish to establish a twenty-five bed cardiac care centre in Visakhapatnam. They have personal savings of one point five crore rupees and intend to take a loan of one crore rupees. They are concerned about personal liability but wish to maintain complete control over clinical decisions. They do not plan to expand beyond this single location.

Venture B: A charitable trust wishes to establish a one hundred bed cancer hospital in a rural district of Andhra Pradesh with high incidence of oral cancer. The hospital will provide free treatment to BPL patients and nominal charges to others. Funding is proposed through CSR

contributions from corporates, government grants and donations. The trust desires perpetual existence and tax exemptions.

Venture C: The Government of Andhra Pradesh proposes to upgrade a four hundred fifty bed district hospital in Guntur. The budget allocation is insufficient for super-speciality services. The government wishes to partner with a private healthcare provider to establish cardiology, nephrology and oncology departments, with the private partner investing in equipment and specialist manpower while the government continues to own the land and building.

Activity 2: Partnership Deed Drafting Exercise
Dr. Lakshmi, Dr. Venkat and Dr. Srinivas propose to form a partnership to run Vijaya Multi-Speciality Clinic in Vijayawada. Dr. Lakshmi contributes thirty lakh rupees and will work full-time as a physician. Dr. Venkat contributes twenty lakh rupees and will work part-time as a surgeon attending three days per week. Dr. Srinivas contributes ten lakh rupees but will not work in the clinic; he is a non-resident Indian who wishes to invest as a silent partner.

Draft the following clauses of the partnership deed. First, the clause on profit and loss sharing ratio considering capital contribution and working time. Second, the clause on remuneration to partners and whether working partners should receive salary before profit distribution. Third, the clause on admission of new partner including procedure and criteria. Fourth, the clause on dissolution covering grounds and mode of settlement of accounts.

Additionally, advise the partners whether they should register the firm under Section 69 of the Partnership Act. Provide reasons citing the disabilities of an unregistered firm.

Activity 3: PPP Contract Analysis
Obtain from open sources the Request for Proposal or Concession Agreement of any healthcare PPP project in India, such as diagnostic PPPs under National Health Mission, dialysis PPPs or hospital management PPPs.

Analyse the document and answer the following questions. What is the scope of services contracted to the private partner? What performance standards are specified and are they measurable and auditable? What is the payment mechanism and is it linked to performance or fixed? How are risks allocated between government and private partner? What are the termination clauses and what compensation is payable upon early termination?
Based on your analysis, identify three strengths and three potential weaknesses of the agreement. Resources include the National Health Mission PPP portal at nhm.gov.in, Karnataka Health Systems Development Project documents and Andhra Pradesh Health Systems Project documents.

2.8 SUMMARY

Partnership under the Indian Partnership Act, 1932 is the simplest legal structure for healthcare organisations. It is defined as the relation between persons who have agreed to share profits of a business carried on by all or any of them acting for all. Section 4 codifies this definition while Section 5 clarifies that partnership arises from contract, not status. Five essential elements constitute a valid partnership: association of two or more persons, agreement, business, sharing of profits and mutual agency. The absence of any element negates partnership.

Mutual agency under Section 19 is the defining feature distinguishing partnership from other forms of co-ownership. Every partner is both an agent binding the firm and a principal bound by other partners. Implied authority under Section 19 enables partners to bind the firm in acts done in the usual way of business, subject to specific statutory exceptions. Registration under Section 69 is not mandatory for the existence of a partnership, but unregistered firms suffer severe disabilities: they cannot sue partners, cannot sue third parties to enforce contracts and cannot claim set-off. Registration requires filing a statement with the Registrar of Firms containing prescribed particulars and is evidenced by a Certificate of Registration.

Joint and several liability under Section 25 is the most significant disadvantage of partnership. Every partner is personally liable for all acts of the firm, and a patient can recover the entire compensation amount from any one partner's personal assets. This unlimited liability makes partnership unsuitable for hospitals beyond a certain scale. Partnership deeds are the constitutional documents of the firm. Essential clauses include profit-sharing ratio, capital contribution, remuneration, admission and retirement of partners, dispute resolution and dissolution. Written deeds prevent disputes under Section 6, which mandates determination of partnership based on real relations between parties.

Corporate hospitals are governed by the Companies Act, 2013 replacing the 1956 Act. A company is an artificial person with separate legal entity, perpetual succession and limited liability of members. Private limited companies under Section 2 are the preferred structure for medium-sized hospitals, offering limited liability with operational flexibility and moderate regulatory burden. Section 8 companies are charitable organisations registered under the Companies Act, 2013 with profits applied for promoting their objects and no dividend distribution. They are eligible for income tax exemptions under Sections 11 and 12 of the Income Tax Act and are suitable for non-profit hospitals, research institutions and philanthropic healthcare ventures.

Public sector hospitals are established under Entry 6 of the State List, public health and hospitals, and Entry 24 of the Union List. They are not registered under the Partnership or Companies Acts but derive legal existence from legislative Acts, executive orders or municipal bye-laws. The doctrine of sovereign immunity has been substantially eroded; government hospitals are vicariously liable for negligence of employees as held in Achutrao Haribhau Khodwa v. State of Maharashtra.

Public-Private Partnerships in healthcare are contractual arrangements where a private entity performs a public function, assumes substantial risk and receives performance-linked payments while the government retains ownership and ultimate accountability. PPPs are not a separate legal entity but a contractual relationship structured through concession agreements, management contracts or service agreements. The Manipal-Wenlock PPP from 1953 to 2024 is the oldest and most successful healthcare PPP in India. Kasturba Medical College manages Wenlock Government Hospital, Mangalore, providing clinical faculty, capital investment and super-speciality services while the government retains ownership and provides budgetary support. This seven-decade partnership demonstrates that PPPs require long-term perspective, complementary strengths, autonomy with accountability and sustained political-bureaucratic support.

The choice of legal structure is a strategic decision for healthcare entrepreneurs. The decision is determined by scale, liability tolerance, funding requirements, succession plans and regulatory compliance capacity. Successful healthcare enterprises typically progress from

proprietorship to partnership to private limited company to public limited company and eventually to PPP operator as they scale.

2.9 KEY WORDS WITH EXPLANATIONS

1. Partnership under Section 4 is the relation between persons who have agreed to share the profits of a business carried on by all or any of them acting for all. Five essential elements are association, agreement, business, profit sharing and mutual agency.
2. Mutual Agency under Section 18 is the legal principle that every partner is both an agent binding the firm and a principal bound by other partners. This is the definitive test of partnership.
3. Implied Authority under Section 19 is the authority of a partner to bind the firm by acts done in the usual way of business of the kind carried on by the firm. Does not extend to arbitration, compromise, acquisition or transfer of immovable property or admission of new partners.
4. Joint and Several Liability under Section 25 is the liability of partners where each partner is personally liable for the entire debt or obligation of the firm. A patient can recover full compensation from any one partner's personal assets.
5. Registration under Section 69 is optional under the Act but practically essential. Unregistered firms cannot sue partners, cannot sue third parties to enforce contracts and cannot claim set-off. Registration confers evidentiary benefits and legal standing.
6. Partnership Deed is the written agreement between partners constituting the constitutional document of the firm. Governs profit sharing, capital, remuneration, admission and retirement, dissolution and dispute resolution.
7. Partnership at Will under Section 7 is partnership where no fixed duration is agreed and no provision is made for determination. Dissolvable by any partner giving notice in writing. Unsuitable for stable healthcare enterprises.
8. Particular Partnership under Section 8 is partnership formed for a single adventure or undertaking. Automatically dissolves upon completion of that venture.
9. Company is an artificial person created by law, having separate legal entity, perpetual succession and limited liability. Registered under the Companies Act, 2013.
10. Private Limited Company under Section 2 is a company with minimum two and maximum two hundred members, restricted right to transfer shares, prohibition on public subscription. Preferred structure for medium-sized hospitals.
11. Public Limited Company under Section 2 is a company with minimum seven members, no upper limit, freely transferable shares, can invite public subscription. Suitable for large hospital chains and listed entities.
12. Section 8 Company is a company registered with charitable objects; profits applied for promotion of objects; no dividend distribution. Exempt from certain provisions of Companies Act; eligible for income tax exemptions.
13. Perpetual Succession is the characteristic of a company whereby its existence continues irrespective of changes in membership. Death or retirement of shareholders does not dissolve the company.
14. Separate Legal Entity is the doctrine established in Salomon v. Salomon and Company Limited in 1897. Company is distinct from its members; can own property, contract, sue and be sued in its own name.
15. Public-Private Partnership is a contractual arrangement between government and private entity for delivery of public services wherein private party assumes substantial risk and receives performance-linked payments while government retains ownership and accountability.

16. Concession Agreement is the foundational contract in PPP defining scope of services, performance standards, payment mechanism, risk allocation, monitoring, dispute resolution and termination terms.
17. Vicarious Liability is the legal principle whereby an employer hospital is held liable for negligent acts of its employees committed in the course of employment. Applies to both private corporate hospitals and government hospitals.
18. Viability Gap Funding is grant from government to make PPP projects commercially viable, covering up to forty per cent of project cost. Governed by VGF Scheme, Ministry of Finance.
19. Special Purpose Vehicle is a separate legal entity, usually a company, created specifically to implement a PPP project. Isolates project risk from parent entities.

2.10 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What are the five essential elements of a partnership under Section 4 of the Indian Partnership Act, 1932?

Ans. The five essential elements are association of two or more persons, agreement between such persons, business including every trade, occupation and profession, sharing of profits of the business, and business carried on by all or any of them acting for all constituting mutual agency. All five elements must coexist; the absence of any element negates partnership.

Q2. Distinguish between partnership at will and particular partnership.

Ans. Partnership at will under Section 7 is a partnership where no fixed period is agreed upon for its duration and no provision is made for its determination. It can be dissolved by any partner giving notice in writing to all other partners of their intention to dissolve the firm. Particular partnership under Section 8 is formed for a single adventure or undertaking such as conducting a specific medical camp or establishing a single-speciality day-care centre. It automatically dissolves upon completion of that venture.

Q3. What are the consequences of non-registration of a partnership firm under Section 69 of the Indian Partnership Act, 1932?

Ans. An unregistered firm suffers three disabilities: it cannot file a suit against any partner to enforce a right arising from contract or the Act, it cannot file a suit against any third party to enforce a contractual right, and it cannot claim set-off or other proceedings in a suit filed against it. Exceptions exist for suits for dissolution of firm and for accounts of dissolved firm.

Q4. What is meant by joint and several liability of partners under Section 25 of the Indian Partnership Act, 1932?

Ans. Joint and several liability means that each partner is personally liable for the entire debt or obligation of the firm, along with all other partners jointly, and also individually severally. A patient who suffers negligence can sue all partners jointly or can select any one partner and recover the full compensation amount from that partner's personal assets. The partner who pays can seek contribution from other partners, but this does not affect the patient's right to recover the full amount from any one partner.

Q5. What is a Section 8 Company under the Companies Act, 2013 and what is its relevance to healthcare?

Ans. A Section 8 Company is a company registered with charitable objects such as promoting commerce, art, science, sports, education, research, social welfare, religion, charity or

protection of environment. Its profits, if any, must be applied for promoting its objects and it cannot pay any dividend to its members. Section 8 companies are relevant to healthcare because charitable hospitals, medical research institutions and philanthropic healthcare ventures can register under this section to obtain corporate structure with limited liability while retaining non-profit character and availing income tax exemptions under Sections 11 and 12 of the Income Tax Act, 1961.

B. Essay Type Questions with Hints

Q1. The choice of legal structure is the most critical strategic decision for a healthcare entrepreneur. Critically evaluate this statement with reference to partnership firms, private limited companies and public-private partnerships, discussing the implications for liability, capital, governance and perpetuity.
Hints: Begin with legal structure as foundation of healthcare enterprise. Discuss partnership with unlimited liability under Section 25, capital constraints, dissolution on partner death, but ease of formation and tax flexibility. Discuss private limited company with limited liability, perpetual succession, ability to raise private equity, moderate regulatory burden. Discuss public limited company with access to public equity, stringent SEBI regulations, suitability for large chains. Discuss PPP as not a separate legal entity but contractual arrangement with risk allocation, long-term concession, public accountability. Present decision matrix based on scale, liability tolerance, funding requirements, succession plans. Conclude that no single optimal structure exists; fitness for purpose determined by specific circumstances.

Q2. Discuss the concept of mutual agency as the defining feature of partnership under the Indian Partnership Act, 1932. How does this feature create both operational flexibility and significant risk for healthcare partnerships? Illustrate with suitable examples.
Hints: Define mutual agency under Section 18 with partner as agent and principal. Contrast with co-ownership where co-owners are not mutual agents. Explain implied authority under Section 19 for acts in usual way of business. Provide healthcare examples of implied authority including admitting patients, prescribing medicines, ordering diagnostic tests, hiring temporary staff in emergency. Discuss limitations on implied authority including cannot acquire immovable property, compromise claims, admit new partners without consent. Analyse risk of reckless partner binding firm and patients recovering from all partners. Discuss mitigation through restricting authority by contract under Section 20, notifying frequent creditors, comprehensive insurance.

Q3. Examine the legal and procedural requirements for registration of a partnership firm under the Indian Partnership Act, 1932. Why do the courts describe registration under Section 69 as optional but essential? Illustrate with reference to the Preeti Nursing Home case.
Hints: Explain registration procedure under Section 58 with statement to Registrar, prescribed form, particulars, verification, entry in Register, Certificate of Registration. Discuss Section 69 disabilities including cannot sue partners, cannot sue third parties, cannot claim set-off. Discuss exceptions for suits for dissolution, accounts, claims up to one hundred rupees. Analyse Preeti Nursing Home case where registered firm could maintain writ petition while unregistered firm would have been disabled. Explain why optional as partnership can exist and carry on business without registration. Explain why essential as without registration firm is legally handicapped, cannot enforce contracts, third parties may refuse to deal. Provide practical advice to register immediately upon formation, update changes, renew certificate.

Q4. Critically analyse the Public-Private Partnership model in Indian healthcare with special reference to the Manipal-Wenlock experiment. What factors contributed to its success over seven decades and what lessons does it offer for contemporary healthcare PPPs?
Hints: Define PPP as contractual arrangement, public function, private risk, performance-linked payment, public ownership. Describe Manipal-Wenlock conceived in 1953 with KMC manages Wenlock Hospital, government ownership retained. Explain resource sharing with government providing land, building, basic budget and KMC providing clinical faculty, capital investment, super-speciality services. Discuss governance through state-level steering committee, hospital management committee, academic council. Analyse success factors including continuity across seven decades and multiple governments, complementary strengths, autonomy with accountability, risk sharing, political-bureaucratic support. Present outcomes with bed capacity from three fifty to one thousand one hundred fifty, super-speciality departments from nil to twelve, NABH accreditation, maternal mortality reduction. Derive lessons that PPPs require long-term perspective with twenty to thirty year concessions, explicit performance standards, operational autonomy, stakeholder alignment, patient trust transferable. Discuss 2025 update with Karnataka Model PPP for District Hospitals scaling up to ten districts.

Q5. You are the Administrator of a fifteen-year-old partnership nursing home in Andhra Pradesh with fifty beds, four partners, annual turnover of eight crore rupees and sixty-five employees. The partners wish to convert the nursing home into a private limited company. Prepare a comprehensive advisory note covering the procedural steps for transition, valuation of partnership assets and goodwill, tax implications, transfer of employees and contracts, and estimated timeline and costs.

Hints: For procedural steps, address partnership dissolution under Sections 39 to 44, settlement of accounts under Section 48, incorporation under Companies Act Section 7, transfer of assets by sale deed or assignment, transfer of liabilities by novation. For valuation, address net asset method, discounted cash flow method, goodwill valuation through capitalisation of super profits, independent valuer report. For tax implications, address capital gains tax on transfer of assets under Section 45 of Income Tax Act, stamp duty on transfer deeds varying by state, tax neutrality under Section 47 if transfer is to resulting company and partners hold at least fifty per cent shares. For transfer of employees, address Section 25FF of Industrial Disputes Act with continuity of service, provident fund transfer, patient contracts through novation, vendor contracts through assignment. For timeline and costs, estimate three to four months with stamp duty of five to eight per cent of asset value, ROC fees, professional fees. Recommend execution of partnership dissolution deed, incorporation of company, transfer of assets by sale deed, novation of contracts, application for fresh licences in company name for drug, PCPNDT and bio-medical waste.

C. Analytical Multiple Choice Questions

1. Under Section 4 of the Indian Partnership Act, 1932, which of the following is NOT an essential element of partnership?
a) Association of two or more persons
b) Agreement to share profits
c) Registration with Registrar of Firms
d) Business carried on by all or any of them acting for all
Correct Answer: c) Registration with Registrar of Firms

2. Dr. Sharma and Dr. Verma jointly own a clinic building and receive rent from a tenant who runs a pharmacy. They do not carry on any business together. Under the Indian Partnership Act, 1932, this relationship is:
a) Partnership at will
b) Particular partnership
c) Co-ownership, not partnership
d) Partnership by estoppel
Correct Answer: c) Co-ownership, not partnership

3. Which of the following acts is within the implied authority of a partner under Section 19 of the Indian Partnership Act, 1932?
a) Submitting a patient dispute to arbitration
b) Purchasing medical equipment worth five lakh rupees for the hospital
c) Selling the hospital building
d) Admitting a new partner
Correct Answer: b) Purchasing medical equipment worth five lakh rupees for the hospital

4. A private limited company under Section 2 of the Companies Act, 2013 has which of the following characteristics?
a) Minimum seven members, maximum unlimited, shares freely transferable
b) Minimum two members, maximum two hundred, restriction on transfer of shares, prohibition on public subscription
c) Minimum two members, maximum fifty, shares freely transferable
d) One person as member, nominee required
Correct Answer: b) Minimum two members, maximum two hundred, restriction on transfer of shares, prohibition on public subscription

5. In the Manipal-Wenlock PPP, which of the following resources is contributed by the private partner, Kasturba Medical College?
a) Land and hospital buildings
b) Salaries of permanent government doctors
c) High-end medical equipment including CT scan, MRI and dialysis machines
d) Electricity and water supply
Correct Answer: c) High-end medical equipment including CT scan, MRI and dialysis machines

6. Under Section 25 of the Indian Partnership Act, 1932, every partner is liable:
a) Only to the extent of their capital contribution
b) Jointly with all other partners, but not severally
c) Jointly with all other partners and also severally
d) Only after the firm's assets are exhausted
Correct Answer: c) Jointly with all other partners and also severally

7. A hospital established by an Act of Parliament, with its own governing body and the President of India as Visitor, is classified as:
a) Public sector undertaking hospital
b) Statutory corporation, Institute of National Importance
c) Government department hospital
d) Section 8 company
Correct Answer: b) Statutory corporation, Institute of National Importance

8. Which provision of the Companies Act, 2013 mandates CSR spending for eligible companies and what is the prescribed percentage?
a) Section 134 – two per cent of average net profits
b) Section 135 – two per cent of average net profits
c) Section 149 – three per cent of turnover
d) Section 198 – one per cent of net w
Correct Answer: b) Section 135 – two per cent of average net profits

2.11 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Triad Hospital: Navigating Growth Through Legal Transformation

Triad Hospital was established in 1998 in Tirupati, Andhra Pradesh, as a registered partnership firm under the Indian Partnership Act, 1932. The three founding partners, Dr. S. Rajasekhar, cardiologist, Dr. P. Vijayalakshmi, paediatrician, and Dr. M. Nageswara Rao, general surgeon, each contributed ten lakh rupees as capital. The partnership deed executed on 15 January 1998 provided for equal profit-sharing at thirty-three point three three per cent each, designated Dr. Rajasekhar as the managing partner with authority over day-to-day administration, and stipulated that disputes would be resolved through arbitration. The firm was registered under Section 69 on 20 February 1998.

Over twenty-five years, Triad Hospital grew from a twenty-bed nursing home to a one hundred eighty-bed multi-speciality hospital offering cardiology, paediatrics, general surgery, orthopaedics, obstetrics and gynaecology, and diagnostic services. Annual turnover reached thirty-two crore rupees in financial year 2024-25 with EBITDA of six point five crore rupees. The hospital employs two hundred ten persons including thirty-five full-time doctors, eighty-five nursing staff, thirty-five paramedical professionals and fifty-five administrative and support staff.

By early 2025, the partners recognised that the partnership structure was no longer adequate for the hospital's scale and aspirations. Liability exposure became critical when a patient filed a consumer complaint claiming one point two crore rupees for alleged negligence in post-operative care. While the hospital's insurer settled the claim for eighty lakh rupees, the partners were personally exposed for the balance and faced significant mental stress. A single catastrophic claim could potentially bankrupt all three partners personally. Capital constraints emerged as the hospital required twenty-five crore rupees for construction of a new super-speciality block for cardiac sciences, procurement of one point five Tesla MRI and one hundred twenty-eight slice CT scan, digital transformation with integrated HIS and telemedicine platform, and NABH accreditation estimated at one point two crore rupees. The partners had exhausted their personal capacity for further capital contribution. Banks were willing to lend only up to ten crore rupees against partnership security. Private equity investors expressed interest but insisted on corporate structure. Succession and continuity became pressing as Dr. Rajasekhar aged sixty-eight wished to retire within three to five years. His two children were settled abroad and did not intend to join the practice. The partnership deed contained no continuation clause; upon Dr. Rajasekhar's retirement, the firm would dissolve under Section 42 unless all partners agreed otherwise. Regulatory compliance difficulties arose as the hospital faced increasing difficulty in maintaining drug licences, PCPNDT registration and bio-medical waste authorisation in the partnership name. Insurance empanelment required corporate structure. The District Medical and Health Officer had informally suggested that the hospital's size warranted transition to corporate entity. Employee retention became critical as the hospital

had lost three senior doctors to corporate hospitals in the preceding two years, citing better career progression and ESOP opportunities not available in a partnership firm.

The partners considered five options. Continuing as partnership offered no transition cost, no regulatory disruption and tax simplicity but carried unlimited liability, capital constraints, succession uncertainty and inability to offer ESOPs. Conversion to private limited company offered limited liability, ability to raise private equity, perpetual succession, ESOP feasibility and enhanced credibility but involved transition costs including stamp duty, ROC fees and professional fees, dual taxation and increased compliance burden. Conversion to public limited company and listing offered access to public equity, liquidity for partners and enhanced brand visibility but carried high regulatory burden under SEBI and LODR, loss of control and quarterly disclosure obligations, and was not immediately suitable given size. Section 8 company offered tax exemptions, CSR eligibility and philanthropic positioning but could not distribute profits and was not aligned with partners' commercial objectives. PPP with State Government offered long-term concession, capital infusion through viability gap funding and public service mandate but involved loss of operational autonomy, competitive bidding process and policy not yet notified in Andhra Pradesh.

The partners engaged M/s. Rao and Associates, Chartered Accountants and M/s. Srinivas and Srinivas, Advocates for comprehensive advice. The professional recommendations were to convert to private limited company under the Companies Act, 2013 as the optimal structure for a hospital of this scale with growth aspirations. The process would require execution of partnership dissolution deed under Sections 39 to 44, settlement of accounts and determination of partners' capital balances under Section 48, independent valuation of goodwill and assets, incorporation of Triad Hospitals Private Limited under Section 7, transfer of assets by sale deed payable in shares or cash, novation of all contracts for employees, vendors, insurers and empanelment, and application for fresh regulatory licences in company name.

Valuation revealed net asset value of thirty-eight crore rupees comprising land and building twenty-two crore rupees, plant and equipment twelve crore rupees and investments four crore rupees. Goodwill valuation through capitalisation of super profits was fourteen crore rupees. Enterprise value was fifty-two crore rupees. Partner-wise capital accounts would be credited with shares or cash accordingly. Tax and stamp duty implications included capital gains tax on transfer of assets under Section 45 of Income Tax Act with exemption under Section 47 available if partners hold at least fifty per cent shares in resulting company for five years. Stamp duty under Andhra Pradesh Stamp Act was seven per cent on immovable property value plus one per cent on movable property, estimated at one point six six crore rupees ad valorem. Total timeline was four to five months with professional fees of eight to ten lakh rupees, ROC fees of two point five lakh rupees and contingency of five lakh rupees.

Post-conversion capital structure proposed authorised share capital of ten crore rupees with paid-up capital of five point two crore rupees comprising fifty-two lakh equity shares of ten rupees each. Partners would hold seventy-four per cent being thirty-eight point four eight lakh shares. Private equity would invest fifteen crore rupees for twenty-six per cent being thirteen point five two lakh shares at post-money valuation of fifty-seven point seven crore rupees.

After four rounds of negotiations, the partners unanimously resolved on 15 March 2025 to dissolve the partnership firm M/s Triad Hospital with effect from 1 April 2025, incorporate Triad Hospitals Private Limited under the Companies Act, 2013, transfer all assets and liabilities of the partnership to the company, allot shares to partners in proportion to their capital

balances as per valuation report, initiate discussions with two private equity firms for fifteen crore rupees investment at the SPV level, apply for NABH accreditation within twelve months of incorporation, and formulate ESOP scheme for retention of senior medical and managerial talent.

Questions for Analysis with Hints

Q1. Identify and explain the legal provisions of the Indian Partnership Act, 1932 that are triggered by the dissolution of M/s Triad Hospital. What procedure must the partners follow for lawful dissolution and settlement of accounts?
Hints: Dissolution of firm under Section 39 means dissolution of partnership between all partners of the firm. Dissolution by agreement under Section 40 requires all partners consent to dissolve. Compulsory dissolution under Section 41 is not applicable as no insolvency or illegality. Dissolution on occurrence of contingencies under Section 42 provides that Dr. Rajasekhar's retirement would dissolve firm unless deed otherwise provides; pre-emptive dissolution by agreement avoids this. Settlement of accounts under Section 48 requires losses paid first, then partners' capitals, surplus divided in profit-sharing ratio. Procedure includes execution of dissolution deed by all partners, settlement of firm's debts and liabilities, realisation of partnership assets or transfer to company, appropriation to partners' capital accounts, payment of surplus in profit-sharing ratio, and notice to Registrar under Section 63 to record dissolution with Registrar of Firms.

Q2. Critically evaluate the choice of private limited company over other available structures. Was this the optimal decision for Triad Hospital? Justify your answer with reference to the facts of the case.
Hints: Strengths of private limited company for Triad include limited liability protecting partners' personal assets from future claims, capital raising ability to accept fifteen crore rupees private equity investment, perpetual succession allowing Dr. Rajasekhar to retire without dissolving entity, ESOPs to issue shares for retaining senior doctors, credibility for easier empanelment, NABH accreditation and insurance tie-ups. Why not other options: partnership has unlimited liability, cannot raise private equity, dissolution on retirement; public limited is premature with thirty-two crore rupees turnover insufficient for listing costs and compliance; Section 8 company not aligned as partners desire profit distribution;
continue for the remaining part of lesson two, without repetition
PPP not suitable as Andhra Pradesh has not yet notified district hospital PPP policy and would involve loss of autonomy. Conclusion: Private limited company is optimal given the hospital's scale of one hundred eighty beds, thirty-two crore rupees turnover, growth plans requiring twenty-five crore rupees investment, and partner objectives of limited liability, perpetual succession and partial exit.

Q3. Discuss the tax and stamp duty implications of the proposed asset transfer from the partnership firm to the company. Can the partners avail the benefit of Section 47 of the Income Tax Act, 1961? What conditions must be satisfied?
Hints: Capital gains tax under Section 45 of the Income Tax Act, 1961 is attracted as transfer of capital assets including land, building and goodwill constitutes transfer under Section 2. Exemption under Section 47 is available for transfer of capital assets by firm to company if all assets and liabilities are transferred, consideration is allotted to partners in their capital proportion, partners hold at least fifty per cent shares in the company for five years, and the company is registered under the Companies Act. Stamp duty is governed by the Andhra Pradesh Stamp Act; transfer of immovable property attracts seven per cent ad valorem,

movable property one per cent, total estimated at one point six six crore rupees representing significant transition cost. Recommendation: Structure consideration partly as shares and partly as cash to manage tax, claim Section 47 exemption, pay stamp duty, apply for Input Tax Credit on GST paid on asset transfer.

Q4. As the proposed Administrator of Triad Hospitals Private Limited, prepare a compliance checklist for the first year of operations covering Companies Act, 2013 compliances, healthcare-specific licences and registrations, and employment and labour law compliances.
Hints: Companies Act, 2013 compliances include Board meeting under Section 173 minimum four per year with gap not exceeding one hundred twenty days, Annual General Meeting under Section 96 once per year within six months of year-end, financial statements under Section 129 and Schedule III annually within six months, ROC filing AOC-4 under Section 137 annually within thirty days of AGM, ROC filing MGT-7 under Section 92 annually within sixty days of AGM, Directors' Report under Section 134 annually with financial statements, appointment of Auditor under Section 139 for five years within thirty days of incorporation, CSR under Section 135 annually if thresholds met. Healthcare licences include AP Private Medical Care Establishments registration fresh under DMHO within thirty days of incorporation, Drug Licence Retail or Wholesale from Drugs Control Administration apply fifteen days before commencement, PCPNDT Registration from Appropriate Authority before commencing ultrasound or imaging, Bio-Medical Waste Authorisation from Pollution Control Board within thirty days of incorporation, Fire NOC from State Fire Department before occupation of new block, Food Safety Licence FSSAI if cafeteria or canteen operates, AERB Certification from Atomic Energy Regulatory Board for radiology equipment, NABH Accreditation voluntary from Quality Council of India with twelve-month roadmap. Employment and labour law compliances include Employee Provident Fund under EPF Act, 1952 mandatory if twenty or more employees, Triad has two hundred ten so register immediately, Employee State Insurance under ESI Act, 1948 mandatory if wages exceed twenty-one thousand rupees per month, Gratuity under Payment of Gratuity Act, 1972 register within sixty days of applicability, Contract Labour under CLRA Act, 1970 if security or housekeeping through contractor requires licence and registration, Shops and Establishment under State Act registration within thirty days, Sexual Harassment under POSH Act, 2013 requires Internal Committee constitution and annual report, Minimum Wages under Minimum Wages Act display rates and maintain registers.

Q5. The partners wish to offer ESOPs to retain senior doctors. Explain the concept of Employee Stock Option Plans under the Companies Act, 2013 and SEBI regulations. What are the advantages and challenges of implementing ESOPs in a newly converted private hospital company?

Hints: ESOPs are schemes under which company grants options to employees to subscribe to shares at predetermined exercise price after specified vesting period. Companies Act, 2013 under Section 62 read with Rule 12 of Companies Rules, 2014 requires special resolution, minimum one year vesting period, maximum five years exercise period. SEBI regulations apply only to listed companies; unlisted companies like Triad are governed by Companies Act, 2013 with simpler compliance. Advantages for Triad Hospital include retention as senior doctors financially incentivised to remain with options vesting over three to five years, alignment creating ownership mindset improving clinical quality and cost efficiency, cash conservation with no immediate cash outflow as employees pay exercise price upon vesting, wealth creation enabling doctors to participate in company's valuation growth as powerful recruitment tool against corporate chains. Challenges include valuation complexity for unlisted

company requiring independent valuer and fair market value certificate, employee expectation management requiring clear communication and ESOP policy document, dilution of promoter holding requiring limit of ESOP pool to five to ten per cent of paid-up capital, regulatory compliance requiring secretarial audit and ROC filings in Form PAS-3, taxation at exercise and sale as perquisite value under Section 17 taxed as salary and capital gains on sale. Recommendation: Form ESOP Committee, frame ESOP Scheme 2025, pass special resolution, allot options to identified senior consultants, implement in tranches linked to NABH accreditation milestones.

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The choice of legal structure is never merely technical. It is a statement of how the organisation views itself—its relationship with risk, its ambitions for growth, its commitment to perpetuity. The partnership is the nursery of Indian healthcare; the corporate form is its university; the PPP is its covenant with the state. Each has its season; the wise administrator knows when to transition.

— Adapted from Dr. T.M.A. Pai, Founder, Manipal Academy of Higher Education

LESSON-3
MEDICAL PROFESSION, ETHICS AND CODE OF CONDUCT

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Explain the statutory role, composition and regulatory functions of the National Medical Commission under the NMC Act, 2019
2. Analyse the fiduciary nature of the physician-patient relationship and its legal consequences for consent, confidentiality and conflict of interest
3. Distinguish the professional duties of medical staff from those of paramedical and administrative staff in healthcare institutions
4. Evaluate the core principles of medical ethics as codified in the NMC Registered Medical Practitioner Regulations, 2023
5. Apply the code of conduct to contemporary medico-legal dilemmas including data privacy and professional misconduct

STRUCTURE OF THE LESSON

3.1 INTRODUCTION: THE MORAL AND LEGAL FOUNDATIONS OF MEDICAL PRACTICE

The practice of medicine is unique among professions. Unlike commerce where the governing principle is caveat emptor, medicine operates on a foundation of trust. The patient comes to the physician in a state of vulnerability, often in pain, anxious and possessing no more than a layperson's understanding of their own condition. They place their life, their secrets and their hope in the hands of another human being. This is not a contract between equals; it is a fiduciary relationship. Medical ethics transforms this moral intuition into codified duties. The law, through the National Medical Commission and State Medical Councils, enforces these duties through disciplinary jurisdiction. Together, ethics and law create a framework of regulated autonomy: the profession retains the freedom to exercise clinical judgment, but that freedom is conditioned upon adherence to standards of conduct designed to protect the patient and uphold public trust in the profession. This lesson traces the evolution from the Hippocratic Oath to the NMC Registered Medical Practitioner Regulations, 2023, dissects the physician-patient relationship as a legal construct, maps the duties of every actor in the healthcare team, and confronts the contemporary ethical challenges posed by digitisation, data commerce and the erosion of traditional boundaries.

3.2 INTRODUCTORY CASE STUDY: MR X v. HOSPITAL Z – THE SILENT BETRAYAL

In 1995, a man referred to in the Supreme Court judgment only as Mr X visited a hospital in Delhi for routine blood donation. The hospital tested his blood and discovered he was HIV positive. Without obtaining his consent, without counselling him on the implications and without any attempt to anonymise his identity, the hospital disclosed his HIV status to his fiancée's family. The marriage was called off. Mr X, now socially ostracised and suffering severe mental distress, approached the National Consumer Disputes Redressal Commission and subsequently the Supreme Court of India.

The Supreme Court held that the doctor-patient relationship is one of trust and confidence. Disclosing a patient's medical condition without consent, especially a condition carrying significant social stigma, is a breach of that trust and violates the patient's right to privacy. The Court affirmed that the Hippocratic Oath and the Code of Medical Ethics Regulations, 2002 mandate strict confidentiality. However, the Court introduced a critical exception where there is a clear and imminent risk to the health or life of an identifiable third person, the physician's duty to society overrides the duty of confidentiality. In this case, the woman whom Mr X was to marry faced a potential health risk; therefore the disclosure was held to be justified in public interest and the claim for compensation was dismissed.

Relevance to the Lesson: This case is the jurisprudential anchor for medical confidentiality in India. It establishes that confidentiality is a core duty but is not absolute, that the public interest exception permits disclosure to protect an identifiable third party from serious imminent harm, that privacy is a constitutional right under Article 21 read with K.S. Puttaswamy v. Union of India, and that consent must be informed. For the hospital administrator, this case demonstrates that confidentiality policies cannot be ad hoc. Hospitals must have clear written protocols governing when and to whom patient information may be disclosed, how to obtain valid consent for data sharing, how to balance confidentiality against

public health obligations, and how to document disclosure decisions to defend against subsequent legal challenge.

3.3 NATIONAL MEDICAL COMMISSION: ROLE AND FUNCTIONS

The National Medical Commission was established by the National Medical Commission Act, 2019, repealing the Indian Medical Council Act, 1956. The Act was passed with the stated objective of ending regulatory capture, reducing the cost of medical education and ensuring the availability of adequate and high-quality medical professionals across India. The NMC commenced operations on 25 September 2020. The constitutional validity of the NMC Act was challenged before the Supreme Court on grounds including the composition of the Commission, the introduction of a National Exit Test and the provision for fee regulation in private medical colleges. By judgment dated 18 January 2022, the Supreme Court upheld the constitutional validity of the Act, holding that it fell within the legislative competence of Parliament under Entry 66 of the Union List relating to coordination and determination of standards in institutions for higher education or research and scientific and technical institutions.

The NMC consists of thirty-three members including a Chairperson who must be a medical professional of outstanding ability appointed by the Central Government, the Presidents of four autonomous Boards who are ex-officio members, part-time members who are experts from other fields including law, economics, consumer protection and health research, and ex-officio members including the Director General of Health Services, the Chief Commissioner of Central Goods and Services Tax, and representatives from NITI Aayog and Ayush.

The NMC functions through four statutory autonomous Boards, each headed by a President and possessing delegated powers to make regulations within their respective domains. The Under-Graduate Medical Education Board prescribes the competency-based dynamic curriculum for MBBS, sets standards for medical education at undergraduate level, approves new medical colleges for undergraduate courses and develops faculty development programmes. The Post-Graduate Medical Education Board prescribes curriculum for postgraduate MD and MS and super-speciality DM and MCh courses, regulates admissions and seat distribution at PG level, approves new PG courses and increase of seats, and formulates guidelines for teacher-student ratios. The Medical Assessment and Rating Board conducts inspections of medical institutions, both government and private, grants permission for establishment of new medical colleges through Letter of Permission, categorises institutions based on compliance and quality, has power to recommend closure of institutions failing to meet minimum standards, and issues show-cause notices and imposes monetary penalties. The Ethics and Medical Registration Board maintains the National Medical Register of all licensed medical practitioners in India which is Aadhaar-linked and publicly accessible, maintains a separate register of AYUSH practitioners if they possess recognised medical qualifications, regulates professional conduct and promotes medical ethics, adjudicates cases of professional misconduct referred by State Medical Councils, exercises appellate jurisdiction over State Medical Council disciplinary orders, and recognises medical qualifications granted by institutions outside India.

Under Section 10 of the NMC Act, 2019, the Commission lays down policies for maintaining high quality and high standards in medical education and for regulating medical institutions, medical research and medical professionals. It assesses the requirements in healthcare including human resources for health and healthcare infrastructure and develops a road map

for meeting such requirements. It ensures co-ordination among the four Autonomous Boards preventing regulatory fragmentation. It ensures compliance by State Medical Councils with the guidelines and regulations framed under the Act; State Medical Councils that fail to perform their statutory functions can be subject to central direction. It exercises appellate jurisdiction over decisions of the Autonomous Boards; a medical college denied permission by MARB can appeal to the full Commission. It lays down policies and codes to ensure observance of professional ethics in the medical profession and to promote ethical conduct during the provision of care by medical practitioners, discharged primarily through the Ethics and Medical Registration Board. It frames guidelines for determination of fees and all other charges in respect of fifty per cent of seats in private medical institutions and deemed universities, operationalising the constitutional goal of ensuring that medical education is not prohibitively expensive.

The Ethics and Medical Registration Board is mandated to maintain an online, publicly accessible, Aadhaar-linked National Medical Register containing the name, address, qualifications and registration number of every licensed medical practitioner in India. Each registrant is assigned a Unique Permanent Registration Number which must be displayed in the clinic and on all prescriptions. The NMR serves three critical functions. Employers including hospitals, insurance companies and government agencies can instantly verify whether a person claiming to be a doctor is lawfully registered. The register records suspensions and cancellations, preventing a doctor penalised in one state from relocating and practising in another. Patients can ascertain their doctor's credentials.

For the practising doctor and hospital administrator, the most significant change from the MCI regime to the NMC regime is enhanced accountability through Aadhaar-linked UPRN and the centralised disciplinary database. A suspension by the Karnataka Medical Council is now immediately visible to the Delhi Medical Council and to any employer conducting a verification check. The NMC Registered Medical Practitioner Regulations, 2023 consolidate and update the 2002 regulations and introduce new provisions on social media conduct and digital prescribing.

3.4 THE PHYSICIAN-PATIENT RELATIONSHIP: FIDUCIARY FOUNDATIONS

The physician-patient relationship is not merely contractual. While a contract may exist where the patient agrees to pay fees and the doctor agrees to provide treatment, the law superimposes upon this contract a set of duties derived from the fiduciary nature of the relationship. A fiduciary is a person who holds something in trust for another. The patient entrusts their body, their secrets and their life to the physician. This trust creates obligations that cannot be waived by agreement and that exceed those found in ordinary commercial relationships. Courts in India have repeatedly characterised the physician-patient relationship as fiduciary requiring the doctor to act in the best interests of the patient and not in their own financial or professional interest, as confidential where information disclosed within the relationship is presumptively protected from disclosure to third parties, and as unequal where the doctor possesses specialised knowledge and the patient is dependent on the doctor's advice, requiring the law to protect the weaker party.

The duties of a physician towards a patient arise from four distinct legal sources. Contract gives rise to express or implied agreement; breach provides remedy of damages or consumer complaint for deficiency in service. Tort gives rise to breach of duty of care imposed by law; remedy is compensation under Law of Torts for negligent diagnosis or treatment.

Constitutional law under Article 21 gives rise to right to life; remedy is writ petition or constitutional tort compensation for denial of emergency care in government hospitals. Statutory and regulatory law under NMC Code of Conduct and State Medical Council jurisdiction gives rise to professional discipline; remedy is disciplinary action, suspension or cancellation of licence for breach of confidentiality or prescribing for personal gain.

No medical treatment may be administered to a competent adult patient without that patient's informed consent. This principle transforms the relationship from one of paternalism where doctor knows best to one of shared decision-making. The legal requirement of informed consent has four dimensions. Consent must be free from coercion, fraud or undue influence; consent obtained by a doctor who threatens to withhold emergency care unless the patient agrees to an additional procedure is invalid. The patient must possess the mental capacity to understand the nature, purpose, consequences and risks of the proposed treatment; patients who are unconscious, intellectually disabled or minors lack capacity and consent must be obtained from a legally authorised representative. The physician must disclose the diagnosis being the nature of the condition, the proposed treatment being what will be done, the material risks being significant or common risks that a reasonable patient would consider relevant, the alternatives including the option of no treatment, and the prognosis being likely outcome with and without treatment. The patient must actively consent; silence or mere compliance with a procedure is not valid consent.

In assessing whether a doctor has adequately informed a patient, Indian courts apply the modified Bolam test. A doctor is not negligent if their disclosure practice is in accordance with a responsible body of medical opinion. However, the Supreme Court in Samira Kohli v. Prabha Manchanda clarified that there are core disclosures including the nature of procedure, its purpose and material risks that cannot be omitted even if a body of medical opinion would omit them.

Regulation 2.2 of the Code of Medical Ethics Regulations, 2002 states that confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the State. The exceptions to confidentiality are patient consent where implied or express authorisation permits sharing records with another treating doctor, legal compulsion where statutory mandate requires notification of birth or death, infectious disease reporting or court order, public interest as established in Mr X v. Hospital Z where disclosure is permitted to protect identifiable third party from serious imminent harm, and research where ethics committee approval is obtained for anonymised data for medical research. The hospital administrator must ensure that every patient-facing document including consent forms, admission forms and patient information leaflets clearly explains what information will be collected, for what purposes it will be used, to whom it may be disclosed, the patient's right to access their records, and the complaint mechanism for breach of confidentiality.

3.5 DUTIES OF MEDICAL AND PARAMEDICAL STAFF

Duties of Registered Medical Practitioners under the Code of Medical Ethics Regulations, 2002

Every physician shall uphold the dignity and honour of the profession. The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate

consideration. The physician shall be an upright man, instructed in the art of healing, pure in character, diligent in caring for the sick, modest, sober, patient and prompt in discharging duty without anxiety.

Every physician shall maintain medical records of indoor patients for a period of three years from the commencement of treatment in the standard proforma prescribed by the Medical Council of India. If a request is made for medical records by the patient, authorised attendants or legal authorities, the documents shall be issued within seventy-two hours of the request. A registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued including identification marks of the patient and shall keep a copy of each certificate.

Every physician shall display the registration number accorded by the State Medical Council or NMC in the clinic and on all prescriptions, certificates and money receipts. Physicians shall display as suffix to their names only recognised medical degrees or such certificates, diplomas, memberships or honours which confer professional knowledge or recognise exemplary achievement.

Every physician should, as far as possible, prescribe drugs with generic names and shall ensure that there is a rational prescription and use of drugs. This provision implements the national policy objective of containing healthcare costs and reducing the influence of pharmaceutical marketing on prescribing behaviour.

A physician should announce fees before rendering service. It is unethical to enter into a contract of no cure no payment. This protects the fiduciary nature of the relationship: the physician is paid for their effort and skill, not for a guaranteed outcome.

No physician shall arbitrarily refuse treatment to a patient. While a physician is free to choose whom he will serve, he should respond to any request for his assistance in an emergency. Once having undertaken a case, the physician shall not neglect the patient nor withdraw without giving adequate notice.

Unnecessary consultations should be avoided. Consulting pathologists, radiologists or requesting other diagnostic laboratory investigations should be done judiciously and not in a routine manner. This provision targets defensive medicine and fee-splitting arrangements.

Duties of Paramedical and Administrative Staff

While the MC regulations directly bind only registered medical practitioners, hospitals as employers are vicariously liable for the acts and omissions of their staff. Nursing staff duties derived from the Indian Nursing Council Act, 1947 and State Nursing Council regulations include accurate administration of medications as prescribed, continuous monitoring and documentation of patient vital signs, immediate reporting of any deterioration or adverse events to the treating physician, maintenance of patient dignity and privacy during procedures, and proper handling and disposal of biomedical waste.

Pharmacists under the Pharmacy Act, 1948 and the Drugs and Cosmetics Act, 1940 are required to dispense only against valid prescription from registered medical practitioner, verify prescription completeness including doctor's signature, registration number and date, counsel

patients on dosage, administration and potential side effects, maintain records of narcotic and psychotropic substances, and not dispense scheduled drugs without prescription.

Technical staff in radiology and laboratory are required to perform investigations only on requisition from registered medical practitioner, ensure quality control and equipment calibration, maintain confidentiality of all patient reports, adhere to radiation safety protocols for radiography, and maintain proper labelling and chain of custody for forensic samples.

Administrative and front office staff, while not directly involved in clinical care, are the first point of contact and must be trained in emergency admission protocols that no patient shall be refused admission or asked to complete financial formalities before stabilisation, confidentiality that patient registration data, diagnosis and billing information are protected health information and must not be disclosed without consent, and medical records that proper indexing, storage and retrieval and timely response to patient requests for records are mandatory.

3.6 MEDICAL ETHICS, OATHS AND CODE OF CONDUCT

The ethical regulation of medicine in India is not a recent import. The Charaka Samhita, composed approximately two millennia ago, enjoined physicians to be compassionate to all creatures, devoted to truth, free from anger and envy, calm, pleasant in speech and pure. Upon entering practice, the physician took a solemn vow before the assembled community. The modern statutory framework began with Section 20A of the Indian Medical Council Act, 1956 inserted by amendment in 1964 which empowered the Medical Council of India to prescribe standards of professional conduct and etiquette and a code of ethics for medical practitioners and to specify which violations constitute professional misconduct. The Code of Medical Ethics Regulations, 2002 remains the foundational document, amended multiple times most substantively in 2016 with restrictions on pharmaceutical gifts and in 2019. In 2023, the NMC published the Registered Medical Practitioner Regulations which consolidate and update the 2002 regulations, incorporate the Physician's Pledge based on the WMA Declaration of Geneva, and introduce new provisions on social media conduct and digital prescribing.

Every applicant for registration under the NMC Act must submit a duly signed declaration in the form of the Physician's Pledge. The pledge states: I solemnly pledge myself to consecrate my life to the service of humanity; I will give to my teachers the respect and gratitude which is their due; I will practise my profession with conscience and dignity; the health of my patient will be my first consideration; I will respect the secrets which are confided in me; I will maintain by all the means in my power the honour and noble traditions of the medical profession; my colleagues will be my sisters and brothers; I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat; I make these promises solemnly, freely and upon my honour. This pledge is not merely ceremonial but is a legally enforceable undertaking; violation of its principles including discrimination, breach of confidentiality and misuse of medical knowledge for harm constitutes professional misconduct.

Medical ethics in India as codified in the NMC regulations rests on four foundational principles. Beneficence requires the physician to act in the best interest of the patient. Every clinical decision, every prescription, every referral must be directed towards the patient's welfare. Financial considerations, institutional convenience or personal reputation are subordinate. Regulation 1.1.2 explicitly states that the prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Non-maleficence or primum non nocere means first, do no harm. This principle prohibits not only intentional harm but also negligence, recklessness and the continuation of treatment that is no longer beneficial. It requires the physician to maintain competence, to recognise the limits of their expertise and to refer to specialists when necessary. Autonomy means the competent adult patient has the right to accept or reject any medical treatment, even if that decision appears irrational to the physician. Autonomy is the ethical foundation of informed consent and also underpins the right to access medical records, the right to seek a second opinion and the right to refuse participation in research. Justice requires that the physician must not discriminate on grounds of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing. Resources must be allocated fairly; emergency care must be provided irrespective of ability to pay.

The Code of Conduct contains key prohibitions. Adulteration of drugs under Regulation 1.1.4 means prescribing or dispensing spurious drugs endangers patients and undermines public trust. Association with unqualified persons under Regulation 1.6 means permitting unregistered persons to attend or treat patients and covering for quacks. Fee splitting or commission under Regulation 6.1.1 means accepting commission for referral of patients or for prescribing particular products. Over-prescribing or irrational use under Regulation 1.5 means prescribing excessive or unnecessary medication for commercial gain. Sexual misconduct under Regulation 7.6 means exploiting the physician-patient relationship for sexual gratification. False, misleading or improper certificates under Regulation 7.7 means issuing certificates without personal examination or certifying what is not true. Advertising or soliciting patients under Regulation 6.1.1 means self-aggrandisement, canvassing or making exaggerated claims of success. Disparaging colleagues under Regulation 7.1 means making unfounded statements that undermine patient confidence in another practitioner. Violation of PCPNDT Act under Regulation 1.9 means sex determination or disclosure of foetal sex.

Regulation 7.7 states that a physician shall not give any false, misleading or improper certificate. In October 2023, the Delhi High Court considered a case where three doctors issued medical certificates without personally examining the patients. The Uttar Pradesh State Medical Council issued a warning; the doctors challenged this and the NMC contended that the only punishment for issuing a false certificate is removal from the register. The High Court held that Regulation 8.2 empowers the Council to impose any punishment as is deemed necessary, not only removal. The court's interpretation preserves the discretion of disciplinary bodies to impose proportionate sanctions from warning to permanent erasure.

3.7 PROFESSIONAL MISCONDUCT AND DISCIPLINARY JURISDICTION

The NMC Act, 2019 does not exhaustively define professional misconduct. Instead, it empowers the Ethics and Medical Registration Board to specify by regulations which violations constitute infamous conduct in any professional respect. The Code of Medical Ethics Regulations, 2002 enumerates specific offences deemed to constitute professional misconduct including contravening any provision of the regulations, adulteration of drugs, covering for unqualified persons, commission or fee splitting, conviction by a court of law for an offence

involving moral turpitude, sexual harassment of patients or colleagues, and issuing false certificates.

Every registered medical practitioner is registered with the State Medical Council of the state in which they reside or primarily practise. Complaints against a practitioner must first be filed with the State Medical Council. The Council examines the complaint, may conduct an inquiry and if prima facie misconduct is established, issues a show-cause notice. After affording an opportunity of hearing, the Council may exonerate the practitioner, issue a warning or censure, suspend registration for a specified period, or cancel registration resulting in permanent removal. The Ethics and Medical Registration Board exercises appellate jurisdiction over orders of State Medical Councils. A practitioner aggrieved by suspension or cancellation may appeal to the NMC within sixty days. The Board may confirm, modify or reverse the order. The Board also has suo motu power to take cognisance of misconduct in exceptional circumstances particularly where the State Medical Council has failed to act, the misconduct involves practitioners in multiple states, or the matter raises a substantial question of professional ethics requiring uniform national standard. The full Commission hears appeals against decisions of the Autonomous Boards; a practitioner whose registration has been cancelled by the Ethics Board may appeal to the Commission.

Invalid disciplinary inquiry under NMC or State Medical Council jurisdiction must adhere to principles of natural justice. Specific allegations must be communicated in writing to the practitioner through a notice of charges. All documents and statements relied upon must be disclosed. The practitioner may submit a written explanation, engage legal counsel, cross-examine witnesses and present evidence. The decision must be in writing, addressing each charge and the evidence adduced. The order must be communicated to the practitioner with reasons.

The punishments that may be imposed are warning or censure which is a reprimand recorded in disciplinary history with no restriction on practice but remains permanent record, suspension which prohibits the practitioner from practising medicine for a specified period such as three months or one year, and removal or cancellation where the name is permanently removed from the register and the practitioner may apply for restoration after prescribed period usually three to five years. Section 32 of the NMC Act, 2019 provides that a medical practitioner convicted by a court of law for an offence under the Act or any other offence involving moral turpitude shall be automatically suspended from the date of conviction until the disciplinary authority passes further orders. This is a significant deterrent as conviction itself triggers immediate professional consequences.

3.8 CONTEMPORARY CHALLENGES: DATA PROTECTION AND DIGITAL ETHICS

The collection, storage and processing of health data have undergone revolutionary change. Paper medical records accessible only within the physical confines of a hospital have been replaced by electronic medical records accessible across multiple facilities, telemedicine platforms storing audio and video consultations, mobile health applications tracking diet, exercise, sleep and vital signs, wearable devices transmitting continuous physiological data, cloud storage with third-party vendors, and artificial intelligence tools analysing large datasets for research and personalised medicine. This transformation creates immense opportunities for improved diagnosis, treatment and public health surveillance. It also creates unprecedented risks to patient privacy.

The Digital Personal Data Protection Act, 2023 is India's first comprehensive cross-sectoral data protection legislation. It replaces the Information Technology Act, 2000 and the Sensitive Personal Data or Information Rules, 2011 which were inadequate to protect health data. Under Section 6, consent must be free, specific, informed, unconditional and unambiguous with clear affirmative action. Patient consent for processing health data must be obtained separately for each purpose; bundled consent is invalid. Under Section 5, the data fiduciary must provide notice containing description of personal data and purpose of processing. Hospitals must provide clear, accessible privacy notice at point of data collection. Under Section 7, data may be processed without consent in specified circumstances including medical emergency, epidemic or outbreak, and public health threat. Emergency treatment is not to be delayed for consent formalities. Under Section 10, the government may notify entities meeting threshold as Significant Data Fiduciary; large hospital chains, insurers and health-tech platforms are likely to be designated SDF and must undertake Data Protection Impact Assessment and appoint Data Protection Officer. Data Principal rights include right to access, correction, erasure and grievance redressal; patients can demand access to digital health records.

The DPDP Act, 2023 has been criticised for reducing the level of protection previously proposed in the Personal Data Protection Bill, 2019. There is no definition of sensitive personal data; the Act does not distinguish between ordinary personal data and sensitive health data and all data receives same level of protection. Unlike the 2019 Bill which required explicit consent for processing sensitive data, the 2023 Act permits processing when data is voluntarily provided. The Act does not restrict processing of health data for commercial purposes nor does it mandate that health data be used only in the data principal's best interest or for direct care. Patients cannot demand transfer of their health records from one healthcare provider to another in interoperable format. The Act does not provide for compensation to data principals harmed by data breach; remedies lie under other laws.

The Telemedicine Practice Guidelines issued jointly by the NMC and the Ministry of Health in March 2020 provide the regulatory framework for remote consultation. Key ethical provisions include that the registered medical practitioner must be registered with NMC or State Medical Council to prevent unqualified persons from offering teleconsultation, patient identity and consent must be verified as informed consent extends to remote care, video consultation is preferred while audio only is permissible in follow-ups and text only in limited circumstances to ensure standard of care is not diluted by medium, prescription must contain doctor's registration number and superscription telemedicine consultation for transparency and pharmacy verification, no controlled substances under Schedule X are to be prescribed for patient safety and abuse prevention, and emergency cases must be referred for physical consultation as telemedicine cannot substitute emergency stabilisation. The Guidelines explicitly state that the same ethical duties of confidentiality, informed consent and non-abandonment apply to telemedicine as to in-person care. Technology is a medium, not an excuse for lower standards.

The NMC Registered Medical Practitioner Regulations, 2023 introduce specific provisions on digital professionalism. A physician shall not solicit patients through social media platforms or engage in self-aggrandisement through exaggerated claims of success rates. Patient testimonials, photographs or clinical images shall not be published without the patient's explicit, informed, written consent. Anonymising images by blurring eyes does not constitute sufficient anonymisation; facial recognition and contextual details may still identify the patient. Responding to online reviews, particularly negative reviews, must be done without breaching

patient confidentiality. A physician cannot disclose protected health information in defence of their reputation.

The integration of AI into clinical decision-making raises novel ethical questions for which the current Code of Conduct provides no explicit guidance. Emerging consensus reflected in NMC advisories and international declarations includes that AI tools are decision-support systems and the ultimate clinical responsibility rests with the registered medical practitioner, patients should be informed when AI is used in their diagnosis or treatment planning, AI models trained on homogeneous datasets may produce biased outcomes for under-represented populations and physicians must be aware of limitations, and AI development requires large datasets and patient data used for algorithm training must be obtained with valid consent or ethics committee waiver and must be anonymised. The NMC constituted an Artificial Intelligence and Digital Ethics Committee in 2024 to develop supplementary guidelines expected in 2026.

3.9 STUDENT LEARNING ACTIVITIES

Activity 1: Confidentiality Audit and Policy Drafting

You are the Administrator of a two hundred bed corporate hospital. A patient has complained that their diagnosis of HIV was disclosed by a receptionist to their employer who called to verify medical leave. The receptionist believed they were just confirming the doctor's note. Examine your hospital's current patient confidentiality policy. Draft a one-page Patient Confidentiality Policy suitable for display in patient areas and inclusion in the staff handbook. Your policy must address what constitutes protected health information, who is authorised to access such information, circumstances under which disclosure is permitted without consent, procedure for valid consent to disclosure, and consequences of unauthorised disclosure. Additionally, prepare a staff training module outline specifying which categories of staff require differentiated training content.

Activity 2: Informed Consent Form Redesign

Obtain a consent form currently in use at any hospital or use the specimen provided in Appendix 3 of the Code of Medical Ethics Regulations, 2002. Critically evaluate the form against the legal requirements of informed consent established in Samira Kohli v. Prabha Manchanda. Assess whether the procedure is described in lay language, whether material risks are disclosed, whether alternatives including no treatment are mentioned, whether there is separate consent for photography, research and teaching, whether there is a provision for indicating that the patient has had an opportunity to ask questions, and whether the form is available in the patient's language. Redesign the form to address identified deficiencies. Your redesigned form should be no longer than two pages and should be comprehensible to a person with limited literacy, considering pictograms or simple language.

Activity 3: Ethical Dilemma Case Analysis

You are the Hospital Administrator. A forty-five year old patient, Mr A, is admitted with advanced liver disease and requires a liver transplant. His twenty-two year old son, Mr B, is a willing living donor. During the pre-transplant workup, Mr B is discovered to be HIV positive. He is unaware of his status and has never been tested before. The transplant surgeon proposes to disclose Mr B's status to Mr A on the ground that Mr A has a right to know the risk of receiving an organ from an HIV positive donor. Mr B has not consented to this disclosure.

Analyse this dilemma from the perspective of duty of confidentiality owed to Mr B under NMC Regulation 2.2, duty of candour owed to Mr A regarding informed consent and material risk, and the public interest exception established in Mr X v. Hospital Z. What course of action would you advise? Provide reasons and identify the legal and ethical principles that support your recommendation.

Activity 4: Disciplinary Proceedings Simulation

Dr Sharma, a gynaecologist, is accused by a patient of making inappropriate sexual advances during a consultation. The patient has filed a complaint with the State Medical Council. Dr Sharma denies the allegation and claims the patient is vindictive because he refused to issue a false medical certificate. As the Registrar of the State Medical Council, draft a show-cause notice to Dr Sharma specifying the charges and calling for his explanation. Draft a checklist of procedural safeguards that must be observed during the disciplinary inquiry to comply with principles of natural justice. Draft a template for the final reasoned order structured to address each charge, evaluate evidence and provide findings with reasons.

3.10 SUMMARY

The National Medical Commission established under the NMC Act, 2019 is the apex regulatory body for medical education and medical profession in India. It operates through four Autonomous Boards: UGMEB, PGMEB, MARB and EMRB which is responsible for maintaining the National Medical Register and adjudicating professional misconduct. The NMC replaces the Medical Council of India with a more transparent, accountable structure incorporating non-medical expertise and centralised disciplinary oversight.

The physician-patient relationship is fiduciary, a relationship of trust and confidence that imposes duties beyond those of ordinary contract. These duties include the duty to obtain informed consent, the duty of confidentiality, the duty to treat in emergencies and the duty to avoid conflicts of interest. The fiduciary character of the relationship has been repeatedly affirmed by the Supreme Court and is codified in the NMC Code of Conduct.

Informed consent is the legal expression of patient autonomy. Consent must be voluntary, given by a person with capacity, based on adequate information and actively communicated. The Samira Kohli standard requires disclosure of the nature, purpose, material risks and alternatives of the proposed treatment. Consent is not a single event but an ongoing process.

Confidentiality is a core ethical duty but it is not absolute. The Supreme Court in Mr X v. Hospital Z recognised a public interest exception disclosure is permitted to protect an identifiable third party from serious imminent harm. The Digital Personal Data Protection Act, 2023 now provides a statutory framework for processing health data, requiring consent, notice and security safeguards.

The duties of medical staff are codified in the NMC Regulations. These include maintenance of medical records for three years to be issued within seventy-two hours, display of registration number, generic prescribing, prohibition of no cure no payment contracts, and the absolute duty to treat emergencies. Paramedical and administrative staff are not directly bound by NMC regulations but are vicariously covered through hospital liability; their duties derive from professional council codes, employer policies and general law.

The Physician's Pledge is the modern equivalent of the Hippocratic Oath. Every registered practitioner must submit a signed pledge. Its principles of service to humanity, patient welfare as first consideration, respect for secrets and non-discrimination are legally enforceable standards of conduct.

The Code of Medical Ethics Regulations, 2002 as amended remains the foundational document, supplemented by the NMC Registered Medical Practitioner Regulations, 2023. The Code prohibits fee-splitting, advertising, association with unqualified persons, false certification, sexual misconduct and irrational prescribing. Each prohibition is backed by disciplinary jurisdiction.

Professional misconduct is adjudicated by State Medical Councils in the first instance with appeal to the NMC Ethics Board. Disciplinary proceedings must adhere to principles of natural justice: notice, disclosure, opportunity to defend and reasoned order. Punishments range from warning to permanent removal from the register. Conviction of an offence involving moral turpitude triggers automatic suspension under Section 32 of the NMC Act.

Contemporary challenges include the ethical regulation of telemedicine, social media conduct, artificial intelligence and the protection of digital health data. The Telemedicine Practice Guidelines extend traditional ethical duties to remote care. The NMC 2023 Regulations impose strict limits on patient testimonials and online solicitation. The DPDP Act, 2023 establishes a consent-based framework for data processing but has significant gaps in health data protection.

The hospital administrator is the custodian of institutional ethics. While individual doctors are regulated by their professional councils, the hospital as an institution is responsible for creating an environment where ethical practice is enabled and enforced through policies, training, audit and accountability mechanisms. A breach of medical ethics is almost invariably a failure of hospital administration as well.

3.11 KEY WORDS WITH EXPLANATIONS

National Medical Commission: is the statutory body established under the NMC Act, 2019 replacing the Medical Council of India. It is responsible for regulating medical education, medical institutions and medical professionals and operates through four Autonomous Boards: the Under-Graduate Medical Education Board, the Post-Graduate Medical Education Board, the Medical Assessment and Rating Board, and the Ethics and Medical Registration Board.

Ethics and Medical Registration Board is one of the four Autonomous Boards of the NMC responsible for maintaining the National Medical Register which is Aadhaar-linked and publicly accessible, and for adjudicating cases of professional misconduct. It exercises appellate jurisdiction over State Medical Council orders and has the power to suspend or cancel registration of medical practitioners.

National Medical Register is the publicly accessible online database of all registered medical practitioners in India. Each practitioner is assigned a Unique Permanent Registration Number that must be displayed on prescriptions and clinic signboards. The register records disciplinary history including suspensions and cancellations, preventing a doctor penalised in one state from relocating and practising in another.

Fiduciary Relationship is a relationship of trust and confidence where one party, the physician, is entrusted with the interests of another party, the patient. The fiduciary owes duties of loyalty, care and confidentiality that exceed ordinary contractual obligations. The physician must act in the best interests of the patient, not in their own financial or professional interest.

Informed Consent is the voluntary authorisation by a patient for medical treatment given after adequate disclosure of the diagnosis, nature of treatment, material risks, alternatives and prognosis. Consent is invalid if obtained by coercion, fraud or without capacity. For major surgical procedures, consent must be specific and in writing. Consent to a diagnostic procedure does not imply consent to therapeutic intervention.

Confidentiality is the ethical and legal duty of a physician to protect information disclosed by the patient within the professional relationship. The duty is not absolute and exceptions include patient consent, legal compulsion such as notifiable diseases and court orders, and public interest where disclosure is necessary to protect an identifiable third party from serious imminent harm as established in Mr X v. Hospital Z.

Professional Misconduct is conduct of a registered medical practitioner that violates the standards of professional conduct and etiquette prescribed by the NMC. It includes both acts of commission such as false certification, fee-splitting and sexual harassment, and acts of omission such as failure to maintain medical records, abandonment of patient and failure to display registration number.

Code of Medical Ethics Regulations, 2002 is the principal delegated legislation specifying the duties, conduct and prohibited practices for medical practitioners. It remains in force under the NMC Act, 2019 and has been supplemented by the NMC Registered Medical Practitioner Regulations, 2023 which consolidate and update the provisions and introduce new regulations on social media conduct and digital prescribing.

Physician's Pledge is the modern version of the Hippocratic Oath adopted by the World Medical Association as the Declaration of Geneva. It is mandatory for all applicants for medical registration in India and constitutes a legally enforceable undertaking. Violation of its principles including discrimination, breach of confidentiality and misuse of medical knowledge for harm constitutes professional misconduct.

State Medical Council is the statutory body at State level responsible for registration of medical practitioners and initial adjudication of professional misconduct. Every registered medical practitioner is registered with the State Medical Council of the state in which they reside or primarily practise. Appeals against orders of the State Medical Council lie to the NMC Ethics Board within sixty days.

Automatic Suspension under Section 32 is the provision of the NMC Act, 2019 whereby a medical practitioner convicted by a court of law for an offence under the Act or any other offence involving moral turpitude stands automatically suspended from the date of conviction until the disciplinary authority passes further orders. The suspension operates by operation of law and no separate order is required.

Telemedicine Practice Guidelines, 2020 are the joint guidelines of the NMC and Ministry of Health and Family Welfare regulating remote consultation. They require registered practitioner status, patient verification, informed consent and restrict prescribing of controlled

substances. The same ethical duties of confidentiality, informed consent and non-abandonment apply to telemedicine as to in-person care.

Digital Personal Data Protection Act, 2023 is India's cross-sectoral data protection law regulating processing of digital personal data based on consent or legitimate uses. Health data is not separately classified as sensitive personal data and the level of protection is lower than previously proposed. Hospitals as data fiduciaries must obtain consent, provide notice and implement security safeguards.

Beneficence is the ethical principle requiring physicians to act in the best interest of the patient. Every clinical decision, prescription and referral must be directed towards patient welfare. Financial considerations, institutional convenience and personal reputation are subordinate considerations. The prime object of the medical profession is to render service to humanity.

Non-Maleficence is the ethical principle requiring physicians to avoid causing harm. Primum non nocere or first do no harm prohibits not only intentional harm but also negligence, recklessness and the continuation of treatment that is no longer beneficial. It requires the physician to maintain competence, recognise the limits of their expertise and refer to specialists when necessary.

Autonomy is the ethical principle recognising the right of competent adult patients to make informed decisions about their own medical care including the right to accept or refuse treatment. It is the ethical foundation of informed consent and also underpins the right to access medical records, the right to seek a second opinion and the right to refuse participation in research.

Justice is the ethical principle requiring fair distribution of healthcare resources and non-discrimination in access to care. The physician must not discriminate on grounds of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing. Emergency care must be provided irrespective of ability to pay.

3.12 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What are the four Autonomous Boards of the National Medical Commission and which Board is responsible for professional ethics and registration?

Ans. The four Autonomous Boards are the Under-Graduate Medical Education Board, the Post-Graduate Medical Education Board, the Medical Assessment and Rating Board, and the Ethics and Medical Registration Board. The Ethics and Medical Registration Board is responsible for maintaining the National Medical Register, regulating professional conduct and adjudicating cases of professional misconduct.

Q2. What is the legal status of the Physician's Pledge in India?

Ans. The Physician's Pledge is a legally enforceable undertaking. Every applicant for registration under the NMC Act, 2019 must submit a duly signed pledge. Violation of its principles including discrimination, breach of confidentiality or misuse of medical knowledge

constitutes professional misconduct and invites disciplinary action by the State Medical Council or NMC Ethics Board.

Q3. State the three core exceptions to the duty of medical confidentiality recognised in Indian law.

Ans. The three recognised exceptions are patient consent which is express or implied authorisation to disclose, legal compulsion which includes statutory reporting requirements for birth, death and infectious diseases or court order, and public interest which permits disclosure to protect an identifiable third party from serious imminent harm as established in Mr X v. Hospital Z.

Q4. Under Regulation 1.3 of the Code of Medical Ethics Regulations, 2002, for how long must medical records of indoor patients be maintained and within what time must records be provided to the patient upon request?

Ans. Medical records of indoor patients must be maintained for a period of three years from the commencement of treatment. Upon request by the patient, authorised attendant or legal authorities, the records must be issued within seventy-two hours of the request.

Q5. What is the effect of Section 32 of the NMC Act, 2019 on a medical practitioner convicted by a court of law?

Ans. Section 32 provides for automatic suspension. A medical practitioner convicted by a court of law for an offence under the NMC Act or any other offence involving moral turpitude stands suspended from the date of conviction until the disciplinary authority passes further orders. The suspension is automatic and no separate order is required.

B. Essay Type Questions with Hints

Q1. The physician-patient relationship is fiduciary in character. Critically examine this statement with reference to the duties of confidentiality, informed consent and conflict of interest under the NMC Code of Medical Ethics Regulations.

Hints: Define fiduciary relationship as one of trust, confidence, unequal bargaining power and vulnerability. Explain confidentiality as fiduciary duty under Regulation 2.2 with the public interest exception from Mr X v. Hospital Z. Explain informed consent as expression of autonomy under the Samira Kohli standard requiring disclosure of nature, purpose, material risks and alternatives. Explain conflict of interest under Regulation 6.1.1 prohibiting fee-splitting, Regulation 1.8 prohibiting no cure no payment contracts, and Regulation 1.5 requiring generic prescribing. Conclude that fiduciary character transforms contract into relationship of trust and NMC regulations operationalise fiduciary duties into enforceable standards.

Q2. Discuss the structure, powers and functions of the Ethics and Medical Registration Board under the NMC Act, 2019. How does it differ from the disciplinary mechanism under the previous MCI regime?

Hints: Explain composition including President EMRB, part-time members and ex-officio members. Explain functions under Section 10 including maintenance of National Medical

Register, regulation of professional conduct and promotion of ethics, and appellate jurisdiction over State Medical Councils. Explain powers including adjudication of misconduct, suspension and cancellation of registration, and recognition of foreign qualifications. Explain differences from MCI including Aadhaar-linked publicly accessible centralised register, explicit codification of appellate jurisdiction, inclusion of non-medical members in disciplinary process, and automatic suspension under Section 32. Discuss challenges including backlog of complaints, variance in State Council capacities and need for uniform standards.

Q3. Analyse the legal and ethical framework governing consent for medical treatment in India. Refer to statutory provisions, judicial precedents and NMC regulations.

Hints: Distinguish consent as battery where no consent obtained versus negligence where consent is inadequate but information insufficient. Explain elements of voluntariness, capacity, information and authorisation. Discuss standard of disclosure under modified Bolam test where responsible body of medical opinion is the benchmark but core disclosures are non-waivable. Explain exceptions including emergency where consent is presumed, therapeutic privilege limited, and waiver. Discuss documentation requirements under Regulation 1.3 and that consent form is not substitute for consent process. Discuss recent developments including digital consent under Telemedicine Guidelines and data consent under DPDP Act, 2023.

Q4. What constitutes professional misconduct under the NMC Code of Medical Ethics Regulations? Discuss the disciplinary procedure and the range of punishments that may be imposed by State Medical Councils and the NMC Ethics Board.

Hints: Categorise misconduct into clinical negligence repeated and gross, boundary violations including sexual misconduct, financial impropriety including fee-splitting and over-prescribing, certification offences including false certificates, association with unqualified persons, and breach of confidentiality. Explain procedure from complaint, preliminary scrutiny, show-cause notice, inquiry adhering to principles of natural justice, to reasoned order. Explain punishments of warning, censure, suspension temporary, and removal permanent. Explain appeal from State Medical Council to NMC Ethics Board within sixty days and then to NMC full Commission. Explain automatic suspension under Section 32 on criminal conviction.

Q5. Examine the adequacy of the Digital Personal Data Protection Act, 2023 in protecting patient health data. What gaps remain and how should hospital administrators address them pending legislative reform?

Hints: Discuss positive features including consent requirement under Section 6, notice under Section 5, legitimate uses for medical emergency under Section 7, and security safeguards. Discuss critical gaps including no separate classification of sensitive health data, no requirement of explicit consent for health data, commercial use permitted, no right to data portability, no compensation mechanism for data principals, and broad exemptions for government agencies. Recommend hospital administrator actions including adoption of NABH data privacy standards, implementation of ISO 27799 for health informatics, contractual clauses with vendors binding them to equivalent standards, patient privacy policies, staff training on data protection, and breach response protocol. Conclude that ethical obligation requires treating health data as sensitive even if statute does not, and transparency with patients about data processing practices.

C. Analytical Multiple Choice Questions

1. Under the NMC Act, 2019, which Autonomous Board is responsible for conducting inspections of medical colleges and granting permissions for establishment of new medical institutions?
a) Under-Graduate Medical Education Board
b) Post-Graduate Medical Education Board
c) Medical Assessment and Rating Board
d) Ethics and Medical Registration Board
Correct Answer: c) Medical Assessment and Rating Board

2. In Mr X v. Hospital Z, the Supreme Court held that disclosure of a patient's HIV status to his fiancée's family was:
a) Unethical and constituted professional misconduct
b) A violation of Article 21 and entitled the patient to compensation
c) Justified in public interest to protect an identifiable third party from imminent harm
d) Permissible only with prior authorisation from the State Medical Council
Correct Answer: c) Justified in public interest to protect an identifiable third party from imminent harm

3. Regulation 1.5 of the Code of Medical Ethics Regulations, 2002 requires physicians to:
a) Prescribe only branded drugs to ensure quality control
b) Prescribe drugs with generic names wherever possible
c) Obtain prior approval from the State Medical Council before prescribing new drugs
d) Maintain a separate register for all prescriptions exceeding five thousand rupees
Correct Answer: b) Prescribe drugs with generic names wherever possible

4. Which of the following constitutes an exception to the requirement of informed consent under Indian law?
a) The patient is over sixty years of age
b) The patient belongs to a lower socio-economic stratum
c) Emergency treatment required to save life and patient is unconscious
d) The physician believes the treatment is in the patient's best interest
Correct Answer: c) Emergency treatment required to save life and patient is unconscious

5. Under Regulation 1.3 of the Code of Medical Ethics Regulations, 2002, medical records of indoor patients must be maintained for a minimum period of:
a) One year from discharge
b) Three years from commencement of treatment
c) Five years from discharge
d) Indefinitely permanent retention
Correct Answer: b) Three years from commencement of treatment

6. The Telemedicine Practice Guidelines, 2020 permit teleconsultation and e-prescribing subject to certain restrictions. Which of the following is NOT permitted under the Guidelines?
a) Video consultation with a known patient for follow-up of hypertension
b) Prescribing Schedule X narcotic or psychotropic drugs to a new patient
c) Audio consultation for an existing patient during COVID-19 lockdown
d) Text-based consultation for a minor ailment with patient identity verified

Correct Answer: b) Prescribing Schedule X narcotic or psychotropic drugs to a new patient

7. Section 32 of the NMC Act, 2019 provides for:
a) Compulsory continuing medical education for licence renewal
b) Automatic suspension of a medical practitioner upon conviction by a court of law
c) Establishment of the National Medical Register
d) Fee regulation in private medical colleges
Correct Answer: b) Automatic suspension of a medical practitioner upon conviction by a court of law

3.13 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Consultant, The Company and The Confidential File

CityCare Hospitals is a three hundred fifty bed corporate tertiary care hospital in Hyderabad, NABH accredited and empanelled under Ayushman Bharat PM-JAY. Dr Meera Krishnamurthy is a senior consultant oncologist registered with the Telangana State Medical Council, heading the Breast Oncology Unit with nine years of service at CityCare. Mr Rajesh Khanna is a fifty-two year old businessman and patient of Dr Meera for three years, diagnosed with carcinoma of the left breast, male breast cancer being rare but documented, and is currently on maintenance endocrine therapy. OncoRx India Private Limited is a pharmaceutical company specialising in oncology drugs that has recently launched a new oral targeted therapy for hormone-receptor-positive breast cancer and is in discussions with CityCare Hospitals for empanelment as a vendor.

On 12 February 2026, Dr Meera attended a continuing medical education programme sponsored by OncoRx India at a five-star hotel in Hyderabad where she was one of three guest speakers and received an honorarium of fifty thousand rupees deposited directly into her personal bank account. She did not declare this honorarium to the hospital administration nor seek prior approval for the speaking engagement. On 15 February 2026, the Regional Business Manager of OncoRx India emailed Dr Meera requesting a brief summary of her experience with the new molecule in her patient population for the company's internal dossier, stating that they understood she had a patient on compassionate use of their product and any anonymised case details would be very helpful. Dr Meera extracted Mr Rajesh Khanna's clinical summary from the hospital's electronic medical records, removed his name and address, but retained his age, occupation as businessman, stage of disease, treatment history and six-month follow-up data. She emailed this summary to the company from her personal Gmail account.

On 18 February 2026, the company's medical affairs team while preparing a marketing brochure included a testimonial stating: Dr Meera K, Senior Oncologist, CityCare Hospitals: Our patient, a fifty-two year old businessman, has shown excellent response to OncoRx therapy with minimal toxicity. The brochure was circulated at a trade exhibition in Mumbai. A relative of Mr Rajesh Khanna visiting the exhibition recognised the description, photographed the brochure and sent it to Mr Khanna. On 25 February 2026, Mr Khanna filed a formal complaint with the Medical Superintendent alleging breach of confidentiality as his clinical details were disclosed to a third party without consent, misuse of personal data as his health information was used for commercial purposes without authorisation, conflict of interest as Dr Meera received financial benefit from the same company to which she provided patient data, and defamation as the brochure implied he was a patient of CityCare Hospitals and OncoRx causing

him embarrassment and mental distress. He demanded a written apology, disciplinary action against Dr Meera and compensation of twenty-five lakh rupees.

The internal inquiry committee comprising the Deputy Medical Superintendent, Head of Medical Records and legal advisor found that Dr Meera had not obtained any consent from Mr Khanna for disclosure of his medical information to OncoRx India nor for use of his case details in marketing material. The hospital's standard consent form signed by Mr Khanna in 2023 contained a clause permitting use of anonymised data for research and academic purposes but not for commercial or marketing purposes. Removal of name and address was not sufficient anonymisation as the combination of age fifty-two, gender male, occupation businessman, diagnosis male breast cancer, treatment centre Hyderabad and treating oncologist Dr Meera was sufficient to identify the patient within the small community of male breast cancer survivors. The information was not truly anonymised but was pseudonymised and readily re-identifiable. Dr Meera had received an honorarium of fifty thousand rupees from OncoRx India for the CME lecture and the hospital's Conflict of Interest Policy required prior disclosure of all honoraria exceeding ten thousand rupees to the Medical Superintendent, prior approval for participation in industry-sponsored programmes where the doctor holds prescribing influence, and declaration of any financial relationship with vendors participating in hospital tenders or empanelment. Dr Meera had complied with none of these. She used her personal Gmail account to transmit patient data, circumventing the hospital's secure audited email system and its encryption protocols, violating the hospital's Information Security Policy and the IT Rules, 2021. The disclosure was not reviewed by the Institutional Ethics Committee or the Hospital Administrator and there was no documented assessment of the public interest or research merit of the disclosure.

The hospital imposed a penalty of withholding two months' incentive pay and issued a formal warning letter to be placed in her personnel file. The hospital reported the matter to the Telangana State Medical Council as required under its own policy for potential professional misconduct. Mr Khanna filed a separate complaint with the State Medical Council alleging breach of confidentiality under Regulation 2.2, violation of patient autonomy and professional misconduct. He filed a consumer complaint before the Telangana State Consumer Disputes Redressal Commission claiming deficiency in service and unfair trade practice against CityCare Hospitals and Dr Meera seeking twenty-five lakh rupees compensation. He filed a complaint with the Data Protection Board of India under the DPDP Act, 2023 alleging unauthorised processing of his personal data and the Board issued notice to CityCare Hospitals as the data fiduciary.

Questions for Analysis with Hints

Q1. Identify and discuss the provisions of the NMC Code of Medical Ethics Regulations that Dr Meera Krishnamurthy has violated. For each violation, cite the specific regulation and explain its application to the facts of this case.

Hints: Regulation 2.2 on confidentiality is violated by disclosure of patient information to third party without consent, inadequate anonymisation, and no consent for commercial use. Regulation 6.1.1 on fee-splitting and commission is violated by receiving fifty thousand rupees honorarium from company whose product she prescribes and not declaring the same. Regulation 1.3 on medical records is violated by improper handling of medical records, exporting records from EMR and transmitting via personal email with no audit trail. Regulation 1.1.2 on service before self is violated by subordinating patient welfare to commercial and

professional interest, accepting honorarium from vendor and using patient data for commercial purposes without authorisation. NMC 2023 Regulations on social media and testimonials are violated as marketing brochure contained identifiable patient description and Dr Meera's name was associated with testimonial without patient consent.

Q2. Critically evaluate the hospital's internal inquiry and the penalty imposed. Was the punishment proportionate to the misconduct? What additional or alternative actions should the Medical Superintendent have taken?

Hints: Strengths of hospital's response include prompt constitution of inquiry committee, documented findings with evidence, show-cause notice and opportunity of hearing afforded, and reporting to State Medical Council. Weaknesses include penalty of withholding two months' incentive pay being insufficient for breach of confidentiality, conflict of interest and policy violation. Recommended alternatives include suspension from headship of Breast Oncology Unit, mandatory ethics training, and probation period. No patient redressal was offered; hospital should have provided immediate written apology, waiver of outstanding bills and good-faith compensation offer. No systemic audit was conducted to examine how many similar undisclosed disclosures occurred. No reporting to NMC Ethics Board was done despite national implications. No data breach notification was made to Data Protection Board or affected patient.

Q3. Discuss the adequacy of the patient's consent obtained by CityCare Hospitals. What should a valid consent form for use of patient data for research, academic and commercial purposes contain? Draft a specific clause for the hospital's admission consent form addressing secondary use of data.

Hints: Deficiencies in existing consent include clause permitting use of anonymised data for research and academic purposes only, no definition of anonymised with standard not specified, no separate opt-in for commercial use, no explanation of how data will be used or with whom it may be shared, and no information about rights of access, correction or withdrawal. Valid consent clause must state that de-identified health information may be used for internal quality improvement, medical education and clinical research, define de-identification as removal of all direct identifiers including name, address, Aadhaar number, mobile number, email and IP address with no reasonable basis to identify patient, explicitly state that health information will not be used for commercial or marketing purposes nor shared with pharmaceutical companies 61 medical device companies without separate specific written consent, and affirm patient's right to refuse or withdraw consent for any secondary use without affecting access to treatment.

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Q4. Analyse the relationship between the NMC Code of Conduct, the Digital Personal Data Protection Act, 2023 and the Telemedicine Practice Guidelines, 2020 in the context of this case. Does the DPDP Act, 2023 provide Mr Khanna an effective remedy? What are its limitations?

Hints: NMC Code of Conduct is professional regulation providing disciplinary jurisdiction with remedy of complaint to State Medical Council leading to suspension or cancellation of licence but no compensation to patient and slow process. DPDP Act, 2023 is data protection regulation providing regulatory oversight with remedy of complaint to Data Protection Board leading to penalty on fiduciary hospital but no compensation to data principal and no private right of action. Consumer Protection Act, 2019 is civil remedy providing compensation with remedy of consumer complaint leading to compensation award but requires proof of deficiency

in service and litigation duration is lengthy. Law of Torts is civil remedy providing damages with remedy of civil suit for breach of confidentiality but is expensive, lengthy and uncertain. Strengths of DPDP Act include recognition of right to data protection as statutory right, mandatory consent for processing personal data, requirement of security safeguards, and Data Protection Board power to impose penalties up to two hundred fifty crore rupees. Weaknesses include no provision for compensation to data principal, no classification of health data as sensitive with enhanced safeguards, exemptions for research purposes where Dr Meera could argue disclosure was for research dossier, no right to data portability, and broad exemptions for government instrumentalities.

Q5. As the Medical Superintendent of CityCare Hospitals, prepare a comprehensive Policy on Engagement with Pharmaceutical and Medical Device Companies to prevent recurrence of such incidents. Your policy should address disclosure of financial relationships, prior approval for industry-sponsored events, use of patient data for commercial purposes, ethical prescribing and disciplinary consequences for non-compliance.

Hints: Policy must require every consultant to submit annual Declaration of Interests disclosing any paid position with healthcare company, honoraria exceeding ten thousand rupees per engagement, research grants, shareholding and hospitality accepted. Prior written approval from Medical Superintendent must be obtained for participation in industry-sponsored CME programmes, speaker engagements or advisory boards. Approval shall not be granted where programme is primarily promotional, venue is resort without educational justification, sponsor controls content, or doctor holds prescribing influence over sponsor's products. All honoraria shall be paid by account payee cheque or bank transfer to the institution, not to the individual practitioner, and credited to departmental research fund. No employee shall disclose any patient health information to any commercial entity without specific informed written consent of patient for that specific commercial use, prior review and approval by Institutional Ethics Committee, and documentation in medical record. Anonymisation is not sufficient for commercial disclosure. All prescribers shall as far as possible prescribe drugs by generic name. No employee shall accept any personal gift, cash or equivalent from any pharmaceutical or medical device company. Violation shall result in disciplinary action commensurate with gravity of offence including written warning, withholding of increments, suspension from administrative positions, dismissal from service, and reporting to State Medical Council for independent disciplinary action

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The health of my patient will be my first consideration.

— Physician's Pledge, National Medical Commission

LESSON-4

LESSON 4: CONTRACTS IN HOSPITAL SERVICES

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Explain the legal framework of the Indian Contract Act, 1872 and its application to hospital services and healthcare transactions
2. Identify and distinguish between the various types of contracts encountered in hospital administration
3. Analyse the ten essential requisites of a valid contract under Section 10 with specific reference to healthcare scenarios
4. Evaluate the unique contractual issues arising in healthcare, particularly the independent contractor liability dilemma and the doctrine of non-delegable duty
5. Apply contractual principles to draft, interpret and enforce healthcare contracts while managing risk and ensuring compliance

STRUCTURE OF THE LESSON

4.1 INTRODUCTION: THE CONTRACTUAL FOUNDATION OF HEALTHCARE DELIVERY

Every encounter between a patient and a healthcare provider, every engagement of a doctor by a hospital, every procurement of equipment and every empanelment with an insurance company is fundamentally a contractual relationship. The Indian Contract Act, 1872 is the foundational statute governing these relationships. It defines what constitutes an enforceable agreement, prescribes the conditions for validity and provides remedies when promises are broken. For the hospital administrator, the law of contracts is not an abstract legal subject but the operational grammar of healthcare management. The admission form signed by a patient is a contract. The appointment letter issued to a consultant is a contract. The purchase order for a CT scanner is a contract. The memorandum of understanding with a public health department is a contract. Each of these documents creates rights and obligations, allocates risks and determines liability when things go wrong. This lesson examines the law of contracts through the lens of hospital administration, beginning with the general principles of the Indian Contract Act, 1872 and progressively focusing on the distinctive contractual challenges that arise in healthcare: the nature of the patient-provider contract, the liability dilemma posed by independent contractors, the allocation of risk in public-private partnerships and the enforcement of service level agreements.

4.2 INTRODUCTORY CASE STUDY: THE GIG-ECONOMIZATION OF HEALTHCARE

The transformation of Indian healthcare from practitioner-owned nursing homes to corporate hospital chains has fundamentally altered the contractual basis of medical practice. A significant and growing proportion of doctors in corporate hospitals are no longer employees; they are engaged as independent contractors. This shift, described as the gig-economization of healthcare, creates a profound liability dilemma for patients, hospitals and the medical profession itself.

Consider this scenario synthesised from multiple reported judgments. A forty-five year old patient undergoes laparoscopic surgery at a prestigious corporate hospital. The surgery is performed by a senior consultant surgeon who is not an employee of the hospital but practices from the hospital premises under a service agreement styled as an independent contractor arrangement. During the procedure, the surgeon inadvertently injures the patient's bowel, a recognised complication but one that due to delayed recognition and repair results in peritonitis, a second surgery, prolonged hospitalisation and permanent morbidity. The patient initiates legal proceedings against both the surgeon and the corporate hospital. The hospital defends itself on the following contractual basis: the surgeon is an independent contractor, not an employee; the hospital exercises no control over the manner in which he performs surgery; the hospital is concerned only with the result, not the process; therefore, under the settled principles of vicarious liability, the hospital is not liable for the surgeon's negligence. The surgeon, while competent, carries indemnity insurance of only fifty lakh rupees, manifestly inadequate for the patient's actual damages. The patient is left with incomplete compensation and the hospital's reputation, despite escaping legal liability, is severely damaged in public perception.

Indian courts have delivered conflicting judgments on this question. In Aparna Dutta v. Apollo Hospitals, courts applied doctrines such as master-servant relationship and apparent agency to impose liability on the hospital, reasoning that the independent contractor was perceived by the patient as an employee acting under the hospital's sanction. However, in Padam Chandra Singhi

v. Dr. P.B. Desai, the court refrained from imposing liability on the hospital precisely because the negligent doctor was an independent contractor and the contract between the hospital and the doctor contained no explicit clause allocating liability.

Relevance to the Lesson: This judicial inconsistency exposes a fundamental gap in the contractual regulation of Indian healthcare. Neither the Indian Medical Association nor the Ministry of Health and Family Welfare has mandated any specific guidelines or model clauses for service agreements between hospitals and independent contractor doctors. It is not mandatory for such engagements to be formalised in writing, and even when written contracts exist, there is no statutory requirement that they contain a liability clause. This regulatory vacuum places the entire burden of contractual risk allocation on the individual hospital administrator. The case establishes the central theme of this lesson: contracts in hospital services are not merely administrative formalities but instruments of risk allocation, patient protection and institutional accountability. The absence of a well-drafted contract, or the presence of a poorly drafted one, can result in the hospital evading liability at the patient's expense or conversely the hospital bearing liability that ought properly to rest with an individual practitioner.

4.3 CONTRACTUAL OBLIGATIONS IN HOSPITAL SERVICES: NATURE AND SCOPE

A contract is defined under Section 2 of the Indian Contract Act, 1872 as an agreement enforceable by law. Every agreement is a promise or set of promises forming consideration for each other, but not every agreement rises to the level of a contract. To be enforceable, an agreement must satisfy the conditions prescribed in Section 10 of the Act: it must be made by the free consent of parties competent to contract, for a lawful consideration, with a lawful object, and must not be expressly declared to be void.

In the hospital context, contractual obligations arise across three distinct axes. The first is the vertical axis between the healthcare provider and the patient. This is the primary contract, whether express or implied, under which the provider undertakes to deliver professional services with reasonable care and skill and the patient undertakes to pay fees and comply with reasonable treatment protocols. The second is the horizontal axis among healthcare providers themselves. This includes partnership deeds among doctor co-owners, employment contracts with salaried medical staff and service agreements with independent consultants. The third is the external axis between the hospital and third-party vendors, suppliers, insurers and government agencies. This includes procurement contracts, insurance empanelment agreements and public-private partnership concessions.

A defining characteristic of healthcare contracts is their fiduciary overlay. While a contract for the sale of goods is an arm's length transaction between equals, a contract for medical treatment is a relationship of trust and confidence. The patient, lacking the specialised knowledge of the physician, reposes faith in the provider's skill and judgment. Courts have consistently held that this fiduciary character imposes duties beyond those explicitly stated in the contract. A hospital cannot by any contractual term exclude its liability for negligence. It cannot by any fine print obtain the patient's consent to substandard care. The fiduciary duty is non-waivable.

Another distinctive feature is the frequent absence of an express written contract. In emergency care, the contract is implied by law. When an unconscious patient is brought to the casualty department and treated, the law implies a promise by the hospital to provide reasonable care

and a reciprocal promise by the patient or their estate to pay reasonable charges. This implied contract is as enforceable as a written agreement, though its terms are determined by the circumstances and professional standards rather than by explicit negotiation.

The hospital administrator must recognise that contractual obligations are not confined to documents labelled contract or agreement. They arise from admission forms, consent forms, patient information leaflets, fee display boards, appointment letters, purchase orders and even representations made on the hospital's website. Any statement that evidences an intention to create legal relations and is relied upon by another party to their detriment may be construed as a contractual term.

4.4 TYPES OF HOSPITAL CONTRACTS

Patient Care Contracts are the most fundamental contracts between the hospital and the patient. They are typically constituted by the admission form signed at the time of registration, supplemented by consent forms for specific procedures, financial guarantees from sponsors or insurance companies, and the hospital's published policies regarding visiting hours, discharge procedures and payment terms. The patient contract is a contract for services, not a contract of sale. The hospital does not promise a cure; it promises to render professional services with reasonable care and skill. This distinction is critical in defending against claims of breach of contract when treatment outcomes are unfavourable despite competent care.

Medical Staff Engagements encompass a spectrum of contractual relationships between hospitals and medical professionals. At one end is the traditional employer-employee relationship governed by an appointment letter, service rules and the disciplinary framework of the Industrial Disputes Act, 1947. At the other end is the independent contractor relationship governed by a service agreement that explicitly negates the master-servant relationship. In between are visiting consultant arrangements, retainership agreements and part-time contracts. The classification of a doctor as employee or independent contractor has profound implications for vicarious liability, statutory compliance including provident fund, ESI and gratuity, and tax deduction at source. The trend towards independent contractor engagements is driven by the hospital's desire to shield itself from liability for medical negligence, but as the introductory case study demonstrates, this shield is porous and its invocation often comes at significant reputational cost.

Vendor and Procurement Contracts govern the hospital's acquisition of goods and services including pharmaceuticals, medical consumables, equipment, laundry, food, security, housekeeping, biomedical waste disposal and maintenance. For high-value capital equipment such as MRI machines, linear accelerators or CT scanners, the contract typically includes not only the purchase price but also warranty terms, maintenance obligations, uptime guarantees and technology upgrade clauses. For consumables, rate contracts establish pricing, delivery schedules and quality specifications. For outsourced services, service level agreements define performance standards, response times and penalty regimes for non-compliance.

Insurance and Payer Contracts have become increasingly significant with the expansion of government-sponsored insurance schemes such as Ayushman Bharat PM-JAY and private health insurance. These are typically standard form contracts drafted by the insurance company or government agency with the hospital as the adhering party. Key contractual terms include the package rates for specific procedures, the documentation required for claim processing, the timeline for claim settlement, the grounds for claim rejection and the dispute resolution

mechanism. Hospitals must carefully scrutinise these contracts; the acceptance of unfavourable terms can render the empanelment financially unviable.

Public-Private Partnership Contracts govern collaborations between government and private entities to deliver healthcare services. These relationships are governed by detailed concession agreements or memoranda of understanding that allocate risks between the public and private partners. In a pure services or management contract, the state retains ownership of the hospital and bears the primary risk while the private partner provides specified services such as cleaning, maintenance, diagnostic services for a fee. In a concession-based model, the private partner undertakes to design, build, finance, operate and maintain the facility for a long concession period, bearing substantial financial and operational risk while the state retains ownership and regulatory oversight. The success of a healthcare PPP depends critically on the clarity of the contract: the scope of services, performance standards, payment mechanism, force majeure provisions and termination compensation must be explicitly defined.

4.5 REQUISITES OF A VALID CONTRACT UNDER THE INDIAN CONTRACT ACT, 1872.

Section 10 of the Indian Contract Act, 1872 provides that all agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not hereby expressly declared to be void. From this statutory provision, together with judicial interpretation, ten essential requisites of a valid contract are derived.

Offer and Acceptance: There must be a lawful offer by one party and a lawful acceptance by the other. The offer defined in Section 2 is the signification by one person to another of their willingness to do or abstain from doing anything with a view to obtaining the assent of that other to such act or abstinence. The acceptance defined in Section 2 is the signification by the offeree of their assent to the offer. For a valid contract, the acceptance must be absolute and unqualified, communicated to the offeror and made while the offer is still subsisting. A mere invitation to offer, such as a hospital displaying its rate list, is not an offer; it is an invitation to the patient to make an offer which the hospital is free to accept or reject.

Intention to Create Legal Relations: The parties must intend that their agreement shall be legally enforceable. Social, domestic or purely honorary agreements are not contracts. In the hospital context, the intention to create legal relations is presumed. When a patient seeks treatment and a hospital provides it, both parties intend that the relationship shall be governed by law.

Lawful Consideration: Consideration defined in Section 2 is when at the desire of the promisor, the promisee or any other person has done or abstained from doing, or does or abstains from doing, or promises to do or abstain from doing, something. Consideration is the price for the promise. It need not be adequate, but it must be real and lawful. In the patient contract, the hospital's consideration is the provision of medical services; the patient's consideration is the payment of fees or the promise to pay. Past consideration, voluntary services and consideration that is forbidden by law are not valid.

Competence of Parties: Section 11 provides that every person is competent to contract who is of the age of majority according to the law to which they are subject, who is of sound mind and is not disqualified from contracting by any law to which they are subject. A minor's

agreement is void ab initio; it is no contract at all. In the hospital context, this requires special attention to consent for treatment of minors which must be obtained from the parent or guardian. Persons of unsound mind during periods of incapacity are also incompetent to contract, though they may be liable for necessaries supplied under Section 68.

Free Consent: Section 14 defines free consent as consent not caused by coercion, undue influence, fraud, misrepresentation or mistake. Consent is said to be free when it is not caused by any of these vitiating factors. Coercion is the committing or threatening to commit any act forbidden by the Indian Penal Code or the unlawful detaining or threatening to detain any property. Undue influence arises where one party is in a position to dominate the will of the other and uses that position to obtain an unfair advantage. The physician-patient relationship is presumptively one of undue influence, placing the burden on the doctor to prove that the patient's consent was free and voluntary. Fraud includes the suggestion of that which is not true by one who does not believe it to be true, active concealment or a promise made without any intention of performing it. Misrepresentation is the positive assertion of that which is not true though the person making it believes it to be true.

Lawful Object: The object of the agreement must be lawful. Section 23 declares that the consideration or object of an agreement is lawful unless it is forbidden by law, is of such a nature that if permitted it would defeat the provisions of any law, is fraudulent, involves or implies injury to the person or property of another, or the court regards it as immoral or opposed to public policy. A contract to perform an illegal medical procedure such as sex determination in violation of the PCPNDT Act is void. A contract to pay a contingency fee based on the outcome of treatment, commonly known as a no cure no payment contract, is unethical and contrary to public policy.

Agreement Not Expressly Declared Void: The Act expressly declares certain agreements to be void. These include agreements in restraint of marriage, agreements in restraint of trade, agreements in restraint of legal proceedings, agreements by way of wager and agreements the meaning of which is uncertain. In the hospital context, a contract that unreasonably restrains a doctor from practising medicine after leaving the hospital may be void under Section 27. A contract that requires a patient to arbitrate all disputes in a distant forum may be void as an unreasonable restraint of legal proceedings.

Certainty of Terms: Section 29 provides that agreements the meaning of which is not certain or capable of being made certain are void. Vague or ambiguous terms cannot be enforced. A contract stating that a consultant shall be paid a reasonable remuneration is enforceable because reasonableness can be ascertained. A contract stating that a consultant shall be paid as mutually agreed without any mechanism for determining the agreement is void for uncertainty.

Possibility of Performance: Section 56 provides that an agreement to do an act impossible in itself is void. The impossibility must be inherent and objective. An agreement to discover treasure by magic is void. An agreement to perform a surgical procedure that is medically impossible at the current state of knowledge is void. However, an agreement that becomes impossible to perform due to subsequent events may be excused under the doctrine of frustration.

Writing and Registration: The general rule under the Indian Contract Act is that a contract may be oral or written. However, certain statutes require specific contracts to be in writing and registered. Contracts for the sale of immovable property require registration under the Transfer of Property Act and the Registration Act. In the hospital context, partnership deeds, lease deeds for hospital premises and agreements creating charges on assets should be in writing and where applicable registered. While patient admission forms need not be registered, written documentation of consent and contractual terms is essential for evidentiary purposes.

4.6 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES

The Implied Contract in Emergency Care: The duty to provide emergency medical care is not merely contractual; it is a constitutional obligation derived from Article 21 and crystallised in Parmanand Katara v. Union of India. However, the financial aspect of emergency care is governed by an implied contract. When an unconscious patient is brought to the emergency department, the law implies a promise by the patient or their legal representatives to pay reasonable charges for the services rendered. This implied contract is enforceable, though the hospital must demonstrate that the charges are reasonable and not unconscionable.

The Independent Contractor Liability Dilemma: The most significant contractual challenge confronting contemporary hospital administration is the engagement of doctors as independent contractors rather than employees. The traditional justification for exempting independent contractors from vicarious liability is that the employer does not exercise control over the manner and method of work and is concerned only with the result. This rationale should not extend to the healthcare sector, which is a safety-critical industry requiring a higher degree of protection and recourse for patients. The non-delegable duty of care doctrine provides a compelling theoretical foundation for reforming this area. Hospitals, unlike other industries, cannot disassociate themselves from the responsibilities inherent in the care provided within their facilities. They bear a non-delegable duty to ensure the safety of their patients or to establish an adequate source of recourse when they are unable to do so. This principle has been applied in various judgments through the doctrines of apparent agency and master-servant relationship, but its application remains inconsistent in the absence of legislative clarity.

The solution proposed by legal scholars is twofold. First, the Indian Medical Association and the Ministry of Health and Family Welfare should mandate that all engagements of independent contractor doctors be formalised through written contracts containing explicit liability clauses. These clauses should clearly allocate responsibility between the hospital and the individual practitioner in cases of medical malpractice or negligence. Second, a mandatory Victim First policy should be instituted mirroring the doctrine of subrogation in contracts of indemnity. Under this policy, hospitals would be required to immediately compensate the victim and subsequently recover costs from the responsible independent contractor or other liable entities. This approach prioritises patient welfare and ensures timely compensation while permitting hospitals to pursue recourse.

Vicarious Liability and Contractual Allocation: While vicarious liability is primarily a tort law doctrine, its application is profoundly influenced by the contractual relationship between the hospital and the doctor. The traditional rule that an employer is vicariously liable for the torts of an employee but not for those of an independent contractor places immense weight on the contractual classification. However, courts have developed several exceptions to this rule. The doctrine of apparent agency or ostensible agency provides that a hospital may be liable for the negligence of an independent contractor if the hospital held out the contractor as its agent

and the patient reasonably relied on that representation. The non-delegable duty doctrine imposes liability regardless of contractual classification where the hospital owes an absolute duty to the patient that cannot be delegated.

The prudent hospital administrator will not rely solely on contractual recitals classifying a doctor as an independent contractor. Such recitals are not conclusive; courts examine the substance of the relationship, not merely its form. The degree of control exercised by the hospital, the integration of the doctor's services into the hospital's core operations, the duration of the engagement and the method of payment are all relevant factors. A contract that recites independent contractor status but provides for hospital supervision, hospital-provided equipment and staff, and integration into the hospital's branding and roster may be held to create an employer-employee relationship for liability purposes.

Standard Form Contracts and Unconscionable Terms: Hospitals, like airlines and banks, typically employ standard form contracts of adhesion. The patient is presented with a pre-printed admission form and given no opportunity to negotiate its terms. Such contracts are not invalid merely because they are standardised, but certain terms may be struck down as unconscionable. An exclusion clause purporting to exempt the hospital from liability for negligence is void as against public policy. A clause requiring the patient to submit all disputes to a distant arbitration forum may be unconscionable if it deprives the patient of an effective remedy. A clause imposing exorbitant interest on delayed payments may be penal and therefore void under Section 74. The hospital administrator must ensure that standard form contracts are drafted in plain language, that material terms are prominently displayed and that no term purports to exclude liability for death or personal injury resulting from negligence.

Contracts with Government and Insurance Agencies: Contracts with government agencies and insurance companies present distinct challenges. These are typically contracts of adhesion drafted by the stronger party. The hospital as the adhering party must carefully review the payment terms, the documentation requirements, the claim processing timelines and the dispute resolution mechanism. Of particular importance is the clause governing claim rejections and recovery of amounts already paid. Some insurance contracts purport to give the insurer an unconditional right to recover payments made under audit adjustments regardless of whether the treatment was medically necessary or properly rendered. Such clauses may be unconscionable if they permit unilateral revision of settled claims without due process. The doctrine of contra proferentem, which provides that ambiguous contractual terms are construed against the party that drafted them, applies to insurance contracts. Where the insurer drafts the contract and a term is ambiguous, the interpretation favourable to the hospital will be adopted.

4.7 BREACH OF CONTRACT AND REMEDIES

When a party fails to perform their promise under a contract or performs it defectively, they are said to have committed a breach of contract. The Indian Contract Act, 1872 provides several remedies to the aggrieved party.

Rescission under Section 39: When a party to a contract has refused to perform or has disabled themselves from performing their promise in its entirety, the promisee may put an end to the contract. Rescission discharges both parties from further performance. In the hospital context, a patient may rescind the contract if the hospital fails to provide the agreed treatment. Conversely, the hospital may rescind the contract if the patient refuses to pay the agreed fees, though it must continue emergency care regardless of payment disputes.

Damages under Section 73: This is the primary remedial provision. When a contract has been breached, the party who suffers by such breach is entitled to receive compensation for any loss or damage caused to them thereby which naturally arose in the usual course of things from such breach or which the parties knew when they made the contract to be likely to result from the breach. This is the rule of remoteness of damages: only those losses that are reasonably foreseeable are recoverable. Damages under Section 73 are compensatory, not punitive. The purpose is to place the aggrieved party in the same financial position as if the contract had been performed, not to punish the breaching party. Special damages, which are losses beyond the natural and probable consequences of the breach, are recoverable only if the special circumstances were communicated to the breaching party at the time of contracting. In healthcare contracts, damages for breach are most commonly claimed under the Consumer Protection Act, 2019 rather than through civil suits under the Contract Act. The consumer forum provides a more accessible and expeditious remedy. However, the principles of assessment are similar: the patient is entitled to compensation for actual financial loss including additional medical expenses, loss of earnings and in cases of negligence compensation for pain, suffering and loss of expectation of life.

Specific Performance: Specific performance is an equitable remedy whereby the court directs the breaching party to perform their promise exactly as agreed. This remedy is not available for contracts of personal service. A court will not compel a surgeon to perform an operation on a reluctant patient, nor will it compel a patient to submit to treatment. The remedy of specific performance is therefore of limited application in healthcare contracts.

Quantum Meruit: The doctrine of quantum meruit, meaning as much as is deserved, applies where a contract is discharged by breach or where work is performed under a void contract. The party who has conferred a benefit on the other is entitled to reasonable compensation for the value of the work done. If a patient terminates treatment before completion, the hospital is entitled to payment on a quantum meruit basis for the services actually rendered prior to termination.

4.8 STUDENT LEARNING ACTIVITIES

Activity 1: Independent Contractor Agreement Drafting

You are the Administrator of a two hundred fifty bed corporate hospital. The board of directors has instructed you to engage five senior consultants in the departments of cardiology, neurology, orthopaedics, oncology and gastroenterology as independent contractors rather than employees. The board's primary motivation is to limit the hospital's vicarious liability for medical negligence. Draft a comprehensive Independent Contractor Service Agreement that includes the following clauses: definition of the relationship explicitly stating that the consultant is an independent contractor and not an employee, scope of services and clinical privileges, fee structure and payment terms, professional indemnity insurance requirements, liability allocation clause specifying responsibility for negligence claims, termination provisions and dispute resolution mechanism. Additionally, prepare a briefing note for the board explaining why a mere contractual recital of independent contractor status is not conclusive and what additional measures the hospital should adopt to minimise liability exposure while maintaining the independent contractor model.

Activity 2: Patient Admission Contract Audit

Obtain a standard patient admission form and consent form from any hospital. Conduct a comprehensive audit of the document against the ten requisites of a valid contract enumerated in this lesson. Identify at least three clauses that may be vulnerable to challenge on grounds of unconscionability, uncertainty or absence of free consent. For each vulnerable clause, draft a revised version that achieves the hospital's legitimate objectives while respecting the patient's rights and complying with the Indian Contract Act, 1872. Pay particular attention to exclusion clauses, consent for ancillary procedures and financial guarantee provisions. Submit your audit report in the form of a memorandum to the Medical Superintendent including specific recommendations for revision of the hospital's standard admission documents.

Activity 3: Public-Private Partnership Contract Analysis

Access the Model Concession Agreement for the Karnataka Model PPP for District Hospitals, publicly available on the Karnataka Health and Family Welfare Department website. Analyse the agreement with specific reference to the scope of services and performance standards identifying how quality is defined and measured, the payment mechanism distinguishing between viability gap funding, user charges and performance-linked payments, the risk allocation matrix identifying which party bears construction risk, demand risk, force majeure risk and regulatory change risk, and the termination provisions including grounds for termination by each party and the formula for termination compensation. Based on your analysis, prepare a critical evaluation of whether the contract achieves an optimal balance between protecting the public interest and providing sufficient commercial flexibility to attract private investment. Identify three clauses that you would recommend modifying in future iterations of the model concession agreement.

4.9 SUMMARY

The law of contracts as codified in the Indian Contract Act, 1872 is the legal foundation upon which all healthcare transactions are constructed. Every patient admission, every doctor engagement, every equipment purchase and every insurance empanelment creates a contractual relationship with distinct rights, obligations and remedies. A valid contract under Section 10 of the Act requires ten essential elements: offer and acceptance, intention to create legal relations, lawful consideration, competence of parties, free consent, lawful object, the agreement not being expressly declared void, certainty of terms, possibility of performance and compliance with any statutory requirement of writing or registration. Each of these elements has specific application in the healthcare context. Free consent is particularly significant given the fiduciary nature of the physician-patient relationship, which places the burden on the provider to establish that the patient's consent was not procured by undue influence or misrepresentation.

Hospital contracts may be classified into five principal categories. Patient care contracts are implied or express agreements for the provision of medical services in exchange for payment. Medical staff engagements range from traditional employment contracts to independent contractor service agreements. Vendor and procurement contracts govern the acquisition of goods and services essential for hospital operations. Insurance and payer contracts establish the terms of empanelment and claim settlement. Public-private partnership contracts allocate risks and responsibilities between government entities and private healthcare providers for the delivery of public health services.

The most significant contractual challenge confronting contemporary hospital administration is the proliferation of independent contractor engagements and the attendant liability dilemma. The traditional rule exempting principals from vicarious liability for the torts of independent contractors is ill-suited to the healthcare sector, where hospitals owe a non-delegable duty of care to patients. Indian courts have delivered inconsistent judgments on this question, and the absence of regulatory guidance from the Indian Medical Association or the Ministry of Health and Family Welfare has created a legal vacuum. The scholarly consensus recommends mandatory written contracts with explicit liability clauses and a Victim First policy ensuring immediate patient compensation followed by hospital recourse against the responsible practitioner.

The hospital administrator must approach contracts not as mere administrative formalities but as strategic instruments of risk allocation, patient protection and institutional accountability. A well-drafted contract prevents disputes, allocates risks to the party best capable of managing them and provides clear remedies when things go wrong. A poorly drafted contract, or the absence of a written contract altogether, exposes the hospital to unpredictable liability and the patient to inadequate recourse. The mastery of contract law is therefore not an optional specialisation for the hospital administrator but a core professional competency.

4.10 KEY WORDS WITH EXPLANATIONS

Contract is defined under Section 2 of the Indian Contract Act, 1872 as an agreement enforceable by law. Every contract is an agreement, but not every agreement is a contract. To be enforceable, an agreement must satisfy the conditions prescribed in Section 10 of the Act including free consent, competent parties, lawful consideration and lawful object.

Offer and Acceptance is the mechanism by which a contract is formed. The offeror signifies their willingness to do or abstain from doing something with a view to obtaining the assent of the offeree. The offeree signifies their assent to the offer. Acceptance must be absolute, unqualified and communicated to the offeror.

Consideration is the price for the promise defined in Section 2 as when at the desire of the promisor the promisee or any other person has done or abstained from doing, or does or abstains from doing, or promises to do or abstain from doing, something. Consideration need not be adequate but must be real and lawful.

Free Consent is defined in Section 14 as consent not caused by coercion, undue influence, fraud, misrepresentation or mistake. In the physician-patient relationship, there is a presumption of undue influence placing the burden on the provider to establish that consent was voluntary and informed.

Competence to Contract under Section 11 requires that every person is competent to contract who is of the age of majority, is of sound mind and is not disqualified from contracting by any law. A minor's agreement is void ab initio and cannot be enforced.

Void and Voidable Contracts: A void contract is one which is not enforceable by law at the option of either party. A voidable contract is one which is enforceable by law at the option of one or more of the parties thereto but not at the option of the other or others. Contracts

induced by coercion, fraud or misrepresentation are voidable at the option of the party whose consent was so caused.

Independent Contractor is a person engaged to perform services for another but who is not under the control of the other regarding the manner and method of performance. The principal is generally not vicariously liable for the torts of an independent contractor, though this rule is subject to exceptions including the doctrine of non-delegable duty and apparent agency.

Vicarious Liability is legal responsibility imposed on one person for the torts of another. Employers are vicariously liable for the torts of employees committed in the course of employment. The application of vicarious liability to independent contractors in healthcare is contested and has produced inconsistent judicial decisions.

Non-Delegable Duty is a duty that cannot be delegated to another; the person owing the duty remains liable for its performance regardless of whether performance is entrusted to an independent contractor. Scholars argue that hospitals owe patients a non-delegable duty of care, which would render them liable for the negligence of independent contractor doctors.

Rescission is the remedy whereby a contract is terminated and the parties are restored to their original positions. Under Section 39, a promisee may rescind a contract where the promisor has refused to perform or disabled themselves from performing their promise in its entirety.

Damages are monetary compensation awarded for breach of contract. Section 73 provides that the aggrieved party is entitled to compensation for any loss or damage caused by the breach which naturally arose in the usual course of things or which the parties knew when they made the contract to be likely to result from the breach.

Standard Form Contract is a contract pre-printed by one party and presented to the other on a take-it-or-leave-it basis without opportunity for negotiation. Such contracts are common in hospital admissions and are valid but unconscionable terms may be struck down.

Contra Proferentem is a rule of contractual interpretation providing that ambiguous terms are construed against the party who drafted the contract. This rule is applied particularly to insurance contracts and other contracts of adhesion.

4.11 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What is the distinction between an agreement and a contract under the Indian Contract Act, 1872?

Ans. An agreement is defined under Section 2 as every promise and every set of promises forming consideration for each other. A contract is defined under Section 2 as an agreement enforceable by law. Thus, all contracts are agreements but not all agreements are contracts. An agreement becomes a contract only when it satisfies the conditions prescribed in Section 10: free consent of parties competent to contract, lawful consideration, lawful object and not being expressly declared void.

Q2. What are the five vitiating factors that render consent not free under Section 14 of the Indian Contract Act, 1872?

Ans. The five vitiating factors are coercion, undue influence, fraud, misrepresentation and mistake. Consent is said to be free when it is not caused by any of these factors. Where consent is caused by coercion, fraud or misrepresentation, the contract is voidable at the option of the party whose consent was so caused. Where consent is caused by undue influence, the contract is voidable at the option of the party whose consent was so caused. Where consent is caused by mistake, the contract is void.

Q3. What is the legal effect of a minor entering into a contract for medical treatment?

Ans. A minor's agreement is void ab initio under Section 11 of the Indian Contract Act, 1872 as a minor is not competent to contract. However, Section 68 provides that a person who supplies necessaries to a person incapable of contracting or to anyone whom such person is legally bound to support is entitled to be reimbursed from the property of such incapable person. Medical treatment constitutes necessaries. Therefore, while the minor cannot be sued personally for payment, the hospital is entitled to recover reasonable charges from the minor's property or from the parent or guardian who is legally bound to support the minor.

Q4. What is the doctrine of quantum meruit and when does it apply in hospital contracts?

Ans. Quantum meruit meaning as much as is deserved is a restitutionary remedy applicable where a contract is discharged by breach, where work is performed under a void contract, or where a party has conferred a benefit on another in circumstances where it would be unjust for the recipient to retain the benefit without payment. In hospital contracts, if a patient terminates treatment before completion, the hospital is entitled to reasonable compensation on a quantum meruit basis for the services actually rendered prior to termination.

Q5. Distinguish between an employee and an independent contractor in the context of hospital medical staff.

Ans. An employee works under a contract of service and is subject to the control of the employer regarding not only what work is to be done but also the manner and method of doing it. An independent contractor works under a contract for services and agrees to achieve a specified result but retains control over the manner and method of performance. Factors relevant to classification include the degree of control exercised by the hospital, the integration of the doctor's services into the hospital's core operations, the duration of engagement, the method of payment and whether the doctor bears the risk of loss and opportunity for profit. The contractual recital of status is not conclusive; courts examine the substance of the relationship.

B. Essay Type Questions with Hints

Q1. Critically examine the ten essential requisites of a valid contract under the Indian Contract Act, 1872 with specific reference to their application in patient admission contracts. How does the fiduciary nature of the physician-patient relationship affect the requirement of free consent?

Hints: Structure your answer by enumerating each of the ten requisites derived from Section 10 and judicial interpretation. For each requisite, provide a healthcare-specific example. Discuss offer and acceptance in the context of emergency admission versus elective admission. Address consideration as the exchange of professional services for fees. Analyse competence with reference to minors and mentally incapacitated persons. Devote substantial attention to free consent, explaining the presumption of undue influence in fiduciary relationships and the burden on the hospital to establish that consent was voluntary and informed. Conclude with the importance of written documentation to satisfy evidentiary requirements even where writing is not statutorily mandated.

**Q2. Discuss the legal and practical challenges arising from the engagement of doctors as independent contractors in corporate hospitals. Evaluate the adequacy of the current legal framework and the reforms proposed by legal scholars.

Hints: Begin by documenting the trend towards independent contractor engagements in Indian corporate healthcare and the stated rationale of limiting vicarious liability. Explain the traditional rule exempting principals from liability for independent contractor torts and the exceptions developed by courts including apparent agency and non-delegable duty. Analyse the inconsistent judicial decisions in Aparna Dutta v. Apollo Hospitals and Padam Chandra Singhi v. Dr. P.B. Desai. Discuss the regulatory vacuum where neither the Indian Medical Association nor the Ministry of Health has mandated model service agreements or liability clauses. Present the scholarly proposals including mandatory written contracts with explicit liability allocation, mandatory indemnity insurance requirements, and the Victim First policy with subrogation. Critically evaluate whether these proposals require legislative intervention or can be implemented through executive or regulatory action. Conclude with the hospital administrator's role in proactively addressing this issue through contract drafting and risk management.

Q3. Analyse the doctrine of frustration under Section 56 of the Indian Contract Act, 1872 and its application to healthcare contracts. Can a hospital rely on force majeure to cancel elective surgeries during a pandemic? Can a patient rely on frustration to claim refund of advance payments when unable to undergo treatment due to illness?

Hints: Explain Section 56: an agreement to do an act impossible in itself is void; a contract to do an act which after the contract is made becomes impossible or unlawful becomes void when the impossibility or unlawfulness is discovered. Distinguish between initial impossibility and supervening impossibility. Discuss the doctrine of frustration as the just solution for supervening impossibility. Apply to pandemic scenarios: government lockdown orders and diversion of hospital resources may render performance impossible or fundamentally different from what was contemplated. Discuss the distinction between prospective and accrued obligations. Address the patient's right to refund of advance payments when treatment cannot proceed. Refer to relevant force majeure clauses in hospital admission contracts and insurance empanelment agreements. Conclude with recommendations for drafting force majeure clauses that clearly allocate risk of such unforeseen events.

Q4. What remedies are available to a patient for breach of contract by a hospital? Distinguish between remedies under the Indian Contract Act, 1872 and the Consumer Protection Act, 2019. Why do patients overwhelmingly prefer the consumer forum?

Hints: Enumerate the remedies under the Contract Act: rescission, damages under Section 73, specific performance under the Specific Relief Act, 1963 and quantum meruit. Explain the measure of damages: compensation for loss naturally arising in the usual course of things and special damages if circumstances were communicated. Explain the remedies under the Consumer Protection Act, 2019: removal of deficiency, replacement of defective goods, refund of price, compensation for loss or injury and punitive damages in appropriate cases. Compare the two regimes on jurisdictional parameters, limitation periods, cost of litigation, procedural complexity and evidentiary burdens. Explain why patients prefer the consumer forum: it is less expensive, faster, does not require court fees on the full claim amount and permits filing by a representative. Conclude that while the Contract Act provides the substantive law of obligations, the Consumer Protection Act provides the more accessible procedural remedy.

Q5. You are the Administrator of a one hundred fifty bed hospital. Draft a detailed policy on contractual risk management addressing patient admission contracts, medical staff engagements, vendor procurement contracts and insurance empanelment agreements.

Hints: Structure your answer as a comprehensive policy document with four distinct sections corresponding to each category. For patient admission contracts, address plain language drafting, prominent display of material terms, prohibition of unconscionable exclusion clauses, separate consent for ancillary procedures and documentation of financial guarantees. For medical staff engagements, distinguish between employment contracts and independent contractor agreements; for the latter, mandate written agreements with explicit liability clauses and minimum indemnity insurance requirements; implement a credentialing and privileging system independent of contractual status. For vendor procurement contracts, establish competitive bidding thresholds, standard terms and conditions, service level agreements with measurable performance indicators and penalty regimes for non-compliance. For insurance empanelment agreements, establish a review protocol before acceptance, identify non-negotiable terms, document audit trails for claim submissions and maintain a disputes register. Conclude with training and monitoring mechanisms to ensure policy implementation.

C. Analytical Multiple Choice Questions

1. Under Section 10 of the Indian Contract Act, 1872, which of the following is NOT an essential requisite of a valid contract?
a) Free consent of parties competent to contract
b) Lawful consideration and lawful object
c) Agreement in writing and registered
d) Not expressly declared to be void
Correct Answer: c) Agreement in writing and registered

2. A patient who is a minor is brought to the emergency department by a neighbour. The hospital provides life-saving treatment. Which of the following correctly states the legal position regarding payment?
a) The minor is personally liable for the hospital charges
b) The neighbour is personally liable for the hospital charges
c) The hospital is entitled to be reimbursed from the minor's property
d) The hospital cannot recover any charges as the minor's agreement is void
Correct Answer: c) The hospital is entitled to be reimbursed from the minor's property

3. Which of the following contractual terms is most likely to be held void as opposed to public policy in a patient admission contract?
a) A clause requiring payment within fifteen days of discharge
b) A clause requiring disputes to be arbitrated in the city where the hospital is located
c) A clause purporting to exempt the hospital from liability for death caused by negligence
d) A clause requiring the patient to inform the hospital of any change in address
Correct Answer: c) A clause purporting to exempt the hospital from liability for death caused by negligence

4. Dr. Sharma is engaged by City Hospital under a written agreement that states: Dr. Sharma is an independent contractor, not an employee. City Hospital exercises no control over the manner and method of Dr. Sharma's professional practice. Despite this clause, a court may nevertheless hold City Hospital vicariously liable for Dr. Sharma's negligence if:
a) Dr. Sharma pays his own professional indemnity insurance
b) City Hospital provides the OT, nursing staff and equipment for Dr. Sharma's surgeries
c) Dr. Sharma's name is not displayed on the hospital letterhead
d) Dr. Sharma bills patients directly and pays the hospital a facility fee
Correct Answer: b) City Hospital provides the OT, nursing staff and equipment for Dr. Sharma's surgeries

5. Under Section 73 of the Indian Contract Act, 1872, damages for breach of contract are awarded to:
a) Punish the breaching party
b) Place the aggrieved party in the same financial position as if the contract had been performed
c) Place the aggrieved party in a better position than if the contract had been performed
d) Apportion loss equally between the parties
Correct Answer: b) Place the aggrieved party in the same financial position as if the contract had been performed

6. Which of the following statements correctly states the legal position regarding the application of the Consumer Protection Act, 2019 to contracts for medical services?
a) Medical services are expressly excluded from the definition of service under the Act
b) Only free services are excluded; paid services are covered
c) All medical services whether paid or free are covered
d) Government hospitals are exempt from the Act regardless of payment
Correct Answer: b) Only free services are excluded; paid services are covered

7. The doctrine of contra proferentem in contract interpretation provides that:
a) All contracts must be interpreted literally according to the dictionary meaning of words
b) Ambiguous contractual terms are construed against the party who drafted the contract
c) Contracts must be interpreted in favour of the weaker party in all cases
d) Oral evidence is always admissible to contradict written terms
Correct Answer: b) Ambiguous contractual terms are construed against the party who drafted the contract

4.12 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Forgotten Sponge and the Independent Contractor Defence

Sunrise Super-Speciality Hospital is a three hundred bed corporate hospital located in Visakhapatnam, Andhra Pradesh, established in 2012 as a private limited company under the Companies Act, 1956. The hospital is NABH accredited and empanelled under the Andhra Pradesh Dr. NTR Vaidya Seva health insurance scheme. It employs eighty-five full-time consultants on salary and engages an additional forty-five consultants under independent contractor service agreements. Dr. Lakshmi Narayan is a senior consultant general and laparoscopic surgeon associated with Sunrise Hospital since 2015 under a written Independent Contractor Service Agreement. The key clauses of the agreement state that Dr. Narayan is an independent contractor and not an employee, agent or partner of the hospital; she exercises independent professional judgment and control over the manner and method of performing surgical services; the hospital provides operation theatre facilities, nursing staff, surgical instruments, sterilisation services and inpatient beds for her patients; she pays the hospital a facility fee of twenty-five per cent of professional fees collected from her patients; she shall maintain professional indemnity insurance of not less than fifty lakh rupees per occurrence; and she shall be solely responsible for her own acts of negligence or omission while the hospital shall not be vicariously liable for any claim arising from her professional services, with Dr. Narayan indemnifying the hospital against all claims arising from her negligence.

On 12 January 2026, Dr. Lakshmi Narayan performed an open cholecystectomy on Mrs. Sarala Devi, a fifty-two year old school teacher, for symptomatic gallstone disease. The surgery was performed at Sunrise Hospital with the hospital's OT staff and equipment. The procedure was documented as uneventful and the patient was discharged on 16 January 2026. On 5 February 2026, Mrs. Devi presented to the emergency department of a government hospital with severe abdominal pain, fever and vomiting. Clinical examination and imaging revealed a large intra-abdominal abscess. Emergency laparotomy was performed by government surgeons who discovered a retained surgical sponge in the right upper quadrant. The sponge was removed, the abscess drained and the patient required prolonged hospitalisation of twenty-one days including eight days in the intensive care unit.

Mrs. Devi initiated three parallel proceedings: a consumer complaint before the Andhra Pradesh State Consumer Disputes Redressal Commission against Sunrise Hospital and Dr. Lakshmi Narayan claiming compensation of thirty-five lakh rupees for medical negligence, deficiency in service and unfair trade practice; a complaint with the Andhra Pradesh State Medical Council against Dr. Lakshmi Narayan alleging professional misconduct arising from gross negligence; and a civil suit before the District Court, Visakhapatnam against both Sunrise Hospital and Dr. Narayan claiming damages under the Law of Torts.

Sunrise Hospital filed its response denying liability on contractual grounds. The hospital admitted that Mrs. Devi was a patient and that Dr. Narayan performed her surgery, but contended that Dr. Narayan was an independent contractor and not an employee; under the well-settled principle of law, a principal is not vicariously liable for the torts of an independent contractor. The Independent Contractor Service Agreement expressly allocated liability to Dr. Narayan with Clause 12 providing that Dr. Narayan shall be solely responsible for her own negligence and shall indemnify the hospital. The hospital exercised no control over the manner and method of Dr. Narayan's surgical practice; she determined the surgical technique, made all intra-operative decisions and was solely responsible for sponge counts and instrument

reconciliation. The hospital had exercised due diligence by verifying Dr. Narayan's credentials and qualifications, granting clinical privileges based on competence and requiring her to maintain professional indemnity insurance.

Mrs. Devi contended through counsel that the independent contractor distinction is artificial and should not absolve the hospital of liability. She approached Sunrise Hospital, not Dr. Narayan individually, and relied on the hospital's reputation, accreditation and branding. She had no knowledge of the contractual arrangement between the hospital and her surgeon. The doctrine of apparent agency applies as the hospital held out Dr. Narayan as its consultant through its website, OPD board and admission documents. Mrs. Devi reasonably believed Dr. Narayan was a hospital employee or at least acting as the hospital's agent. The hospital exercised significant de facto control over Dr. Narayan's practice by granting her clinical privileges, scheduling her OT time, providing nursing staff who were hospital employees and dictating the format of medical records. The sponge count is a system responsibility requiring collaboration between the surgeon and nursing staff; the hospital's nursing staff were responsible for the initial count, intra-operative count and closing count, and their failure contributed to the retention. The hospital cannot delegate its responsibility for ensuring safe systems of work and then disclaim liability. The indemnity clause in Clause 12 is an unconscionable term in a contract of adhesion; Dr. Narayan as an individual practitioner had no bargaining power to negotiate this clause and the hospital with superior bargaining power imposed this term to shield itself from liability, rendering such clause void as against public policy.

The State Consumer Commission passed an interim order directing Sunrise Hospital to pay ten lakh rupees as interim compensation to Mrs. Devi pending final adjudication, observing that the question of vicarious liability and the validity of independent contractor exclusion clauses in healthcare contracts required detailed examination and could not be decided summarily. The hospital was directed to pay the amount within four weeks and was granted liberty to recover the same from Dr. Narayan in accordance with their contract.

Questions for Analysis with Hints

Q1. Analyse the validity and enforceability of Clause 12 of the Independent Contractor Service Agreement. Can a hospital contractually exclude its vicarious liability for the negligence of independent contractor doctors? Is such a clause binding on a patient who is not a party to the hospital-doctor contract?

Hints: As between hospital and Dr. Narayan, the clause is generally enforceable as contractual allocation of risk between two sophisticated parties. Dr. Narayan voluntarily accepted liability allocation in exchange for facility fee arrangement and right to practice. However, the clause is not binding on Mrs. Devi who is not a party to the contract and is not privy to its terms. The doctrine of privity of contract provides that only parties to a contract may enforce its terms or be bound by them. Mrs. Devi contracted with the hospital through the admission agreement; she did not contract with Dr. Narayan individually. The hospital cannot rely on a contractual clause to which Mrs. Devi was not a party to defeat her claim. Moreover, an exclusion clause purporting to completely exempt a hospital from liability for negligence is void as against public policy. The non-delegable duty of care doctrine would render such clauses ineffective regardless of privity.

Q2. Evaluate the hospital's defence based on the independent contractor status of Dr. Narayan. Applying the doctrines of apparent agency and non-delegable duty, is Sunrise Hospital liable to Mrs. Devi? What factors should the court consider in determining whether the independent contractor shield should be pierced?

Hints: The doctrine of apparent agency applies where the hospital held out Dr. Narayan as its agent or employee, Mrs. Devi relied on this holding out and reasonably believed Dr. Narayan was acting on behalf of the hospital. Sunrise Hospital listed Dr. Narayan on its website as consultant surgeon, displayed her name on departmental boards and provided hospital letterhead and admission forms bearing the hospital's name. Mrs. Devi had no means of knowing the internal contractual arrangement. The elements of apparent agency are satisfied. The non-delegable duty of care doctrine provides that hospitals owe a direct and non-delegable duty to patients extending to all care provided within the hospital facility regardless of the contractual status of the individual practitioner. The substance of the relationship reveals significant de facto control: the hospital granted clinical privileges, determined OT schedule, provided all infrastructure and support staff, and integrated Dr. Narayan's practice into its operational and branding framework. The independent contractor defence should fail.

Q3. Discuss the evidentiary and procedural issues arising from the sponge count protocol. Was this exclusively Dr. Narayan's responsibility or did the hospital's nursing staff bear shared responsibility? How should liability be apportioned between the individual surgeon and the institutional system?

Hints: Retention of surgical sponge is a never event that should never occur under any circumstances. Standard operating procedures require initial count before procedure begins, counts during procedure when additional sponges are opened and closing count before wound closure. The count is a shared responsibility between the surgical team, not the exclusive duty of any single individual. The circulating nurse and scrub nurse, both employees of Sunrise Hospital, were responsible for initiating and documenting the counts. The hospital's duty to provide safe systems of work includes ensuring count protocols are established, staff are trained and compliance is monitored. The failure of the count protocol indicates systemic failure of the hospital's safety systems. Dr. Narayan as operating surgeon bears ultimate responsibility for ensuring the count is correctly performed and reconciled. Liability should be apportioned on the basis of contribution: the hospital through its nursing staff bears responsibility for failure of count protocol; Dr. Narayan bears responsibility for proceeding with closure without confirming the count. Both parties are jointly and severally liable to Mrs. Devi.

Q4. As Dr. Anand Reddy, Medical Superintendent of Sunrise Hospital, you have received the interim order directing payment of ten lakh rupees to Mrs. Devi. Draft a memorandum to the Board of Directors analysing the implications of this case, the deficiencies in the hospital's current contractual framework and recommending specific contractual and operational reforms to minimise future liability exposure.

Hints: The interim order exposes critical vulnerabilities in the hospital's contractual framework and risk management practices. The defence based on independent contractor status is legally vulnerable because courts are increasingly applying apparent agency to impose liability regardless of contractual labels, the hospital's actual operational control over independent contractors contradicts the contractual recital of independence, and the sponge count protocol failure demonstrates systemic institutional responsibility that cannot be delegated. Recommended contractual reforms include revising the Independent Contractor Service

Agreement to replace complete exclusion with shared liability allocation model, mandating higher professional indemnity insurance limits tiered by specialty, and introducing mandatory liability contribution agreements creating clear contractual right of recovery. Recommended operational reforms include immediate audit of surgical safety protocols, implementation of mandatory surgical safety checklist compliant with WHO and NABH standards, introduction of technology solutions such as radio-frequency tagged sponges, and independent credentialing and privileging system separate from contractual engagement process.

Q5. Critically evaluate the adequacy of the current regulatory framework governing independent contractor engagements in Indian healthcare. Should the National Medical Commission or the Ministry of Health mandate model service agreements with minimum mandatory terms? What should those terms include?

Hints: The current regulatory framework is inadequate and fragmented. There is no central legislation specifically addressing this issue. The NMC Act, 2019 empowers the Ethics Board to regulate professional conduct but does not extend to regulating contractual relationships between hospitals and doctors. State-specific Clinical Establishments Acts focus on infrastructure and minimum standards, not contractual arrangements. This regulatory vacuum produces three adverse consequences: significant judicial inconsistency creating uncertainty, no standardisation of contract terms leaving practitioners with unequal bargaining power, and patients left without predictable recourse. The NMC should exercise power under Section 10 to lay down policies ensuring observance of professional ethics, extending to regulating terms of engagement between hospitals and medical practitioners. The Commission should mandate that all engagements be formalised through written contract and prescribe a Model Service Agreement containing mandatory minimum terms including a clear statement of the nature of the relationship with proviso that contractual recital is not conclusive, mandatory liability clause providing that hospital and practitioner shall be jointly and severally liable to patient with contribution rights, mandatory professional indemnity insurance clause prescribing minimum coverage limits, mandatory dispute resolution clause providing for institutional arbitration, and mandatory non-discrimination clause ensuring independent contractors are not denied clinical privileges on grounds unrelated to competence.

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The duty of care owed by a hospital to its patient is non-delegable. The patient who enters the hospital doors looks to the institution for care, not to the contractual fine print that would allocate responsibility away from those who invited the patient's trust.

— Adapted from Supreme Court of India judgments on vicarious liability

LESSON-5
CONTRACTUAL LIABILITY AND CRIMINAL LIABILITY

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Distinguish between contractual liability, tortious liability and criminal liability arising from healthcare delivery
2. Explain the basis of contractual liability of doctors and hospitals under express and implied contracts
3. Analyse the principles governing damages in healthcare contracts, distinguishing economic and non-economic damages
4. Evaluate the scope of criminal liability of medical professionals under the Indian Penal Code and the Bharatiya Nyaya Sanhita
5. Apply the defences available to medical professionals in criminal prosecutions including the Jacob Mathew principles

STRUCTURE OF THE LESSON

5.1 INTRODUCTION: THE THREE DIMENSIONS OF LIABILITY

A single adverse medical event can simultaneously attract three distinct forms of liability. Contractual liability arises from the breach of an express or implied promise to provide medical services with reasonable care and skill. Tortious liability arises from the breach of a duty of care imposed by law independently of contract. Criminal liability arises when the negligence is so gross, so reckless, so utterly disregardful of patient safety that it shocks the judicial conscience and merits punishment by the State. These three dimensions of liability are not mutually exclusive. They may coexist, and the same act or omission may found proceedings in

contract, tort and criminal law concurrently. However, they are governed by different legal principles, require different standards of proof, attract different remedies and are adjudicated before different forums. The hospital administrator must understand each dimension distinctly, appreciate their interrelationship and recognise the strategic considerations that influence which forum a patient may choose to pursue. This lesson examines contractual liability and criminal liability in depth. Contractual liability is the least frequently litigated of the three, yet it provides the foundational theory of the patient-provider relationship. Criminal liability is the most feared, carrying not only financial penalty but the deprivation of liberty and the irrevocable stigma of conviction. The defences available to medical professionals in criminal prosecutions, particularly the landmark judgment of the Supreme Court in Jacob Mathew v. State of Punjab, are essential knowledge for every hospital administrator.

5.2 INTRODUCTORY CASE STUDY: DR. YASH MEHTA v. STATE OF MADHYA PRADESH

On the night of 13 February 2008, a sixteen-year-old boy was admitted to a private hospital in Gwalior, Madhya Pradesh with complaints of acute abdominal pain. He was examined by the attending surgeon who diagnosed acute appendicitis and recommended emergency appendectomy. The surgery was scheduled for the following morning. Dr. Yash Mehta, an anaesthetist with twelve years of experience, was engaged to administer anaesthesia. The surgery commenced at approximately 9:30 AM on 14 February 2008. Dr. Mehta administered general anaesthesia and intubated the patient. Approximately twenty minutes into the procedure, the patient's oxygen saturation began to decline. Bradycardia developed, followed by hypotension. Dr. Mehta attempted to ventilate the patient manually but encountered difficulty. He attempted reintubation but was unsuccessful. A code blue was announced. The surgeon abandoned the procedure. Resuscitation efforts continued for forty-five minutes but were unsuccessful. The patient was declared dead at 11:15 AM.

The patient's father lodged an FIR on 15 February 2008 alleging medical negligence against Dr. Mehta and the surgeon. After investigation, the police filed a charge-sheet against Dr. Mehta alone under Section 304A of the Indian Penal Code for causing death by a rash or negligent act not amounting to culpable homicide. The prosecution alleged that Dr. Mehta had failed to conduct a proper pre-anaesthetic evaluation, had not reviewed the patient's investigation reports including a chest X-ray that revealed mild cardiomegaly, had proceeded with general anaesthesia without obtaining written high-risk consent, and when the patient desaturated, had persisted with multiple unsuccessful intubation attempts instead of promptly inserting a laryngeal mask airway or securing the airway surgically. The Sessions Court convicted Dr. Mehta under Section 304A IPC and sentenced him to rigorous imprisonment for one year and a fine of twenty-five thousand rupees. The Madhya Pradesh High Court confirmed the conviction but reduced the sentence to the period already undergone.

The Supreme Court set aside the conviction and acquitted Dr. Mehta. The Court reaffirmed the principles laid down in Jacob Mathew v. State of Punjab: to constitute criminal negligence, the negligence must be gross, reckless or such a high degree of negligence that it amounts to a culpable disregard for the safety of the patient. A mere lack of adequate care or an error of judgment in choosing one acceptable course of treatment over another is not sufficient. The prosecution had failed to establish gross negligence. The evidence did not conclusively establish that the patient's death was caused by Dr. Mehta's acts or omissions rather than by the underlying pathology or unforeseeable complications. There was no expert evidence establishing that the standard of care fell so far below the expected standard as to merit criminal

sanction. The alleged failure to conduct pre-anaesthetic evaluation was disputed and not proven beyond reasonable doubt. The unsuccessful intubation attempts, while regrettable, did not in themselves constitute gross negligence in the absence of expert opinion condemning the approach.

Relevance to the Lesson: This case illustrates the high threshold for criminal liability in medical practice. The same facts that might support a claim for compensation in contract or tort do not automatically justify criminal prosecution. The Supreme Court has erected a protective jurisprudence around medical professionals, requiring a clear finding of gross negligence and recklessness before criminal sanction can be imposed. The judgment reinforces that errors of judgment, even those with fatal consequences, are not crimes. The distinction between civil and criminal liability is not merely one of degree but of kind.

5.3 CONTRACTUAL LIABILITY OF DOCTORS AND HOSPITALS

The Contractual Foundation

The relationship between a patient and a healthcare provider is fundamentally contractual. When a patient consults a doctor and the doctor agrees to treat, an implied contract arises. The patient promises to pay reasonable fees; the doctor promises to bring to the patient's service their professional knowledge, skill and care. This implied contract is as binding as a written agreement, though its terms are ascertained from the circumstances and the established standards of the profession. The Indian Contract Act, 1872 governs this relationship. Section 2 defines a contract as an agreement enforceable by law. Section 10 prescribes the conditions for a valid contract. The patient-doctor relationship satisfies all these conditions: there is an offer and acceptance, intention to create legal relations, lawful consideration, competent parties, free consent and a lawful object. The absence of a written document does not negate the contract; it is an implied contract evidenced by the conduct of the parties.

Express and Implied Terms

The terms of a patient-doctor contract may be express or implied. Express terms are those explicitly agreed between the parties. These may include the specific treatment to be rendered, the fees to be charged, the duration of hospitalisation and the payment schedule. In practice, express terms in healthcare contracts are minimal. Admission forms contain basic financial terms but rarely define the scope of clinical care. Implied terms fill the gaps left by express agreement. The law implies certain terms into every contract for professional services. The most important is the implied undertaking by the doctor to possess a reasonable degree of skill and to exercise reasonable care in the application of that skill. This is not a promise to cure. A doctor does not guarantee a successful outcome. The law recognises that medicine is an inexact science, that complications are inherent in treatment and that adverse outcomes may occur despite competent care. The contractual duty is to exercise reasonable care and skill, not to achieve a cure.

Basis of Contractual Liability

Contractual liability arises when a party fails to perform their promise under the contract or performs it defectively. In the healthcare context, contractual liability is established by proving the existence of a contract, express or implied, between the patient and the healthcare provider. This is rarely disputed as the act of seeking treatment and the act of providing it create the

ntract. The patient must prove the terms of the contract, particularly the implied undertaking to exercise reasonable care and skill. The patient need not prove that the doctor explicitly promised to be careful; the law implies this term into every contract for medical services. T patient must prove breach of the contract by establishing that the healthcare provider failed to ercise reasonable care and skill. This is essentially the same evidence r ired to establish negligence in tort. The standard of care is the same: the provider must act in accordance with the practice of esponsible body of medical opinion. The patient mu prove damage caused by the breach. Causation is established on a balance of probabilities. The distinction between contractual liability and tortious liability is often immaterial in practice because the duty of care is coextensive. However, there are procedural and substantive differences. Co actual claims may have a longer limitation p od. Contractual damages may be available for pure economic loss without physical injury. The Consumer Protection Act, 2019, which is the most common forum for medical negligence claims, treats the claim as one for deficiency in service, a contractual concept.

Liability of Hospitals

A hospital's contractual liability arises from its direct contract with the patient. When a patient is admitt to a hospital, the contract is with the hospital, not merely with the individual doctors. The hospital undertakes to provide not only facilities and support services but also medical car through its medical staff. Whether the doctors are employees or independent contractors, the hospital's contractual duty to the patient extends to the reasonable care and skill of all persons providing treatment within its facility. This contractual duty is non-delegable. A hospital cannot, by contracting with independent contractors, absolve itself of the contractual obligation it owes directly to the patient. The patient's contract is with the hospital; the hospital's arrangement with its doctors is a separate contract to which the patient is not a party. A breach by the doctor is a breach by the hospital of its contract with the patient.

Limitation of Contractual Liability

Contractual liability is subject to limitations. Damages are restricted to those asonably foreseeable at the time of contracting. ecial damages, being losses beyond the natural and probable consequences of the breach, are recoverable only if the special circumstances were communicated to the provider. A patient who suffers unusual financial loss due to a delayed diagnosis cannot recover that loss unless the hospital was informed of the special circumstances at the time of admission. Exclusion clauses purporting to limit or exclude contractual liability are strictly construed against the hospital and are void if they seek to exclude bility for negligence causing death or personal injury. A hospital admission form that states the hospital shall not be liable for any medical negligence is void and unenforceable.

5.4 DAMAGES: ECONOMIC AND NON-ECONOMIC

Principles of Assessment

Damages for breach of contract are governed by Section 73 of the Indian Contract Act, 187 The section provides that when a contract is broken, the party who suffers by such breach is entitled to receive compensation for any loss or damage caused to them thereby which naturally arose in the usual course of things from such breach or which the parties knew when they made the contract to be likely to result from the breach. Damages are compensatory, not punitive. The purpose is to restore the aggrieved party to the financial position they would have occupied

had the contract been performed. In the context of a failed medical treatment, this is inherently difficult to measure. How does one compensate for permanent paralysis, loss of vision or chronic pain? There is no market price for physical integrity or freedom from pain. The law addresses this difficulty through a distinction between economic damages and non-economic damages.

Economic Damages

Economic damages, also called special damages, are quantifiable monetary losses directly attributable to the breach. They are capable of relatively precise calculation. In healthcare contracts, economic damages include medical expenses incurred to correct or mitigate the consequences of the breach. This includes the cost of additional surgery, prolonged hospitalisation, rehabilitation, medication and assistive devices. Future medical expenses reasonably anticipated are also recoverable. Loss of earnings during the period of treatment and recovery is calculated by reference to the patient's actual income at the time of injury. For employed persons, this is the actual salary lost. For self-employed persons, it is the actual loss of business profits. For persons with irregular income, courts adopt a reasonable estimate based on past earnings. Loss of future earning capacity applies where the patient suffers permanent disability that impairs their ability to earn a livelihood. Compensation is awarded for the reduction in earning capacity calculated by applying a multiplier to the annual loss of income based on the patient's age and the expected remaining years of working life. The Supreme Court has established a structured formula for this calculation with multipliers ranging from eighteen for the youngest victims to five for those near retirement age. Cost of care compensates patients rendered dependent on others for daily activities and is awarded for the cost of attendant care whether provided by family members or hired professionals. Courts recognise that family care is not free; the caregiver sacrifices alternative employment and incurs physical and emotional burden. Incidental expenses including travel expenses for treatment, costs of medical aids and appliances and other miscellaneous expenditures directly caused by the breach are recoverable.

Non-Economic Damages

Non-economic damages, also called general damages, compensate for non-pecuniary losses that cannot be precisely quantified. Pain and suffering compensates for the physical pain, discomfort and distress endured by the patient from the time of injury through recovery and, in cases of permanent injury, for the remainder of life. The quantum is determined by the severity and duration of pain, the nature of the treatment and the permanence of the condition. Loss of amenities of life compensates for the impairment of the patient's ability to enjoy life. This includes loss of ability to pursue hobbies, participate in sports, travel, engage in social activities and experience the ordinary pleasures of daily living. A patient rendered paraplegic loses not only earning capacity but also the ability to walk, run, dance and engage in countless ordinary activities. This loss is compensated separately. Loss of expectation of life applies where the patient's life expectancy is reduced by the injury. Compensation is awarded for the curtailment of life itself, distinct from loss of future earnings; it compensates for the loss of years of life, not the loss of income during those years. Disfigurement and scarring compensates for the psychological impact of permanent visible scarring or disfigurement. Loss of consortium is compensation payable to the spouse for loss of companionship, affection and sexual relations, distinct from the patient's own claim.

Assessment Methodology

Indian courts, particularly in consumer forums and motor accident claims tribunals, have developed structured methodologies for assessing damages. The Supreme Court's decisions in Lata Wadhwa v. State of Bihar, Sarla Verma v. Delhi Transport Corporation and National Insurance Company v. Pranay Sethi provide detailed guidance on the calculation of economic damages, the selection of multipliers and the quantification of non-economic damages in standard categories. For medical negligence cases, the Consumer Protection Act, 2019 empowers consumer forums to award compensation for loss or injury suffered due to negligence. The forums adopt the same principles of assessment as civil courts. Compensation awarded in consumer forums has ranged from modest amounts for minor reversible injuries to several crores for catastrophic permanent injuries to young professionals.

Contribution and Apportionment

Where multiple parties are responsible for the patient's injury, liability is joint and several. The patient is entitled to recover the entire compensation from any one defendant. The paying defendant may then seek contribution from other tortfeasors. In the hospital context, where both the hospital and the individual doctor are liable, the patient may recover the full amount from either. The hospital and doctor then resolve contribution between themselves in accordance with their contractual arrangement or, in the absence of contract, in proportion to their relative fault.

5.5 CRIMINAL LIABILITY UNDER IPC AND BNS

The Constitutional Boundary

Criminal liability occupies a distinct and constitutionally protected domain. A criminal conviction results not merely in financial penalty but in the deprivation of liberty and the enduring stigma of a criminal record. The standard of proof is higher: guilt must be established beyond reasonable doubt. The consequences are graver: imprisonment, fine and for a medical professional, automatic suspension under Section 32 of the National Medical Commission Act, 2019 followed by potential cancellation of registration. The Supreme Court has repeatedly emphasised that criminal liability should not be lightly imposed on medical professionals. Medicine is a complex, uncertain and high-risk endeavour. Errors of judgment, failures of skill and adverse outcomes are inevitable even in the best-regulated systems. To criminalise such errors would be to paralyse the profession, to encourage defensive medicine and ultimately to harm patients. Criminal process is reserved for cases where the negligence is so gross, so reckless, so utterly disregardful of patient safety that it merits the condemnation of the State.

Section 304A of the Indian Penal Code, 1860

Section 304A IPC provides that whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both. This is the principal provision under which medical professionals are prosecuted for negligence resulting in death. The essential ingredients are that the accused must have done a rash or negligent act. The act may be one of commission or omission. The negligence must be more than mere carelessness; it must be gross or reckless. Such act must have caused the death of a person. Causation must be established beyond reasonable doubt. It must be the direct and

proximate cause, not a remote or contributing factor. The act must not amount to culpable homicide. This excludes intentional killing and acts done with the knowledge that death is likely to occur.

Section 106 of the Bharatiya Nyaya Sanhita, 2023

The Bharatiya Nyaya Sanhita, 2023, which received presidential assent in December 2023 and replaces the Indian Penal Code, re-enacts the offence with minor rephrasing. Section 106 BNS provides that whoever causes death of any person by doing any rash or negligent act not amounting to culpable homicide shall be punished with imprisonment of either description for a term which may extend to five years and shall also be liable to fine. The significant change is the enhancement of the maximum punishment from two years to five years imprisonment. This reflects a legislative judgment that rash and negligent acts causing death merit more severe punishment than previously prescribed. Whether this enhancement will affect prosecutions of medical professionals remains to be seen. The Supreme Court's protective jurisprudence regarding the standard of gross negligence is not displaced by the enhanced penalty; the definition of the offence remains substantially unchanged.

Other Relevant Penal Provisions

Section 336 IPC corresponding to Section 115 BNS penalises acts which endanger human life or personal safety of others. Section 337 IPC corresponding to Section 116 BNS penalises causing hurt by an act which endangers human life or personal safety. Section 338 IPC corresponding to Section 117 BNS penalises causing grievous hurt by such an act. These provisions are occasionally invoked in cases of non-fatal medical negligence, though prosecutions are rare. Section 328 IPC corresponding to Section 128 BNS penalises causing hurt by means of poison or any stupefying, intoxicating or unwholesome drug with intent to commit an offence. This provision has been invoked in cases of alleged administration of sedatives without consent or for improper purposes.

The Gross Negligence Standard

The watershed judgment in Jacob Mathew v. State of Punjab decided in 2005 definitively settled the standard for criminal liability in medical negligence. The Supreme Court held that to prosecute a medical professional for negligence under criminal law, it must be shown that the accused did something or failed to do something which in the ordinary course of things a medical professional in his senses would have done or failed to do. The negligence must be gross or reckless, of such a high degree that it amounts to a culpable disregard for the safety of the patient. A mere lack of adequate care, an error of judgment or an accident is not sufficient. A doctor cannot be held criminally liable for patient death unless his negligence or incompetence shows such a high degree of recklessness as to be totally disregardful of the consequences. The Court further prescribed procedural safeguards to protect medical professionals from frivolous or harassing prosecution. A doctor should not be arrested in a routine manner. The investigating officer should, before proceeding against the doctor, obtain an independent and competent medical opinion preferably from a government doctor in the same field. Such opinion should be from a doctor of seniority and standing. Only if that opinion clearly and unambiguously indicates gross negligence should criminal proceedings be initiated. These principles were reaffirmed and elaborated in Dr. Suresh Gupta v. Government of NCT of Delhi decided in 2004 and Dr. Yash Mehta v. State of Madhya Pradesh decided in 2020. In Dr. Suresh Gupta, the Court held that criminal liability cannot be fastened on a doctor for a

mistake of judgment in performing a surgical procedure where the standard of care was not grossly deficient. The Court distinguished between civil liability which arises from simple negligence and criminal liability which requires a higher degree of recklessness.

Automatic Suspension on Conviction

Section 32 of the National Medical Commission Act, 2019 provides that a medical practitioner convicted by a court of law for an offence under the Act or any other offence involving moral turpitude shall be automatically suspended from the date of conviction until the disciplinary authority passes further orders. A conviction under Section 304A IPC or Section 106 BNS, being an offence involving negligence causing death, is an offence involving moral turpitude. The practitioner stands automatically suspended upon conviction regardless of whether the conviction is under appeal. The Ethics and Medical Registration Board subsequently conducts an inquiry and may impose further punishment including permanent removal from the register.

5.6 DEFENCES AVAILABLE TO MEDICAL PROFESSIONALS

The Good Faith Defence: Sections 88 and 92 IPC

The Indian Penal Code contains specific provisions protecting medical professionals acting in good faith. Section 88 IPC provides that nothing is an offence which is done by a person who, by reason of youth, unsoundness of mind, intoxication or any other cause is incapable of giving consent, in good faith for that person's benefit, even if such act causes harm or carries the risk of harm, provided the act is done without any intention of causing death. Section 92 IPC extends this protection to acts done for the benefit of a person without consent where the person is incapable of giving consent and the act is done in good faith for that person's benefit. This provision protects emergency treatment of unconscious patients and others incapable of consenting. To avail the protection of these sections, the medical professional must establish that the act was done in good faith and for the benefit of the patient. Good faith is defined in Section 52 IPC as an act done with due care and attention. There is no general presumption of good faith; it must be established on the evidence. However, where the medical professional has acted in accordance with established medical practice, the court will readily infer good faith.

The Accident or Misfortune Defence: Section 80 IPC

Section 80 IPC provides that nothing is an offence which is done by accident or misfortune, and without any criminal intention or knowledge, in the doing of a lawful act in a lawful manner by lawful means, and with proper care and caution. This provision applies to unforeseen complications and adverse outcomes that occur despite the exercise of proper care and caution. An anaphylactic reaction to a drug to which the patient had no known allergy, administered in accordance with standard protocol, is an accident. A cardiac arrest during a procedure in a patient with undiagnosed coronary artery disease where no warning signs were present is a misfortune. Such events, though resulting in patient harm or death, are not offences. The defence requires proof that the act was lawful, done in a lawful manner, by lawful means and with proper care and caution. A doctor who fails to take a proper history, fails to conduct appropriate pre-procedure evaluation or fails to monitor the patient adequately cannot invoke this defence. The care and caution must be proper and reasonable in the circumstances.

Absence of Gross Negligence

The most frequently invoked defence in criminal prosecutions of medical professionals is the absence of gross negligence. As established in Jacob Mathew, criminal liability requires a degree of negligence substantially higher than that sufficient for civil liability. The prosecution must prove that the doctor's conduct was not merely negligent but grossly negligent, reckless or so far below the accepted standard as to amount to a culpable disregard for patient safety. This defence is established by adducing expert evidence that the doctor's conduct was in accordance with a responsible body of medical opinion, even if other practitioners would have acted differently. The Bolam test, modified in Samira Kohli, applies equally in criminal proceedings. A doctor is not guilty of criminal negligence if their actions or omissions were in accordance with a practice accepted as proper by a responsible body of medical professionals skilled in that particular field.

Absence of Causation

The prosecution must prove beyond reasonable doubt that the doctor's negligence caused the patient's death. This is often the most difficult element to establish. Patients who suffer adverse outcomes frequently have underlying disease processes that may have caused death irrespective of any negligence. The burden is on the prosecution to exclude reasonable doubt that the death was caused by the disease rather than the negligence. In Dr. Yash Mehta, the Supreme Court noted that the prosecution had not adduced expert evidence establishing that the patient's death was caused by the alleged negligence rather than by the underlying pathology or unforeseeable complications. This failure was fatal to the prosecution. The defence of absence of causation is particularly potent in cases where the patient had severe pre-existing illness, where the standard of care was disputed or where multiple factors contributed to the outcome.

Lack of Criminal Intent or Knowledge

Criminal negligence requires more than inadvertence or carelessness. It requires a state of mind that is reckless or utterly disregardful of consequences. The prosecution must establish that the doctor knew or ought to have known that their conduct posed a serious risk to patient safety and nevertheless proceeded with that conduct. This is a higher threshold than the objective standard of care applicable in civil proceedings. A doctor who makes an error of judgment, even a serious one, does not thereby manifest criminal intent. The defence may be established by showing that the doctor acted in accordance with their training, that they believed their actions were appropriate and that they did not consciously disregard a known risk.

Procedural Safeguards

The procedural safeguards prescribed in Jacob Mathew are themselves a powerful defence. Where the police have registered an FIR and proceeded with investigation without obtaining an independent expert opinion from a government doctor of seniority and standing in the same field, the defence may move the High Court under Section 482 CrPC or Article 226 of the Constitution to quash the proceedings. The Supreme Court has repeatedly quashed criminal proceedings against doctors where the investigation failed to comply with these procedural requirements.

Automatic Suspension and Its Consequences

A conviction, even if ultimately overturned on appeal, triggers automatic suspension under Section 32 of the NMC Act, 2019. The suspended practitioner cannot practise medicine during the pendency of the appeal. This can have devastating professional and financial consequences. The defence strategy in serious cases must therefore be to avoid conviction at the trial stage, not merely to secure acquittal on appeal. This requires intensive preparation, expert testimony and often senior counsel.

5.7 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES

Condition and Warranty

In the law of contract, terms are classified as conditions or warranties. A condition is a term of such essential importance that its breach destroys the foundation of the contract and entitles the aggrieved party to treat the contract as repudiated and claim damages. A warranty is a term of lesser importance; its breach entitles the aggrieved party to claim damages but does not justify repudiation of the contract. In healthcare contracts, the distinction is rarely litigated. The patient's primary remedy for breach of the implied term to exercise reasonable care and skill is damages, not repudiation. A patient cannot refuse to pay for treatment on the ground that the outcome was unsatisfactory; they may only claim compensation for the loss caused by the breach. The contract continues; the patient remains liable for fees for services actually rendered.

Exemption Clauses and Unconscionable Terms

Hospitals occasionally include clauses in admission forms purporting to exclude or limit their liability. A clause may state that the hospital shall not be liable for any loss or damage to patient property. Another may purport to require the patient to indemnify the hospital against any claims arising from treatment. A third may seek to limit the time within which claims may be brought. Such clauses are strictly construed by courts. Any ambiguity is resolved against the hospital as the drafting party. Clauses purporting to exclude liability for death or personal injury caused by negligence are void as against public policy. Clauses imposing unreasonable procedural restrictions, such as requiring arbitration in a distant forum or imposing a limitation period shorter than that prescribed by law, may be struck down as unconscionable. However, clauses that reasonably allocate risk between the parties are enforceable. A clause requiring the patient to bear the cost of replacing stolen property left in an unlocked room where the hospital has provided a safe deposit facility is enforceable. A clause requiring the patient to inform the hospital of any change in address is enforceable. A clause specifying the hospital's policy on payment of bills by third-party sponsors is enforceable.

Force Majeure and Frustration

Section 56 of the Indian Contract Act, 1872 codifies the doctrine of frustration. A contract to do an act which after the contract is made becomes impossible or unlawful becomes void when the impossibility or unlawfulness is discovered. The doctrine applies not only to physical impossibility but also to circumstances where performance would be radically different from what was contemplated by the parties. The COVID-19 pandemic generated numerous force majeure and frustration issues in healthcare contracts. Hospitals were compelled to cancel

elective surgeries to divert resources to pandemic response. Patients were unable to travel for scheduled treatment due to lockdowns. A force majeure clause in a contract expressly allocates the risk of specified supervening events. Where the contract contains such a clause, its terms govern. In the absence of a force majeure clause, the doctrine of frustration may apply if the supervening event renders performance impossible or fundamentally different from what was contemplated. A hospital that cancels elective surgeries due to a government order directing diversion of resources is not in breach of contract; the contract is frustrated and becomes void. The patient is entitled to refund of any advance payments but not to damages for non-performance. However, frustration does not apply where the supervening event was foreseeable and the party could have protected themselves by contractual provision. A hospital that fails to maintain adequate insurance or business continuity arrangements cannot rely on frustration to avoid liability for its own lack of preparation.

Contracts of Indemnity and Insurance

Professional indemnity insurance is a contract of indemnity. The insurer undertakes to indemnify the insured doctor or hospital against claims for compensation arising from professional negligence. The policy defines the scope of cover, the limit of indemnity, the excess or deductible and the conditions for notification and settlement. The hospital administrator must ensure that all medical staff, whether employees or independent contractors, maintain adequate professional indemnity insurance. The adequacy of cover is determined by the specialty and risk profile of the practitioner. High-risk specialties such as neurosurgery, cardiothoracic surgery and obstetrics require substantially higher limits than low-risk specialties. The hospital should verify compliance annually and maintain copies of certificates of insurance. The contract of indemnity is between the insurer and the insured. The patient has no direct rights against the insurer unless the policy is a third-party beneficiary contract or the insurer has assumed direct liability under a claims-made and reported policy. In practice, most claims are negotiated and settled with the insurer's participation and the insurer discharges the liability on behalf of the insured.

Employment Contracts and Restraint of Trade

Section 27 of the Indian Contract Act, 1872 declares void any agreement by which anyone is restrained from exercising a lawful profession, trade or business. This is the Indian rule against restraint of trade, which is significantly stricter than the common law rule. In England, restraints are void only if unreasonable; in India, they are void unless they fall within the narrow exceptions recognised by judicial interpretation. Employment contracts in hospitals often contain non-compete clauses restricting a doctor from practising within a specified geographical area for a specified period after leaving the hospital. Such clauses are void under Section 27. The Supreme Court has consistently held that any restraint, even if partial and reasonable, is void unless it is for the protection of a legitimate interest and is ancillary to the main contract. Non-compete clauses operating after termination of employment are generally unenforceable. However, a clause that protects the hospital's confidential information, trade secrets or patient lists is enforceable as a restraint ancillary to the contract. A doctor may be restrained from soliciting the hospital's patients using the hospital's confidential information. This is not a restraint on practising the profession; it is a restraint on the misuse of confidential information.

5.8 STUDENT LEARNING ACTIVITIES

Activity 1: Distinguishing Civil and Criminal Negligence

You are the Administrator of a two hundred bed hospital. A fifty-five year old patient underwent elective hip replacement surgery. During the procedure, the anaesthetist administered a drug to which the patient had a documented allergy clearly noted in the medical records. The patient suffered an anaphylactic reaction, cardiac arrest and despite resuscitation, severe hypoxic brain injury. The patient is now in a permanent vegetative state. The patient's family has initiated both a consumer complaint claiming two crore rupees compensation and a criminal complaint under Section 304A IPC. The police have registered an FIR and are conducting an investigation. Prepare a briefing note for the anaesthetist explaining the distinction between civil negligence and criminal negligence with specific reference to the facts of this case, the standard of proof applicable in each proceeding, the elements the prosecution must establish to secure a conviction under Section 304A IPC, the defences available including the Jacob Mathew principles, and the potential consequences of conviction including automatic suspension under Section 32 of the NMC Act, 2019.

Activity 2: Assessment of Damages

Mrs. Sharma, a forty-two year old chartered accountant with an annual income of twenty-four lakh rupees, underwent a laparoscopic hysterectomy at your hospital. Due to negligence in the surgical technique, her right ureter was ligated and transected. The injury was not recognised intra-operatively. She presented five days post-discharge with acute renal failure. She required a second surgery for ureteric reimplantation, prolonged hospitalisation of eighteen days and will require lifelong follow-up for renal function monitoring. She has been advised that she has a twenty per cent risk of developing chronic kidney disease within ten years. She was unable to work for four months. She has incurred medical expenses of eight lakh fifty thousand rupees for the second surgery and hospitalisation which she has paid out of pocket. She expects to require annual renal function tests and consultations at a cost of approximately twenty-five thousand rupees per year for the remainder of her life expectancy of thirty-eight years. Calculate the compensation payable to Mrs. Sharma under the heads of past medical expenses, future medical expenses, loss of earnings during treatment period, loss of future earning capacity assuming ten per cent permanent disability, pain and suffering and loss of amenities, and loss of expectation of life. Provide a reasoned calculation for each head with reference to the principles established in Sarla Verma v. Delhi Transport Corporation and other relevant precedents.

Activity 3: Force Majeure and Frustration Analysis

In March 2020, your hospital entered into a five-year contract with a private diagnostic company for the operation and maintenance of your MRI and CT scan equipment. The contract contained a force majeure clause defining force majeure events as acts of God, war, terrorism, riots and any other event beyond the reasonable control of the affected party. The contract did not specifically mention pandemic or epidemic. In April 2020, the Government of India imposed a nationwide lockdown. Your hospital suspended all elective diagnostic imaging for six weeks to conserve resources for COVID-19 response and to comply with government directives. During this period, the diagnostic company continued to invoice your hospital for the monthly service charge. You refused payment on the ground of force majeure. The

diagnostic company has threatened legal action for recovery of eighteen lakh rupees in unpaid invoices, claiming that the lockdown did not render performance impossible as the equipment remained functional and their engineers were available to perform maintenance. Draft a legal opinion addressed to the Hospital Board analysing whether the COVID-19 lockdown constitutes a force majeure event under the contract, whether the doctrine of frustration under Section 56 applies in the absence of a force majeure clause or in addition to it, whether your hospital is liable for the service charges during the period when the equipment was operational but not used due to your suspension of services, and what remedial steps you should now take including potential renegotiation of the contract.

Activity 4: Expert Opinion on Gross Negligence

The State Medical Council has sought your expert opinion as a senior hospital administrator in a disciplinary inquiry against Dr. Rajan, a general surgeon. Dr. Rajan performed an open cholecystectomy on a sixty-year-old diabetic patient. During the procedure, he encountered dense adhesions from a previous abdominal surgery. He continued the dissection despite poor visualisation. The common bile duct was inadvertently transected. Dr. Rajan recognised the injury, performed a primary repair over a T-tube and consulted a gastrointestinal surgeon by telephone during the procedure. The patient developed a bile leak post-operatively, required re-operation by the GI surgeon and suffered prolonged hospitalisation. The patient has filed a criminal complaint under Section 304A IPC. The investigating officer has obtained an opinion from a government surgeon stating that Dr. Rajan's decision to continue dissection in the presence of dense adhesions without obtaining immediate intra-operative senior consultation constituted gross negligence. Prepare a detailed expert opinion analysing whether the facts establish gross negligence sufficient for criminal prosecution under the Jacob Mathew standard. Define the standard of care expected of a general surgeon performing laparoscopic cholecystectomy, identify the specific acts or omissions alleged to constitute negligence, assess whether these acts or omissions fall below the standard of care, determine whether any deficiency is best characterised as an error of judgment, simple negligence or gross negligence, evaluate whether the prosecution has satisfied the procedural safeguards prescribed in Jacob Mathew, and recommend whether disciplinary proceedings should be initiated and on what grounds.

5.9 SUMMARY

The liability of healthcare providers in India operates across three distinct but overlapping dimensions: contractual liability, tortious liability and criminal liability. Each dimension is governed by different legal principles, requires different standards of proof, attracts different remedies and is adjudicated before different forums.

Contractual liability arises from the breach of an express or implied promise to provide medical services with reasonable care and skill. Every patient-doctor relationship is founded on an implied contract wherein the doctor undertakes to possess and exercise reasonable skill and care and the patient undertakes to pay reasonable fees. The hospital's contractual duty is direct and non-delegable; it cannot be discharged by engaging independent contractors. Damages for breach of contract are governed by Section 73 of the Indian Contract Act, 1872 and are assessed on a compensatory basis.

Damages are classified as economic or non-economic. Economic damages compensate for quantifiable monetary losses: medical expenses, loss of earnings, loss of future earning capacity and cost of care. Non-economic damages compensate for non-pecuniary losses: pain and suffering, loss of amenities of life, loss of expectation of life, disfigurement and loss of consortium. The Supreme Court has established structured methodologies for calculating damages including the multiplier method for loss of future earning capacity and standardised awards for non-economic losses in catastrophic injury cases.

Criminal liability is reserved for cases of gross negligence or recklessness that exhibit a culpable disregard for patient safety. The principal provision is Section 304A IPC for causing death by rash or negligent act, carrying punishment of up to two years imprisonment. The Bharatiya Nyaya Sanhita, 2023 re-enacts this provision as Section 106 with an enhanced maximum punishment of five years. The watershed judgment in Jacob Mathew v. State of Punjab definitively settled the standard for criminal liability: to prosecute a medical professional under criminal law, the negligence must be gross or reckless, of such a high degree that it amounts to a culpable disregard for the safety of the patient. A mere lack of adequate care, an error of judgment or an accident is not sufficient. The Court further prescribed procedural safeguards: investigating officers must obtain an independent expert opinion from a government doctor of seniority and standing in the same field before proceeding against a doctor.

Defences available to medical professionals in criminal prosecutions include the good faith defence under Sections 88 and 92 IPC, the accident or misfortune defence under Section 80 IPC, the absence of gross negligence as established by expert evidence that the doctor's conduct was in accordance with a responsible body of medical opinion, the absence of causation particularly where the patient had severe pre-existing illness, lack of criminal intent or knowledge, and the procedural safeguards prescribed in Jacob Mathew.

Automatic suspension under Section 32 of the National Medical Commission Act, 2019 is triggered by conviction for an offence involving moral turpitude. A conviction under Section 304A IPC or Section 106 BNS constitutes such an offence. The practitioner stands suspended from the date of conviction regardless of appeal, with the Ethics and Medical Registration Board empowered to impose further punishment including permanent removal from the register.

Healthcare-specific contractual issues include the distinction between condition and warranty, which is rarely litigated in healthcare contracts as the patient's primary remedy is damages rather than repudiation. Exemption clauses purporting to exclude liability for negligence causing death or personal injury are void as against public policy. Force majeure clauses allocate risk of supervening events; in their absence, the doctrine of frustration under Section 56 may apply where performance becomes impossible or radically different from what was contemplated. Restrictive covenants in employment contracts, particularly non-compete clauses operating after termination, are void under Section 27 of the Indian Contract Act, 1872, though restraints on misuse of confidential information are enforceable.

The hospital administrator must maintain a clear conceptual distinction between civil and criminal liability. The same facts may support a claim for compensation in contract or tort but fall far short of establishing the gross negligence required for criminal conviction. The protective jurisprudence of the Supreme Court, while robust, is not absolute. Administrators must ensure that systems are in place to prevent the kind of egregious, reckless conduct that

attracts criminal sanction: thorough credentialing, adequate supervision, functional equipment, trained staff and a culture of safety that prioritises patient welfare over institutional convenience.

5.10 KEY WORDS WITH EXPLANATIONS

Contractual Liability is liability arising from the breach of an express or implied promise contained in a contract. In healthcare, the doctor impliedly promises to possess and exercise reasonable skill and care; breach of this promise gives rise to contractual liability. The remedy is damages under Section 73 of the Indian Contract Act, 1872.

Implied Contract is a contract created by the conduct of the parties rather than by express written or oral agreement. When a patient seeks treatment and a doctor provides it, the law implies a contract wherein the doctor promises reasonable care and the patient promises to pay reasonable fees.

Economic Damages are quantifiable monetary losses arising from breach of contract or negligence. They include medical expenses, loss of earnings, loss of future earning capacity and cost of care. They are also termed special damages.

Non-Economic Damages are compensation for non-pecuniary losses that cannot be precisely quantified. They include pain and suffering, loss of amenities of life, loss of expectation of life, disfigurement and loss of consortium. They are also termed general damages.

Section 304A IPC is the penal provision under the Indian Penal Code, 1860 punishing causing death by a rash or negligent act not amounting to culpable homicide. Maximum punishment is imprisonment for two years or fine or both. This is the provision under which medical professionals are most commonly prosecuted for negligence resulting in death.

Section 106 BNS is the corresponding provision under the Bharatiya Nyaya Sanhita, 2023 re-enacting the offence with enhanced maximum punishment of five years imprisonment.

Gross Negligence is negligence of a very high degree amounting to a reckless or culpable disregard for the safety of others. It is the threshold for criminal liability under Section 304A IPC and is distinguished from simple negligence which suffices for civil liability.

Jacob Mathew Principles are the standard for criminal liability of medical professionals established by the Supreme Court in Jacob Mathew v. State of Punjab. To constitute criminal negligence, the negligence must be gross, reckless or such a high degree that it amounts to a culpable disregard for patient safety. Procedural safeguards include mandatory independent expert opinion before prosecution.

Good Faith Defence is the protection under Sections 88 and 92 IPC for acts done in good faith for the benefit of a person even if such acts cause harm or carry risk of harm. It requires that the act be done with due care and attention and without intention to cause death.

Accident or Misfortune Defence is the protection under Section 80 IPC for acts done by accident or misfortune, without criminal intention or knowledge, in the doing of a lawful act in

a lawful manner by lawful means, with proper care and caution. It applies to unforeseen complications and adverse outcomes despite proper care.

Automatic Suspension is the provision under Section 32 of the National Medical Commission Act, 2019 whereby a medical practitioner convicted by a court of law for an offence under the Act or any offence involving moral turpitude stands suspended from the date of conviction until the disciplinary authority passes further orders.

Force Majeure is a contractual clause allocating risk of specified supervening events beyond the control of the parties such as acts of God, war, terrorism and epidemics. It suspends or excuses performance during the continuance of the event.

Frustration is the doctrine codified in Section 56 of the Indian Contract Act, 1872 whereby a contract becomes void when performance becomes impossible or unlawful or when the supervening event renders performance radically different from what was contemplated by the parties.

Exemption Clause is a contractual term purporting to exclude or limit liability for breach of contract. It is strictly construed against the drafting party. Clauses excluding liability for death or personal injury caused by negligence are void as against public policy.

Restraint of Trade under Section 27 of the Indian Contract Act, 1872 declares void any agreement restraining a person from exercising a lawful profession, trade or business. Non-compete clauses in employment contracts are generally unenforceable, though restraints on misuse of confidential information are permissible.

5.11 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What is the legal basis of contractual liability of a doctor towards a patient in the absence of a written agreement?

Ans. The legal basis is an implied contract arising from the conduct of the parties. When a patient seeks treatment and a doctor provides it, the law implies a promise by the doctor to possess and exercise reasonable skill and care in the treatment of the patient and a reciprocal promise by the patient to pay reasonable fees for such services. This implied contract satisfies the requisites of a valid contract under Section 10 of the Indian Contract Act, 1872: there is offer and acceptance, intention to create legal relations, lawful consideration, competent parties, free consent and lawful object.

Q2. Distinguish between economic damages and non-economic damages in the context of medical negligence claims.

Ans. Economic damages, also called special damages, compensate for quantifiable monetary losses directly attributable to the negligence. These include past and future medical expenses, loss of earnings during treatment and recovery, loss of future earning capacity and cost of attendant care. They are capable of relatively precise calculation. Non-economic damages, also called general damages, compensate for non-pecuniary losses that cannot be precisely quantified. These include pain and suffering, loss of amenities of life, loss of

expectation of life, disfigurement and loss of consortium. They are assessed by courts based on the severity and duration of the injury and the impact on the patient's quality of life.

Q3. What is the essential ingredient of the offence under Section 304A of the Indian Penal Code, 1860?

Ans. The essential ingredient is causing death by doing a rash or negligent act not amounting to culpable homicide. The act must be the direct and proximate cause of death. The negligence must be more than mere carelessness; it must be gross or reckless, of such a high degree that it amounts to a culpable disregard for the safety of the patient. A mere error of judgment, lack of adequate care or accident does not constitute the offence.

Q4. What procedural safeguards did the Supreme Court prescribe in Jacob Mathew v. State of Punjab for prosecution of medical professionals?

Ans. The Court prescribed that a doctor should not be arrested in a routine manner. The investigating officer should, before proceeding against the doctor, obtain an independent and competent medical opinion preferably from a government doctor in the same field. Such opinion should be from a doctor of seniority and standing. Only if that opinion clearly and unambiguously indicates gross negligence should criminal proceedings be initiated. These safeguards are designed to protect medical professionals from frivolous or harassing prosecution.

Q5. What is the effect of Section 32 of the National Medical Commission Act, 2019 on a medical practitioner convicted under Section 304A IPC?

Ans. Section 32 provides for automatic suspension. A medical practitioner convicted by a court of law for an offence under the Act or any other offence involving moral turpitude shall be automatically suspended from the date of conviction until the disciplinary authority passes further orders. A conviction under Section 304A IPC for causing death by negligence is an offence involving moral turpitude. The practitioner is automatically suspended immediately upon conviction regardless of whether an appeal is filed. The Ethics and Medical Registration Board thereafter conducts an inquiry and may impose further punishment including permanent removal from the register.

B. Essay Type Questions with Hints

Q1. Critically examine the distinction between civil liability and criminal liability for medical negligence in India. How has the Supreme Court defined the threshold for criminal negligence and what policy considerations underlie this distinction?

Hints: Begin by identifying the three dimensions of liability and the distinct legal frameworks governing each. Explain that the same set of facts may simultaneously found proceedings in contract, tort and criminal law. Elaborate the differences in standard of proof, forum, remedy and consequences. Analyse the Jacob Mathew standard in depth: negligence must be gross, reckless or such a high degree that it amounts to a culpable disregard for patient safety. Explain why this high threshold is necessary: to protect doctors from harassment, to prevent defensive medicine, to encourage innovation and because criminal sanction is disproportionate for errors of judgment. Discuss the procedural safeguards and their rationale. Conclude with the

observation that the distinction is not merely one of degree but of kind, reflecting the constitutional protection of liberty and the unique nature of medical practice.

Q2. Explain the principles governing assessment of damages for medical negligence under the Consumer Protection Act, 2019. How are economic damages calculated and what factors influence the quantification of non-economic damages?

Hints: Structure your answer around the distinction between economic and non-economic damages. For economic damages, explain the calculation of past medical expenses based on actual bills, future medical expenses based on life expectancy and periodic cost, loss of earnings during treatment as actual income lost, loss of future earning capacity using the multiplier method established in Sarla Verma and Pranay Sethi. Explain how the multiplier is selected based on the patient's age and how the annual loss is computed as the difference between pre-accident and post-accident earning capacity. For non-economic damages, discuss the factors considered: severity and duration of pain, extent of permanent disability, impact on quality of life, age of the patient. Explain that while there are no fixed tariffs, courts have developed standard ranges for common injuries. Conclude with the observation that compensation must be fair, reasonable and just, neither a pittance nor a windfall.

Q3. Evaluate the adequacy of the defence of good faith under Sections 88 and 92 of the Indian Penal Code in protecting medical professionals from criminal prosecution. What must a doctor establish to successfully invoke this defence?

Hints: Explain the text and scope of Sections 88 and 92. Section 88 protects acts done in good faith for the benefit of a person with consent, even if harm is caused or risked. Section 92 protects acts done in good faith for the benefit of a person without consent where the person is incapable of consenting. Analyse the elements: good faith, benefit of the person and in the case of Section 88, consent. Define good faith under Section 52 IPC as an act done with due care and attention. Explain that there is no presumption of good faith; the doctor must establish it on the evidence. Discuss how the defence applies to emergency treatment of unconscious patients, treatment of minors with parental consent and innovative procedures with uncertain outcomes. Evaluate the adequacy of the defence: it provides substantial protection but requires the doctor to demonstrate that they acted with due care and attention, which is essentially the same standard as the Bolam test. Conclude that the defence is adequate but procedurally underutilised.

Q4. Discuss the validity and enforceability of exemption clauses in hospital admission contracts. Under what circumstances will a court strike down such a clause?

Hints: Define exemption clauses and classify them as exclusion clauses or limitation clauses. Explain the general principles of construction: contra proferentem, ambiguity resolved against the drafting party. Discuss the specific rule regarding exclusion of liability for negligence: such clauses are strictly construed and will not be effective unless the language is absolutely clear and unambiguous. Explain the public policy limitation: a clause purporting to exclude liability for death or personal injury caused by negligence is void as against public policy. Discuss other grounds for striking down clauses: unconscionability where the clause is hidden in fine print or uses incomprehensible language; lack of notice where the clause was not brought to the patient's attention before contract formation; fundamental breach where the breach goes to the root of the contract. Conclude with practical advice for hospital administrators: do not include

clauses purporting to exclude liability for negligence; instead focus on clear communication of financial terms, patient responsibilities and dispute resolution mechanisms.

Q5. You are the Administrator of a hospital against which criminal proceedings have been initiated under Section 304A IPC following a surgical death. The investigating officer has not obtained any independent expert opinion. Draft a petition under Section 482 CrPC before the High Court seeking quashing of the FIR, citing the Jacob Mathew principles and the procedural safeguards prescribed therein.

Hints: Structure your petition in the standard format: cause title, introduction, facts of the case, grounds, prayer. In the facts section, succinctly describe the surgical procedure, the adverse event, the death and the registration of the FIR. Emphasise that the patient had severe pre-existing illness and that the death was due to complications of the disease process rather than any negligence. In the grounds section, argue that the investigating officer has failed to comply with the mandatory procedural safeguards prescribed in Jacob Mathew; no independent expert opinion from a government doctor of seniority and standing in the same speciality has been obtained; in the absence of such opinion, the FIR is a product of non-application of mind and an abuse of process of law; the allegations on their face do not constitute the offence of causing death by rash or negligent act; the alleged acts, even if accepted, amount at best to an error of judgment which does not attract criminal liability. Cite Jacob Mathew, Dr. Suresh Gupta and Dr. Yash Mehta. Pray for quashing of the FIR and all consequential proceedings.

C. Analytical Multiple Choice Questions

1. Under the Indian Contract Act, 1872, the liability of a doctor for breach of the implied undertaking to exercise reasonable care and skill is:
a) Strict liability, requiring no proof of fault
b) Absolute liability, with no defences available
c) Fault-based liability, requiring proof of failure to exercise reasonable care and skill
d) Criminal liability, requiring proof of guilty intention
Correct Answer: c) Fault-based liability, requiring proof of failure to exercise reasonable care and skill

2. In assessing compensation for loss of future earning capacity in a medical negligence case, Indian courts apply the multiplier method. The multiplier is derived from:
a) The patient's life expectancy at the time of judgment
b) The patient's age at the time of the injury, as per the Second Schedule to the Motor Vehicles Act, 1988 and the judgments in Sarla Verma and Pranay Sethi
c) The actual number of years the patient would have worked until retirement, without any discounting
d) The amount claimed by the patient in the consumer complaint
Correct Answer: b) The patient's age at the time of the injury, as per the Second Schedule to the Motor Vehicles Act, 1988 and the judgments in Sarla Verma and Pranay Sethi

3. Which of the following statements correctly states the law regarding criminal liability of medical professionals under Section 304A IPC as interpreted in Jacob Mathew v. State of Punjab?
a) Any act of medical negligence resulting in death is punishable under Section 304A IPC
b) Criminal liability requires that the negligence be gross, reckless or such a high degree that it amounts to a culpable disregard for patient safety

c) The investigating officer may arrest a doctor without any prior expert opinion
d) The burden of proof is on the doctor to establish that they were not negligent
Correct Answer: b) Criminal liability requires that the negligence be gross, reckless or such a high degree that it amounts to a culpable disregard for patient safety

4. A clause in a hospital admission form states: The hospital shall not be liable for any death or injury caused to the patient during the course of treatment, howsoever caused. This clause is:
a) Fully enforceable as a valid contractual term
b) Enforceable only if the patient signed the form voluntarily
c) Void as against public policy
d) Valid but subject to strict construction
Correct Answer: c) Void as against public policy

5. Section 32 of the National Medical Commission Act, 2019 provides for automatic suspension of a medical practitioner upon:
a) Registration of an FIR alleging medical negligence
b) Filing of a consumer complaint before the State Consumer Commission
c) Conviction by a court of law for an offence involving moral turpitude
d) Issuance of a show-cause notice by the State Medical Council
Correct Answer: c) Conviction by a court of law for an offence involving moral turpitude

6. The doctrine of frustration under Section 56 of the Indian Contract Act, 1872 applies when:
a) Performance of the contract has become more expensive or onerous than anticipated
b) A party finds it commercially inconvenient to perform the contract
c) A supervening event renders performance impossible or radically different from what was contemplated by the parties
d) One party commits a breach of contract
Correct Answer: c) A supervening event renders performance impossible or radically different from what was contemplated by the parties

7. A non-compete clause in a doctor's employment contract restricting the doctor from practising within a ten kilometre radius of the hospital for two years after leaving employment is:
a) Fully enforceable as a valid restraint of trade
b) Enforceable only if the restriction is reasonable in extent and duration
c) Void under Section 27 of the Indian Contract Act, 1872
d) Enforceable if the doctor voluntarily agreed to it
Correct Answer: c) Void under Section 27 of the Indian Contract Act, 1872

5.12 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Post-Partum Haemorrhage: Contract, Compensation and Criminal Prosecution

Sushrusha Maternity and Nursing Home is a fifty-bed private maternity hospital located in a district town in Andhra Pradesh, established in 2005 as a partnership firm under the Indian Partnership Act, 1932 with two partners: Dr. Vasudha Reddy, an obstetrician and gynaecologist, and her husband Mr. Ramesh Reddy, a non-medical administrator. The hospital is registered under the Andhra Pradesh Private Medical Care Establishments Act, 2002 and is

empanelled under the Dr. NTR Vaidya Seva health insurance scheme for cashless delivery services to Below Poverty Line families.

Mrs. Lalitha Kumari, a twenty-eight year old primigravida, was admitted to Sushrusha Maternity and Nursing Home on 10 October 2025 at thirty-nine weeks gestation for elective induction of labour. Her antenatal records indicated no significant medical or obstetric risk factors. She had registered with the hospital at sixteen weeks gestation and had attended all scheduled antenatal consultations with Dr. Vasudha Reddy. Her husband, Mr. Srinivasan, a school teacher, had paid the package fee of thirty-five thousand rupees for normal delivery which included obstetric care, hospital stay for three days, neonatal care and all routine medications.

On 11 October 2025 at 8:00 AM, Dr. Reddy commenced induction of labour with oxytocin infusion. The progress of labour was monitored by the nursing staff. At 4:30 PM, cervical examination revealed seven centimetres dilation. At 6:15 PM, the patient complained of severe headache and blurred vision. Her blood pressure was recorded as 160 over 110 mmHg. Urine dipstick testing revealed three plus proteinuria. Dr. Reddy was notified and arrived at 6:40 PM. She diagnosed severe pre-eclampsia and administered intravenous labetalol. She decided to proceed with emergency caesarean section.

The caesarean section commenced at 7:30 PM. A live female baby was delivered without complication. However, following delivery of the placenta, the uterus failed to contract. There was brisk haemorrhage from the placental bed. Dr. Reddy administered oxytocin, methylergometrine and carboprost sequentially. The haemorrhage continued. She performed uterine massage and attempted uterine artery ligation but was unsuccessful in controlling the bleeding. By 8:15 PM, the patient had lost an estimated 1.8 litres of blood and was hypotensive and tachycardic. Dr. Reddy decided to perform a peripartum hysterectomy. She commenced the procedure at 8:30 PM. The hospital did not have a blood bank; it maintained a blood storage unit with cross-matching facilities but relied on arranged donors for transfusion. Mr. Srinivasan and two relatives were sent to a government hospital twelve kilometres away to arrange for blood donation. The first unit of packed red blood cells was administered at 9:50 PM. The hysterectomy was completed at 10:15 PM. The patient was transferred to the recovery room. Her blood pressure remained low despite continued transfusion. At 11:30 PM, she became unresponsive. Cardiopulmonary resuscitation was initiated. Dr. Reddy attempted to secure the airway but was unable to intubate. The hospital had no anaesthetist on duty; the only anaesthetist associated with the hospital resided thirty minutes away and was contacted but arrived at 12:10 AM. Resuscitation efforts were discontinued at 12:25 AM. Mrs. Lalitha Kumari was declared dead.

Mr. Srinivasan lodged a police complaint on 12 October 2025 alleging medical negligence against Dr. Vasudha Reddy and Sushrusha Maternity and Nursing Home. The police registered an FIR under Sections 304A, 337 and 338 IPC. The investigating officer referred the matter to the District Medical and Health Officer for an expert opinion. The DMHO constituted a medical board comprising the Civil Surgeon, the Head of Obstetrics and Gynaecology at the district hospital and the Head of Anaesthesiology. The board opined that Dr. Reddy's management exhibited several deficiencies: failure to recognise and respond promptly to the signs of severe pre-eclampsia, delay in decision-making for caesarean section, failure to arrange for blood products in advance for a high-risk patient, failure to perform intra-operative cell salvage or other blood conservation techniques, delay in performing hysterectomy, performance of a complex surgical procedure without an anaesthetist present, and failure to

secure the airway during resuscitation. The board concluded that the cumulative effect of these deficiencies constituted gross negligence. On the basis of this opinion, the investigating officer filed a charge-sheet against Dr. Vasudha Reddy on 10 December 2025 charging her with offences under Section 304A IPC and in the alternative under Section 337 IPC.

Mr. Srinivasan filed a consumer complaint before the Andhra Pradesh State Consumer Disputes Redressal Commission against Dr. Vasudha Reddy and Sushrusha Maternity and Nursing Home on 15 November 2025 claiming compensation of seventy-five lakh rupees for medical negligence and deficiency in service. The complaint alleged breach of the implied contractual duty to provide medical services with reasonable care and skill and deficiency in service under the Consumer Protection Act, 2019 including failure to diagnose and manage pre-eclampsia in a timely manner, failure to arrange adequate blood products, failure to ensure availability of an anaesthetist and failure to provide appropriate resuscitative care.

The admission form signed by Mrs. Lalitha Kumari at the time of registration contained Clause 7 stating that the hospital shall provide medical care through qualified doctors and staff but the hospital does not guarantee any specific outcome or result from treatment and the patient acknowledges that medicine is an inexact science and that complications may arise despite the exercise of reasonable care. Clause 12 stated that the hospital shall not be liable for any delay in arrangement of blood products where such delay is caused by factors beyond the hospital's control including non-availability of donors, transportation difficulties or technical problems in cross-matching. Clause 15 stated that any dispute arising out of or in connection with this admission contract shall be referred to arbitration by a sole arbitrator appointed by the hospital, the arbitration shall be held at the hospital premises and the decision of the arbitrator shall be final and binding on the parties. Mr. Srinivasan stated in his complaint that he had not read these clauses at the time of admission and that they were not explained to him. He submitted that Clause 12 was an unfair exclusion clause and that Clause 15 was unconscionable and void.

Dr. Reddy was committed to the Sessions Court for trial under Section 304A IPC. The prosecution examined twelve witnesses including the three nursing staff members, the expert board members and the investigating officer. The defence examined Dr. Reddy and two expert witnesses, a retired professor of obstetrics and gynaecology from a government medical college and a senior consultant anaesthetist. The defence experts testified that the management of post-partum haemorrhage in a patient with pre-eclampsia is challenging even under ideal conditions; that the sequence of interventions attempted by Dr. Reddy was in accordance with standard protocols; that the decision to proceed with hysterectomy was timely and appropriate; that the absence of an on-site anaesthetist was a systemic deficiency of the hospital, not a personal failing of Dr. Reddy; that the airway difficulty during resuscitation was a recognised complication and not evidence of negligence; and that the patient's death was caused by the severity of the underlying condition, amniotic fluid embolism or consumptive coagulopathy rather than by any act or omission of Dr. Reddy.

Questions for Analysis with Hints

Q1. Analyse the contractual liability of Sushrusha Maternity and Nursing Home to Mr. Srinivasan. What are the express and implied terms of the patient contract? Did the hospital breach its contractual obligations? Discuss the validity and enforceability of Clauses 7, 12 and 15 of the admission form.

Hints: The patient contract was constituted by the admission form and the conduct of the parties. Express terms included the package fee of thirty-five thousand rupees for normal delivery, duration of hospital stay and services covered. Implied terms included the hospital's undertaking to provide care through qualified and competent staff, to maintain adequate facilities and equipment, to exercise reasonable care and skill and to act in good faith and in the patient's best interest. The hospital breached its contractual obligations by failing to recognise and respond promptly to severe pre-eclampsia, failing to arrange adequate blood products in advance for a high-risk obstetric patient, and performing emergency caesarean section and peripartum hysterectomy without an anaesthetist on the premises. Clause 7 is declaratory of the legal position and not objectionable. Clause 12 purporting to exclude liability for delay in arrangement of blood products is void as against public policy to the extent it seeks to exclude liability for negligence in failing to anticipate the need for blood, failing to maintain adequate blood storage or failing to have arrangements with blood banks. Clause 15 requiring arbitration by a sole arbitrator appointed by the hospital at the hospital premises with the decision final and binding is manifestly unconscionable, violates the principle that no person shall be a judge in their own cause, and is void and unenforceable.

Q2. Assess the compensation claimed by Mr. Srinivasan before the State Consumer Commission. Calculate the appropriate compensation under each head applying the principles established in Sarla Verma, Pranay Sethi and the Consumer Protection Act, 2019. Identify any heads of claim that may be overstated or insufficiently supported.

Hints: Medical expenses of two lakh thirty-five thousand rupees are supported by bills and should be awarded in full. Funeral expenses of fifty thousand rupees are high; the Supreme Court standardised funeral expenses at fifteen thousand rupees subject to indexation; applying ten per cent indexation per three years since 2017, a reasonable amount is approximately twenty thousand rupees. Loss of dependency: deceased was twenty-eight years old with notional income of twenty-five thousand rupees per month. Multiplier of eighteen applies for age group twenty-six to thirty. Deduction for personal expenses for a married person with one dependent is one-third. Future prospects for self-employed persons aged below forty is forty per cent addition. Calculation: annual income three lakh rupees, add forty per cent future prospects one lakh twenty thousand rupees, total four lakh twenty thousand rupees, deduct one-third personal expenses one lakh forty thousand rupees, annual loss of dependency two lakh eighty thousand rupees, multiplier eighteen gives fifty lakh forty thousand rupees. Loss of consortium: spousal consortium at fifty thousand rupees and parental consortium to the newborn daughter at fifty thousand rupees, total one lakh rupees. Pain and suffering: five lakh rupees is not excessive for the pain and suffering endured over approximately six hours from onset of severe pre-eclampsia to cardiac arrest. Mental agony and harassment: three lakh rupees is appropriate given the insensitivity and trauma. Punitive damages: ten lakh rupees is appropriate given the systemic failures. Total assessed compensation is approximately seventy-two lakh rupees.

Q3. Evaluate whether the facts of this case meet the threshold for criminal liability under Section 304A IPC as interpreted in Jacob Mathew v. State of Punjab and Dr. Yash Mehta v. State of Madhya Pradesh. Is the expert opinion obtained by the prosecution sufficient to establish gross negligence? What is the significance of the systemic deficiencies of the hospital in assessing Dr. Reddy's individual criminal liability?

Hints: The threshold for criminal liability under Section 304A IPC is exceptionally high. The prosecution must establish beyond reasonable doubt that Dr. Reddy's negligence was gross, reckless or of such a high degree that it amounted to a culpable disregard for the patient's safety.

The expert opinion identifies several deficiencies but does not clearly differentiate between those attributable to Dr. Reddy individually and those that are systemic failures of the hospital. The absence of an anaesthetist is a systemic deficiency; the hospital administrator bears primary responsibility for ensuring adequate staffing. The failure to arrange blood in advance is both individual and systemic. The defence expert opined that the sequence of interventions was in accordance with standard protocols and that the patient's death was likely caused by the severity of the underlying condition. This opinion, from qualified experts of seniority and standing, creates reasonable doubt. Applying the Jacob Mathew standard, the facts do not establish gross negligence. Dr. Reddy made errors of judgment but these errors, viewed cumulatively, reflect a system under stress and a practitioner working beyond her institutional support, not a reckless disregard for patient safety.

Q4. Discuss the defences available to Dr. Reddy in the criminal trial. How should her counsel structure the defence and what evidence should be adduced to rebut the presumption of gross negligence arising from the expert opinion?

Hints: Dr. Reddy's defence should be structured on four pillars. First, absence of gross negligence: defence experts should articulate that Dr. Reddy's management was within the range of acceptable practice, that her decisions were reasonable judgments made in good faith under difficult circumstances, and that any deviations from ideal management do not rise to the level of recklessness. Second, absence of causation: defence experts should testify that the patient's death was equally consistent with amniotic fluid embolism, severe pre-eclampsia with HELLP syndrome or irreversible disseminated intravascular coagulation, conditions that are not caused by negligence and are often fatal despite optimal care. Third, good faith: Dr. Reddy should testify that she acted throughout in what she believed to be the patient's best interests, that she did not consciously disregard any known risk, and that she regretted the outcome but was not reckless. Fourth, procedural: counsel should highlight the systemic deficiencies of the hospital and argue that the prosecution has unfairly attributed to Dr. Reddy failures that were primarily institutional.

Q5. As a consultant appointed by the Andhra Pradesh State Health Systems Resource Centre, you are tasked with preparing a report on the lessons from this case for improving maternal safety in private maternity homes. Your report should address mandatory infrastructure and staffing standards for obstetric care, protocols for management of obstetric emergencies, blood transfusion services, professional indemnity insurance requirements and the role of district-level regulatory authorities in monitoring compliance.

Hints: Mandatory infrastructure and staffing standards must require that any facility conducting caesarean sections have twenty-four by seven availability of an anaesthetist within fifteen minutes, that facilities with more than twenty obstetric beds or conducting more than fifty deliveries per month maintain a designated obstetric high-dependency unit, and that mandatory equipment list for obstetric emergencies include obstetric emergency trolley with uterotonic drugs, magnesium sulphate, antihypertensives, adult resuscitation trolley with defibrillator and airway equipment. Protocols for management of obstetric emergencies must mandate active management of third stage of labour for all deliveries, a structured time-bound escalation pathway from pharmacological to surgical interventions, clear criteria for proceeding to hysterectomy, and mandatory documentation of estimated blood loss and time of each intervention. Blood transfusion services must require that all facilities conducting caesarean sections either maintain a licensed blood storage centre with inventory of at least two units of O-negative and two units of group-specific blood or have a formal time-bound agreement with

a licensed blood bank for emergency supply with guaranteed response time. Professional indemnity insurance requirements must mandate that all registered medical practitioners practising obstetrics maintain professional indemnity insurance of not less than one crore rupees per occurrence and that all registered private medical establishments maintain institutional indemnity insurance of not less than five crore rupees covering vicarious liability. Regulatory oversight must require annual inspections of all registered obstetric facilities using a standardised checklist, mandatory maternal death review for all maternal deaths occurring in registered facilities, and public dashboard displaying facility-level obstetric outcomes, inspection findings and disciplinary actions.

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LESSON-6

TORTIOUS, VICARIOUS LIABILITY AND PATIENT REMEDIES

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Distinguish between tortious liability and contractual liability in healthcare and explain the essential elements of the tort of negligence
2. Analyse the doctrine of vicarious liability and its application to hospitals for the negligence of employed and independent contractor medical staff
3. Evaluate the legal relationship of bailment between hospital and patient regarding custody of personal property and the hospital's duty of care as bailee
4. Compare the multiple legal remedies available to aggrieved patients under consumer protection law, civil tort law, constitutional law and criminal law
5. Apply the provisions of the Consumer Protection Act, 2019 and the Right to Information Act, 2005 in securing patient redressal and institutional accountability

STRUCTURE OF THE LESSON

6.1 INTRODUCTION: THE WEB OF CIVIL LIABILITY

The preceding lessons examined contractual liability arising from the breach of express or implied promises and criminal liability arising from gross negligence meriting state punishment. This lesson addresses the vast middle ground of civil liability that exists independently of contract: the law of torts. Tortious liability is the legal obligation arising from breach of a duty primarily fixed by law, owed to persons generally and redressible by an action for unliquidated damages. Unlike contractual duty which is created by the agreement of the parties, tortious duty is imposed by law regardless of consent. Unlike criminal liability which is prosecuted by the state and results in punishment, tortious liability is enforced by the aggrieved individual and results in compensation. For the hospital administrator, tortious liability is the most frequently encountered form of legal exposure. Every day, in every department, the hospital owes duties to patients, visitors, staff and the public. The duty to exercise reasonable care in treatment, the duty to maintain safe premises, the duty to protect patient property and the duty to refrain from interfering with personal liberty are all tortious duties. Their breach sounds in damages. This lesson examines the three principal pillars of tortious liability in healthcare: the tort of negligence as the foundational theory of medical malpractice, vicarious liability as the doctrine by which the hospital is held responsible for the negligence of its staff, and the law of bailment governing the hospital's responsibility for patients' property. The lesson then surveys the multiple legal remedies available to aggrieved patients with particular focus on the Consumer Protection Act, 2019 which has displaced civil courts as the primary forum for medical negligence claims and the Right to Information Act, 2005 which has empowered patients to access their medical records and hold institutions accountable.

6.2 INTRODUCTORY CASE STUDY: BAI BAI v. FRAMJI M. PALLA – THE MISSING JEWELS

In 1904, the Bombay High Court decided a case that would become the foundation of the law of bailment in India. Bai Bai, a patient admitted to a hospital, entrusted her jewellery to the hospital compounder for safekeeping. The jewellery was stolen. The hospital denied liability, arguing that the compounder had no authority to accept such deposits and that the patient had assumed the risk. The court held the hospital liable as bailee. The duty of care under Section 151 of the Indian Contract Act, 1872 had been breached and the hospital was answerable for its servant's failure to exercise the care of an ordinary prudent person.

More than a century later, Indian hospitals continue to struggle with the same issue. Patients undergoing surgery, particularly in obstetric, gynaecological and orthopaedic departments, frequently arrive wearing gold jewellery, mangalsutras and other valuables of significant monetary and sentimental value. Admission forms contain fine-print clauses disclaiming hospital responsibility. Staff are inconsistent in advising patients to deposit valuables in safe custody. Lockers, where provided, are often inadequate in number or security. Theft occurs. The patient demands compensation. The hospital invokes the disclaimer. Litigation ensues. The law, as declared in Bai Bai and affirmed in subsequent decisions, is clear. When a patient entrusts personal property to a hospital or its staff, a contract of bailment arises. The hospital becomes the bailee and owes the duty under Section 151 to take the same care of the goods as a person of ordinary prudence would take of their own goods of the same bulk, quality and value. This duty cannot be excluded by fine-print disclaimers unless they are brought to the patient's attention and specifically agreed. The hospital is vicariously liable for the negligence of its employees in discharging this duty.

Relevance to the Lesson: This case study introduces the three interconnected themes of this lesson. First, tortious liability exists independently of contract and may be founded on relationships recognised by law such as bailment. Second, vicarious liability renders the hospital answerable for the defaults of its staff. Third, patients possess multiple legal remedies in contract, in tort, under consumer protection law and under special statutes, and the hospital administrator must understand the distinctive features and strategic advantages of each.

6.3 TORTIOUS LIABILITY: FOUNDATION AND ELEMENTS

The Tort of Negligence

Negligence is the most significant tort in healthcare litigation. It is defined as the breach of a legal duty to take care which results in damage to the claimant undesired by the defendant. The essential elements, repeatedly affirmed by the Supreme Court, are threefold: the defendant owed a duty of care to the claimant; the defendant breached that duty by failing to meet the requisite standard of care; and the breach caused damage to the claimant.

Duty of Care

The duty of care arises from the relationship between the parties. In healthcare, the duty of a doctor to a patient is established by the undertaking of treatment. Once a doctor accepts a patient for treatment, a duty of care attaches and continues until the relationship is lawfully terminated. The duty extends to diagnosis, advice, treatment and follow-up care. It also extends to persons who may foreseeably be affected by the doctor's negligence such as family members advised on genetic risks or third parties exposed to communicable diseases. The hospital owes a direct duty of care to the patient independent of the duty owed by individual doctors. This duty includes the provision of adequate facilities, competent staff, safe systems of work and appropriate supervision. The hospital cannot delegate this duty to independent contractors and thereby escape liability for its breach.

Standard of Care

The standard of care is the measure of the duty. The law does not require the highest possible degree of skill nor guarantee a successful outcome. It requires the doctor to possess and exercise the ordinary skill of a competent practitioner in the same field. This is the Bolam test, approved by the Supreme Court in Indian Medical Association v. V.P. Shantha and Samira Kohli v. Prabha Manchanda. A doctor is not negligent if their actions are in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art, even if other practitioners adopt a different practice. The standard is adjusted for specialists. A neurosurgeon is judged by the standard of an ordinary competent neurosurgeon, not by the standard of a general surgeon or a general practitioner. The law recognises that specialisation implies a higher level of knowledge and skill in that particular field.

Breach of Duty

Breach is established by proving that the defendant's conduct fell below the standard of care. This is ordinarily a matter of expert evidence. The claimant must adduce opinion from a qualified expert in the same field that the defendant's actions deviated from accepted practice. In rare cases where the negligence is so obvious that it speaks for itself, the doctrine of res ipsa

loquitur applies. The maxim means the thing speaks for itself. Where the instrumentality causing the injury was under the exclusive control of the defendant and the accident is such that in the ordinary course of events would not occur if proper care were used, the court may infer negligence without direct evidence. A surgical instrument left in the abdomen, a wrong-side surgery or a patient burned by an uninsulated electrical cautery are classic examples.

Causation

The claimant must prove that the breach of duty caused the damage. Causation has two components. Cause in fact is established by the but for test: but for the defendant's negligence, would the damage have occurred? If the damage would have occurred regardless, the negligence is not the cause. Legal causation requires that the damage not be too remote from the negligence. The defendant is liable only for damage that was reasonably foreseeable as a consequence of the breach. In medical negligence cases, causation is often the most contested element. Patients who suffer adverse outcomes frequently have severe pre-existing illness. The question is whether the negligence materially contributed to the outcome or whether the outcome was inevitable regardless of the quality of care. The burden of proof is on the claimant, but where the defendant's negligence has deprived the claimant of the opportunity to avoid the damage, the burden may shift.

Damage

Damage is the gist of the action in negligence. Negligence without damage is not actionable. The damage may be physical injury, psychiatric illness or economic loss consequential upon physical injury. Pure economic loss not consequent upon physical injury is not recoverable in tort.

Defences to Negligence

The principal defences are contributory negligence and volenti non fit injuria. Contributory negligence is the claimant's failure to take reasonable care for their own safety which contributed to the damage. The damages are reduced proportionately to the claimant's degree of fault. Volenti non fit injuria, meaning to a willing person no injury is done, is the defence of consent to risk. For this defence to succeed, the defendant must prove that the claimant voluntarily consented to accept the legal risk of negligence, not merely the risk of injury. In healthcare, this defence is rarely successful; consent to treatment is not consent to negligence.

6.4 VICARIOUS LIABILITY OF HOSPITALS

The Doctrine Stated

Vicarious liability is the legal responsibility imposed on one person for the tort of another. In the hospital context, the employer is vicariously liable for the tort of the employee committed in the course of employment. The liability is joint and several; the claimant may sue the employer alone, the employee alone or both and may recover the entire damages from either. The justification for vicarious liability is twofold. First, the employer sets in motion the enterprise from which the tort arises and should bear the cost of accidents inherent in that enterprise. Second, the employer is better placed to distribute the loss through insurance and pricing than the employee who may lack the financial capacity to satisfy a judgment. These

justifications apply with particular force to hospitals which invite patients to rely on their institutional reputation and systems of care.

The Control Test

The traditional test for vicarious liability is the control test. An employer controls not only what work the employee shall do but also the manner in which it shall be done. An independent contractor agrees to achieve a specified result but retains control over the manner and method of performance. Hospitals, seeking to limit liability, have increasingly engaged doctors as independent contractors rather than employees. However, the control test is not the exclusive test and courts have developed alternative bases for imposing vicarious liability on hospitals. The organisation test asks whether the doctor's work is an integral part of the hospital's enterprise. The integration test examines whether the doctor is fully integrated into the hospital's organisation, working on its premises, using its equipment and co-ordinating with its staff. The apparent or ostensible agency test, also called the holding out test, imposes liability where the hospital holds out the doctor as its agent and the patient reasonably relies on that representation.

The Independent Contractor Dilemma

The classification of doctors as independent contractors remains the most contested area of vicarious liability in Indian healthcare. The National Consumer Disputes Redressal Commission and various High Courts have delivered inconsistent judgments. In Aparna Dutta v. Apollo Hospitals Enterprises Limited, the NCDRC held the hospital vicariously liable for the negligence of a consultant urologist who was an independent contractor, applying the doctrine of apparent agency. The patient had approached Apollo Hospitals, not the individual doctor; the hospital had provided the premises, staff and equipment; the doctor had used the hospital's letterhead and prescription pads. The Commission held that it would be unjust to permit the hospital to disclaim responsibility after holding out the doctor as its consultant. In Padam Chandra Singhi v. Dr. P.B. Desai, however, a different bench of the NCDRC refused to impose vicarious liability on the hospital, emphasising the contractual recital of independent contractor status and the absence of evidence that the hospital exercised control over the manner of the doctor's work. This judicial inconsistency leaves the law uncertain and places patients at risk. A patient who suffers injury at the hands of a consultant at a major corporate hospital may be fully compensated or left with an inadequate remedy against an underinsured individual practitioner, depending on which bench hears the case and which precedent is followed.

The Non-Delegable Duty Doctrine

Legal scholars have proposed the non-delegable duty of care as a more coherent and patient-protective alternative to the vicarious liability analysis. A non-delegable duty is a duty that cannot be delegated to another; the person owing the duty remains liable for its performance regardless of whether performance is entrusted to an independent contractor. The argument is that hospitals, as institutions that hold themselves out to the public as providers of comprehensive medical care, owe a direct, non-delegable duty to their patients. This duty extends to all care provided within the hospital facility. The hospital cannot discharge this duty by engaging independent contractors; it remains liable for their negligence. The patient is entitled to look to the hospital for redress, regardless of the contractual arrangements between the hospital and its staff. While the Supreme Court has not yet definitively adopted the non-

delegable duty doctrine in the healthcare context, its reasoning in other contexts, particularly in cases of statutory duties and public utilities, provides strong support.

Vicarious Liability for Administrative and Support Staff

Vicarious liability is not confined to medical staff. The hospital is liable for the negligence of its administrative, nursing, paramedical and support staff committed in the course of employment. A receptionist who refuses emergency admission in violation of hospital policy and the Parmanand Katara principle renders the hospital liable. A nurse who administers the wrong medication or the wrong dose renders the hospital liable. An orderly who negligently drops a patient during transfer renders the hospital liable. The employer bears the risk of its employees' negligence.

6.5 HOSPITAL AS A BAILEE

The Law of Bailment

Bailment is defined in Section 148 of the Indian Contract Act, 1872 as the delivery of goods by one person to another for some purpose, upon a contract that they shall, when the purpose is accomplished, be returned or otherwise disposed of according to the directions of the person delivering them. The person delivering the goods is the bailor; the person receiving them is the bailee. When a patient entrusts personal property to a hospital or its staff, a contract of bailment arises. The patient is the bailor, the hospital is the bailee. The purpose of the bailment is safekeeping during the period of hospitalisation. The hospital is obliged to return the property when the patient is discharged or, in the event of death, to deliver it to the legal representatives.

Duty of Care under Section 151

Section 151 of the Indian Contract Act, 1872 prescribes the duty of care of the bailee. The bailee is bound to take as much care of the goods bailed as a person of ordinary prudence would, under similar circumstances, take of their own goods of the same bulk, quality and value. This is not an absolute duty; the bailee is not an insurer. The duty is to exercise reasonable care. If the goods are lost or damaged despite the exercise of reasonable care, the bailee is not liable. However, the standard of care is not minimal. The bailee must take the same care as a prudent person would take of their own property. A hospital that places patient valuables in an unlocked cupboard accessible to multiple persons, or that accepts valuables without issuing a receipt and recording the transaction, has not exercised the care of a prudent person.

Liability for Negligence

If the hospital fails to exercise the requisite care and the goods are lost, damaged or destroyed, the hospital is liable to the bailor for the loss. The burden of proof is on the hospital to show that it took reasonable care. This is a significant reversal from the general rule that the claimant bears the burden of proving negligence. Under Section 152, the bailee is not liable for loss or damage caused by circumstances beyond their control, provided they have taken the requisite care, but the burden of establishing that care is on the bailee.

Disclaimers and Exemption Clauses

Many hospital admission forms contain clauses disclaiming responsibility for loss of patient property. Such clauses are subject to strict construction. A general disclaimer, printed in fine print and not specifically brought to the patient's attention, is unlikely to be effective. The patient is entitled to assume that the hospital will exercise reasonable care for their safety and property. A clause that purports to exclude liability entirely, even for negligence of the hospital's employees, is void as against public policy. The bailee cannot contract out of the fundamental duty to exercise reasonable care. A clause that reasonably allocates risk, such as requiring patients to deposit valuables in a designated safe and limiting liability for items retained in the patient's room, may be enforceable if it is clearly communicated and fairly balances the interests of both parties.

Practical Recommendations

Every hospital should have a written policy on patient valuables. The policy should provide that patients be advised at admission to deposit jewellery, large sums of cash and other valuables in the hospital's safe custody. A proper system for such deposits should be established including a secure storage facility, a register recording the deposit and each access, and a receipt issued to the patient. The policy should also provide that where patients decline to deposit valuables and insist on retaining them in their possession, this decision should be documented and acknowledged.

6.6 LEGAL REMEDIES AVAILABLE TO PATIENTS

The Plurality of Remedies

A patient aggrieved by medical negligence or deficient hospital services is not confined to a single legal remedy. The law provides multiple, concurrent avenues of redress. The same set of facts may found proceedings before the consumer forum, the civil court, the criminal court, the medical council and the High Court or Supreme Court in its constitutional jurisdiction. These remedies are not mutually exclusive and a patient may pursue several simultaneously. The choice of remedy is strategic. Each forum has distinct advantages and disadvantages in terms of cost, speed, evidentiary burden, compensation quantum and appellate remedies. The hospital administrator must understand the characteristics of each forum to anticipate the patient's likely strategy and to mount an appropriate defence.

Consumer Forum

The consumer forum under the Consumer Protection Act, 2019 provides compensation for deficiency in service. Its advantages are that it is inexpensive, speedy, requires no court fees on the full claim amount and permits representative filing. Its limitations are pecuniary jurisdiction limits and that it cannot award punitive damages in all cases.

Civil Court

The civil court provides damages under the Law of Torts. Its advantages are that there is no pecuniary limit, it can award full compensation and it has established procedure for complex evidence. Its limitations are that it is expensive, protracted, requires court fees on the claim amount and appeals lie to the High Court and Supreme Court.

Criminal Court

The criminal court provides punishment of the offender under IPC or BNS. Its advantages are deterrence, vindication and automatic suspension of the doctor on conviction. Its limitations are the high standard of proof beyond reasonable doubt, no compensation to the patient and it does not address systemic deficiencies.

Medical Council

The medical council provides disciplinary action against the doctor. Its advantages are suspension or cancellation of licence and public record of misconduct. Its limitations are no compensation to the patient, slow process and is limited to individual practitioner.

Constitutional Court

The constitutional court under Article 226 or 32 provides compensation for violation of fundamental rights. Its advantages are direct access to High Court or Supreme Court and it recognises the right to health as a fundamental right. Its limitation is that it is available only against State actors or those performing public functions; private hospitals are generally excluded.

RTI Application

The RTI application under the Right to Information Act, 2005 provides access to information. Its advantages are that it empowers the patient with evidence, is inexpensive and has a statutory timeline. Its limitation is that it provides information only, no compensation.

Strategic Considerations

The consumer forum is the overwhelming preference of patients and their advocates. It is inexpensive, relatively speedy and does not require the claimant to pay court fees on the full amount claimed. The claimant may file the complaint in person or through a representative and the forum is not bound by the strict rules of evidence applicable to civil courts. These procedural advantages, combined with the substantive law of deficiency in service that closely tracks the law of negligence, have made the consumer forum the primary adjudicatory body for medical negligence claims. Civil courts retain significance for claims exceeding the pecuniary jurisdiction of the National Consumer Disputes Redressal Commission which is two crore rupees for original complaints. Claims for catastrophic injury to high-income professionals or for wrongful death of young earners frequently exceed this limit and must be filed in the High Court or the civil court. Criminal proceedings are initiated not for compensation but for punishment. The patient's primary motivation may be deterrence, vindication or the desire to prevent the doctor from harming other patients. However, criminal proceedings are lengthy, emotionally draining and subject to a high threshold of proof. Medical council proceedings address the doctor's licence to practise, not the patient's compensation. A complaint to the State Medical Council may result in the doctor being censured, suspended or permanently removed from the register. This is a powerful remedy for egregious misconduct but it operates independently of compensation and does not relieve the patient of the need to pursue other remedies for financial redress. Constitutional remedies under Article 226 before the High Court or Article 32 before the Supreme Court are available only against State actors

or those performing public functions. Private hospitals are not subject to constitutional tort jurisdiction unless they are performing delegated governmental functions or are regulated by law to such an extent that their actions are attributable to the State.

6.7 CONSUMER PROTECTION ACT, 2019

Medical Services as Service

The Consumer Protection Act, 2019 defines service to mean service of any description which is made available to potential users. The definition expressly excludes services rendered free of charge or under a contract of personal service. In Indian Medical Association v. V.P. Shantha decided in 1995, the Supreme Court held that medical services rendered for payment, whether by private practitioners, private hospitals or government hospitals where charges are levied, constitute service under the Act. Services rendered free of charge in government hospitals are excluded, but where the hospital charges for specific services, those services are covered. The effect of this judgment was transformative. Patients became consumers. Doctors and hospitals became service providers. Medical negligence became deficiency in service. The consumer forum, with its summary procedure, low cost and liberal approach to evidence, became the preferred forum for medical negligence claims.

Deficiency in Service

Section 2 of the Consumer Protection Act, 2019 defines deficiency as any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service. The definition of deficiency is substantially wider than the tort of negligence. It includes not only negligent conduct but also breach of contract, failure to maintain prescribed standards and failure to perform the service undertaken. A hospital that fails to maintain medical records for three years as required by the NMC Code of Medical Ethics Regulations has committed deficiency, regardless of whether the patient suffered actual injury. A hospital that fails to display its rate list or issues bills without itemised details has committed deficiency.

Consumer and Complainant

A consumer is defined as any person who hires or avails of any service for a consideration which has been paid or promised, or partly paid and partly promised, or under any system of deferred payment. The definition includes the beneficiary of the service in addition to the hirer. A patient who receives treatment paid for by a family member is a consumer. A newborn who receives neonatal care is a consumer. A complainant may be the consumer, any voluntary consumer association registered under the Act, the Central or State Government, or one or more consumers with the same interest. This liberal standing provision enables representative actions and public interest litigation before consumer forums.

Pecuniary and Territorial Jurisdiction

The Consumer Protection Act, 2019 establishes a three-tier quasi-judicial machinery. The District Consumer Disputes Redressal Commission has jurisdiction where the value of services paid as consideration does not exceed one crore rupees. The State Consumer Disputes Redressal Commission has jurisdiction where the value exceeds one crore rupees but does not

exceed ten crore rupees. The National Consumer Disputes Redressal Commission has jurisdiction where the value exceeds ten crore rupees. Appeals lie from the District Commission to the State Commission, from the State Commission to the National Commission and from the National Commission to the Supreme Court of India. Territorial jurisdiction is determined by the place of residence or business of the opposite party or the place where the cause of action wholly or in part arises. A patient may file the complaint at the place where the hospital is located, where they reside or where they were referred for further treatment.

Procedure and Evidence

The consumer forum is not bound by the Code of Civil Procedure, 1908 or the Indian Evidence Act, 1872. It is required to follow principles of natural justice and to decide complaints expeditiously. Complaints are to be decided within three months from the date of notice to the opposite party where no analysis or testing of goods is required and within five months where such analysis or testing is required. The forum may order the opposite party to pay compensation, remove the deficiency, cease and desist from unfair trade practice or withdraw the hazardous goods. It may also award punitive damages and costs.

The 2019 Amendments

The Consumer Protection Act, 2019 replaced the 1986 Act with several significant changes. Pecuniary jurisdiction limits were substantially enhanced. Provisions for e-filing and video-conferencing were introduced. The concept of unfair contracts was introduced, enabling consumer forums to strike down contractual terms that are one-sided and unconscionable. Product liability provisions were added, enabling claims against manufacturers of defective medical devices and pharmaceuticals. The Act also established the Central Consumer Protection Authority with powers to investigate, recall goods and file class action complaints.

6.8 RIGHT TO INFORMATION ACT, 2005

The Statutory Right

The Right to Information Act, 2005 confers on all citizens the right to access information held by or under the control of public authorities. The Act defines information as any material in any form, including records, documents, memos, e-mails, opinions, advices, press releases, circulars, orders, logbooks, contracts, reports, papers, samples, models and data material held in any electronic form. For patients, the RTI Act has been a transformative instrument. It has empowered patients to access their medical records which hospitals were often reluctant to provide. It has enabled scrutiny of hospital accreditation, doctor qualifications and regulatory compliance. It has exposed corruption, negligence and systemic failures in both public and private healthcare institutions.

Applicability to Hospitals

The RTI Act applies directly to public authorities, which include government hospitals, government medical colleges, ESIC hospitals and other institutions substantially financed by the government. Private hospitals not substantially financed by the government are not public authorities under the Act. However, the Central Information Commission and various State Information Commissions have held that private hospitals are subject to the RTI Act in respect of information relating to treatment of patients under government-sponsored health insurance

schemes. Where the government pays for the treatment, the hospital is performing a public function and is obligated to disclose information to the patient. The Delhi High Court in Ramlal v. Government of NCT of Delhi held that private medical establishments receiving land at concessional rates, tax exemptions or other government patronage may be treated as public authorities for the purpose of disclosing information relating to the utilisation of such benefits.

Access to Medical Records

The right to access one's own medical records is inherent in the right to information and has been repeatedly affirmed by Information Commissions. The patient is entitled to copies of admission forms, consent forms, investigation reports, operation notes, discharge summaries and all other documents forming part of the medical record. The hospital may charge photocopying fees as prescribed under the Act but cannot deny access on grounds of confidentiality or intellectual property. The failure to provide medical records within the statutory period of thirty days constitutes deemed refusal and attracts penalties. The Central Information Commission has imposed penalties on public hospitals for unjustified denial of medical records.

Procedure for Filing RTI Application

An application under the RTI Act must be made in writing to the Central Public Information Officer or the State Public Information Officer of the concerned public authority. The application must be accompanied by the prescribed fee. The applicant is not required to give any reason for seeking the information. The information officer must provide the information within thirty days. If the information concerns the life or liberty of a person, it must be provided within forty-eight hours. Refusal of information must be by a reasoned order and the applicant may appeal to the First Appellate Authority within the institution and thereafter to the Information Commission.

Limitations and Exemptions

Section 8 of the RTI Act exempts certain categories of information from disclosure, including information affecting national security, information expressly forbidden by court order and information the disclosure of which would constitute a breach of privilege of Parliament or State Legislature. Medical records are not exempted from disclosure to the patient to whom they pertain. However, disclosure of medical records of one patient to another patient or to a third party without consent would violate confidentiality and may be refused.

RTI in Litigation Strategy

RTI applications are frequently used by patients and their advocates as an evidence-gathering tool before initiating consumer complaints or civil suits. The medical records obtained through RTI provide documentary evidence of the treatment provided, the personnel involved and the chronology of events. Discrepancies between the RTI-obtained records and the records subsequently produced by the hospital in litigation may be used to impeach the hospital's credibility.

6.9 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES

The Interface of Contract and Tort

The relationship between contractual liability and tortious liability in healthcare is complex and overlapping. The same set of facts may found an action in contract for breach of the implied term to exercise reasonable care and skill and an action in tort for breach of the duty of care. The remedies are similar, the measure of damages is similar and the limitation periods are similar. The distinction is often immaterial in practice, but there are circumstances where it matters. Contractual liability is strict in the sense that the parties are bound by their promises, but the relevant promise in healthcare contracts is to exercise reasonable care and skill, not to achieve a cure. The content of the duty is identical in contract and tort. The advantage of proceeding in tort is that the duty is imposed by law and cannot be excluded by contractual terms. The advantage of proceeding in contract is that the limitation period is generally longer than in tort.

Unfair Terms in Hospital Contracts

The Consumer Protection Act, 2019 introduced the concept of unfair contracts. Section 2 defines an unfair contract as a contract between a consumer and a service provider which causes significant change in the rights of the consumer, including contracts that require manifestly unjust security deposits, impose excessive penalties for breach, permit unilateral termination without cause or otherwise impose terms which are one-sided and unconscionable. Hospital admission contracts frequently contain terms that may be challenged as unfair. Clauses requiring patients to indemnify the hospital against claims arising from the hospital's own negligence are unconscionable. Clauses imposing exorbitant interest rates on delayed payments may be penal and therefore void. Clauses requiring arbitration in a distant forum or imposing a limitation period shorter than that prescribed by law may be struck down.

Product Liability for Medical Devices and Pharmaceuticals

The Consumer Protection Act, 2019 introduced Chapter VI on product liability. A product liability action may be brought against a manufacturer, product seller or service provider for harm caused by a defective product or by deficiency in services. This provision has significant implications for hospitals. A hospital that implants a defective hip prosthesis is liable as a product seller. A hospital that administers a contaminated intravenous fluid is liable as a service provider for deficiency in service and, in appropriate cases, under product liability. The hospital may seek indemnity from the manufacturer, but this does not affect its direct liability to the patient.

Novation and Assignment of Contracts

When a patient is transferred from one hospital to another or when a hospital outsources services to a third-party provider, questions of novation and assignment of contracts arise. Novation is the substitution of a new contract for an existing one with the consent of all parties. Assignment is the transfer of rights under a contract to a third party. The original hospital remains liable for services rendered before transfer. The receiving hospital assumes liability for services rendered after transfer. The transfer itself does not discharge the transferring hospital from liability for negligence occurring during its period of care. A well-drafted transfer

agreement should address the allocation of liability, the transfer of medical records and the communication of responsibility to the patient.

6.10 STUDENT LEARNING ACTIVITIES

Activity 1: Vicarious Liability Audit

You are the Administrator of a two hundred bed corporate hospital that engages forty-five consultants as independent contractors. The hospital's standard independent contractor agreement contains a clause stating that the consultant is solely responsible for their own negligence and shall indemnify the hospital against any claims arising from their professional services. The board of directors has requested your opinion on whether this clause effectively shields the hospital from vicarious liability. Prepare a memorandum analysing the judicial precedents on vicarious liability of hospitals for independent contractor doctors including Aparna Dutta v. Apollo Hospitals and Padam Chandra Singhi v. Dr. P.B. Desai. Assess the hospital's exposure under the doctrines of apparent agency, integration and non-delegable duty. Recommend whether the hospital should continue with the independent contractor model, modify the contractual arrangements or transition to employment relationships. Propose specific amendments to the independent contractor agreement and operational practices to minimise liability exposure.

Activity 2: Patient Valuables Policy Design

A patient has filed a consumer complaint against your hospital alleging that gold jewellery valued at two lakh fifty thousand rupees was stolen from their room during surgery. The patient claims they entrusted the jewellery to the ward nurse who placed it in an unlocked cupboard. The admission form signed by the patient contains a clause in fine print stating that the hospital is not responsible for loss of patient property. The patient was not advised to deposit valuables in the hospital safe and no system for such deposits exists. Draft a comprehensive Patient Valuables Policy for the hospital. Your policy should address the obligation to advise patients at admission, the procedure for voluntary deposit of valuables in safe custody, the system for secure storage, receipting and retrieval, the procedure for patients who decline deposit and insist on retaining valuables, the training of staff in implementation of the policy and the placement of notices in patient areas. Provide a legal opinion on the validity of the existing disclaimer clause and recommend whether it should be retained, amended or deleted.

Activity 3: Comparative Remedies Analysis

Mrs. Sharma, a forty-five year old school teacher, underwent a laparoscopic hysterectomy at a private hospital. Due to negligence in the surgical technique, her right ureter was ligated and transected. The injury was not recognised intra-operatively. She presented five days post-discharge with acute renal failure. She required a second surgery for ureteric reimplantation, prolonged hospitalisation of eighteen days and will require lifelong follow-up for renal function monitoring. She has suffered fifteen per cent permanent disability. The hospital has admitted negligence and offered to settle the claim for fifteen lakh rupees. Mrs. Sharma believes this amount is inadequate and seeks your advice. Prepare a comprehensive advisory note for Mrs. Sharma analysing the multiple legal remedies available to her. Your note should address the procedure, pecuniary jurisdiction, limitation period, evidentiary requirements and potential compensation range in the consumer forum; the same parameters for a civil suit in tort; the availability and limitations of criminal prosecution; the process and outcomes of medical

council complaints; the use of RTI to obtain medical records; and the strategic considerations in selecting among these remedies or pursuing them concurrently. Conclude with a specific recommendation.

Activity 4: RTI Application Drafting

The son of a deceased patient has approached you for assistance. His sixty-eight year old mother underwent coronary artery bypass grafting at a government medical college hospital and died on the third post-operative day from suspected sepsis. The hospital has refused to provide copies of the medical records including the operation notes, anaesthesia records, intensive care unit charts and investigation reports, stating that the records are confidential and cannot be released without a court order. Draft a comprehensive RTI application addressed to the Central Public Information Officer of the hospital seeking all medical records pertaining to the deceased patient. The application should include the specific details identifying the patient and the period of admission, a clear description of each document sought, the statutory basis for the right to access medical records, the time limit for response under the Act and the fee payment details. Also draft a brief note explaining to the patient's son the procedure for filing the application, the expected timeline, the appeal mechanism if information is denied and how the obtained records can be used in subsequent legal proceedings.

6.11 SUMMARY

Tortious liability in healthcare is founded on the breach of a duty of care imposed by law, independent of contract. The essential elements of the tort of negligence are duty, breach, causation and damage. The duty of care arises from the undertaking of treatment; the standard of care is that of an ordinary competent practitioner in the same field; breach is established by expert evidence or, in exceptional cases, by the doctrine of res ipsa loquitur; causation requires proof that the negligence materially contributed to the damage; and damage is the gist of the action.

Vicarious liability renders the hospital answerable for the negligence of its employees committed in the course of employment. The justification is that the employer sets the enterprise in motion and is best placed to distribute the loss. The traditional control test, under which an employer is liable for employees but not independent contractors, has been supplemented by the organisation test, the integration test and the doctrine of apparent agency. The classification of doctors as independent contractors does not conclusively shield the hospital from liability; courts examine the substance of the relationship and the patient's reasonable expectations. The non-delegable duty of care, which would impose direct liability on hospitals regardless of contractual arrangements, has been proposed by scholars and adopted in some judgments but awaits definitive endorsement by the Supreme Court.

The hospital is a bailee of patient property entrusted to its custody. Bailment is the delivery of goods by one person to another for a purpose, upon a contract that they shall be returned when the purpose is accomplished. Section 151 of the Indian Contract Act, 1872 requires the bailee to take the same care of the goods as a person of ordinary prudence would take of their own goods of the same bulk, quality and value. The burden of proof is on the bailee to establish that it took such care. Disclaimer clauses purporting to exclude liability for negligence are void as against public policy and are strictly construed against the hospital. Every hospital should have a written, systematically implemented policy for handling patient valuables.

A patient aggrieved by medical negligence or deficient hospital services has multiple, concurrent legal remedies. The consumer forum under the Consumer Protection Act, 2019 is the preferred remedy, offering inexpensive, speedy and procedurally accessible adjudication of claims for compensation for deficiency in service. The civil court offers unlimited pecuniary jurisdiction and established procedures for complex evidentiary issues but is expensive and protracted. The criminal court offers punishment of the offender but no compensation to the patient and requires proof of gross negligence. The medical council offers disciplinary action against the doctor, including suspension or cancellation of licence, but no compensation. The constitutional court offers compensation for violation of fundamental rights but is available only against State actors. The RTI Act offers access to information, empowering patients with documentary evidence.

The Consumer Protection Act, 2019 defines medical services rendered for payment as service and medical negligence as deficiency in service. The definition of deficiency is wider than negligence and includes breach of contract, failure to maintain prescribed standards and failure to perform the service undertaken. The three-tier consumer forum has pecuniary jurisdiction up to one crore rupees at the district level, ten crore rupees at the state level and above ten crore rupees at the national level. The procedure is summary, not bound by the Code of Civil Procedure or the Indian Evidence Act. The 2019 amendments introduced provisions on unfair contracts, product liability and the Central Consumer Protection Authority.

The Right to Information Act, 2005 confers on every citizen the right to access information held by public authorities. Government hospitals and institutions substantially financed by government are public authorities. Private hospitals are not public authorities but are subject to the Act in respect of information relating to treatment under government-sponsored health insurance schemes and, according to some decisions, in respect of utilisation of government patronage. The patient's right to access their own medical records has been repeatedly affirmed. Information must be provided within thirty days and failure to provide information attracts penalties.

The interface of contract and tort in healthcare is complex and overlapping. The same conduct may constitute both breach of contract and breach of tortious duty. The distinction is often immaterial but may affect limitation periods and the availability of certain remedies. Hospital admission contracts frequently contain terms that may be challenged as unfair under the Consumer Protection Act, 2019, including exclusion clauses, unilateral termination clauses and arbitration clauses. Product liability provisions in the 2019 Act expose hospitals to liability as product sellers for defective medical devices and pharmaceuticals. Issues of novation and assignment arise when patients are transferred between hospitals or when services are outsourced to third-party providers.

The hospital administrator must maintain a clear understanding of the multiple dimensions of civil liability. Tortious duty is imposed by law and cannot be excluded by contract. Vicarious liability is not defeated by contractual recitals of independent contractor status. The duty of care as bailee is non-delegable and requires systematic policies and procedures. Patients possess multiple legal remedies, each with distinct strategic characteristics, and the administrator must anticipate which remedy the patient is likely to pursue and prepare the defence accordingly.

6.12 KEY WORDS WITH EXPLANATIONS

Tort is a civil wrong independent of contract for which the remedy is an action for unliquidated damages. The law of torts imposes duties on persons to act in a manner that does not cause injury to others. Medical negligence is a tort.

Negligence is the breach of a legal duty to take care which results in damage to the claimant undertaken by the defendant. The essential elements are duty, breach, causation and damage. The standard of care is that of an ordinary competent practitioner in the same field.

Duty of Care is a legal obligation to conform to a standard of care imposed by law to protect others from unreasonable risk of harm. In healthcare, the duty arises from the undertaking of treatment. The hospital owes a direct, non-delegable duty of care to patients.

Bolam Test is the standard for determining breach of duty in medical negligence cases. A doctor is not negligent if their actions are in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art, even if other practitioners adopt a different practice. It was approved by the Supreme Court in V.P. Shantha and Samira Kohli.

Res Ipsa Loquitur is a Latin maxim meaning the thing speaks for itself. It is a rule of evidence permitting the court to infer negligence from the mere occurrence of an accident where the instrumentality was under the exclusive control of the defendant and the accident is such that in the ordinary course of events would not occur if proper care were used. It is applied in cases of retained surgical instruments, wrong-side surgery and unexplained patient burns.

Causation is the link between the defendant's breach of duty and the claimant's damage. The but for test asks whether the damage would have occurred regardless of the breach. Legal causation requires that the damage not be too remote. The burden of proof is on the claimant but may shift where the defendant's negligence has deprived the claimant of the opportunity to prove causation.

Vicarious Liability is legal responsibility imposed on one person for the tort of another. Employers are vicariously liable for torts of employees committed in the course of employment. The justification is that the employer sets the enterprise in motion and is best placed to distribute the loss. Liability is joint and several.

Independent Contractor is a person engaged to perform services for another but who is not under the control of the other regarding the manner and method of performance. The principal is generally not vicariously liable for the torts of an independent contractor, but this rule is subject to exceptions including apparent agency and non-delegable duty.

Apparent Agency is a doctrine imposing vicarious liability on a principal for the torts of an independent contractor where the principal holds out the contractor as its agent and the claimant reasonably relies on that representation. It is applied in healthcare where the hospital presents the doctor as its consultant and the patient looks to the hospital for care.

Non-Delegable Duty is a duty that cannot be delegated to another; the person owing the duty remains liable for its performance regardless of whether performance is entrusted to an independent contractor. Scholars argue that hospitals owe patients a non-delegable duty of care.

Bailment is the delivery of goods by one person to another for some purpose, upon a contract that they shall, when the purpose is accomplished, be returned or otherwise disposed of according to the directions of the person delivering them. The person delivering the goods is the bailor; the person receiving them is the bailee.

Bailee's Duty of Care under Section 151 of the Indian Contract Act, 1872 requires the bailee to take as much care of the goods bailed as a person of ordinary prudence would take of their own goods of the same bulk, quality and value. The burden of proof is on the bailee to establish that it took such care.

Consumer Protection Act, 2019 is legislation establishing consumer forums for adjudication of complaints against providers of goods and services. Medical services rendered for payment are service; medical negligence is deficiency in service. The Act provides for compensation, removal of deficiency and punitive damages.

Deficiency in Service is defined in Section 2 of the Consumer Protection Act, 2019 as any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law or has been undertaken to be performed. It is wider than negligence and includes breach of contract and failure to maintain prescribed standards.

Right to Information Act, 2005 is legislation conferring on all citizens the right to access information held by public authorities. Government hospitals are public authorities; private hospitals are subject to the Act for information relating to government-sponsored schemes. Patients have a right to access their medical records.

Unfair Contract is defined in Section 2 of the Consumer Protection Act, 2019 as a contract between a consumer and a service provider which causes significant change in the rights of the consumer, including contracts that require manifestly unjust security deposits, impose excessive penalties for breach, permit unilateral termination without cause or otherwise impose one-sided and unconscionable terms.

Product Liability is liability under Chapter VI of the Consumer Protection Act, 2019 of a manufacturer, product seller or service provider for harm caused by a defective product or by deficiency in services. Hospitals are liable as product sellers for defective medical devices and pharmaceuticals.

Novation is the substitution of a new contract for an existing one with the consent of all parties. It is relevant when a patient is transferred from one hospital to another and the receiving hospital assumes responsibility for ongoing care.

6.13 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What are the essential elements of the tort of negligence?

Ans. The essential elements of the tort of negligence are duty, breach, causation and damage. The defendant must owe a duty of care to the claimant. The defendant must breach

that duty by failing to meet the requisite standard of care. The breach must cause damage to the claimant. The damage must not be too remote a consequence of the breach. All four elements must be established by the claimant on a balance of probabilities.

Q2. What is the Bolam test and how does it apply to medical negligence cases in India?

Ans. The Bolam test, derived from Bolam v. Friern Hospital Management Committee, provides that a doctor is not negligent if their actions are in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art, even if other practitioners adopt a different practice. The test was approved by the Supreme Court in Indian Medical Association v. V.P. Shantha and Samira Kohli v. Prabha Manchanda. The test is modified to require that the practice be reasonable and logical and that the doctor must inform the patient of material risks.

Q3. What is the doctrine of res ipsa loquitur and in what circumstances does it apply to medical negligence claims?

Ans. Res ipsa loquitur, meaning the thing speaks for itself, is a rule of evidence permitting the court to infer negligence from the mere occurrence of an accident. The doctrine applies where the instrumentality causing the injury was under the exclusive control of the defendant and the accident is such that in the ordinary course of events would not occur if proper care were used. In medical negligence claims, it applies to cases such as retained surgical instruments, wrong-side surgery and patient burns from uninsulated equipment. The burden then shifts to the defendant to rebut the inference of negligence.

Q4. What is the distinction between a bailee and a mere custodian? How does this distinction affect hospital liability for patient property?

Ans. A bailee is a person to whom goods are delivered for a specific purpose, upon a contract that they shall be returned when the purpose is accomplished. A mere custodian has possession of goods without the contractual obligation of bailment. When a patient entrusts valuables to a hospital or its staff for safekeeping, a contract of bailment arises. The hospital is a bailee and owes the duty under Section 151 of the Indian Contract Act, 1872 to take the care of a person of ordinary prudence. A mere custodian, such as a person who finds lost property, owes a lesser duty. The distinction determines the standard of care and the burden of proof.

Q5. What is the limitation period for filing a consumer complaint under the Consumer Protection Act, 2019?

Ans. Section 69 of the Consumer Protection Act, 2019 provides that a complaint shall be filed within two years from the date on which the cause of action has arisen. The consumer forum may entertain a complaint after the expiry of two years if the complainant satisfies the forum that there was sufficient cause for not filing the complaint within the period. Such delay condonation must be recorded in writing.

B. Essay Type Questions with Hints

**Q1. Critically examine the doctrine of vicarious liability as applied to hospitals for the negligence of medical staff. To what extent does the engagement of doctors as independent

contractors shield hospitals from liability and what reforms are necessary to protect patient interests?**

Hints: Structure your answer around the distinction between employees and independent contractors. Explain the traditional control test and its limitations in the healthcare context. Discuss the alternative tests developed by courts: organisation test, integration test and apparent agency. Analyse the conflicting decisions in Aparna Dutta v. Apollo Hospitals and Padam Chandra Singhi v. Dr. P.B. Desai. Evaluate the non-delegable duty doctrine as a proposed alternative. Assess the adequacy of current law in protecting patients and compensating victims. Recommend reforms: mandatory written contracts, minimum indemnity insurance requirements, the Victim First policy and legislative clarification of hospital liability.

Q2. Discuss the law of bailment as it applies to hospitals in India. What is the duty of care of a hospital as bailee of patient property and what defences are available? Critically evaluate the validity of disclaimer clauses in admission forms.

Hints: Begin with the definition of bailment under Section 148 of the Indian Contract Act, 1872. Explain how the relationship arises when a patient entrusts property to the hospital. Analyse the duty of care under Section 151 and the burden of proof under Section 152. Discuss the leading case of Bai Bai v. Framji M. Palla and subsequent decisions. Examine the validity of disclaimer clauses: strict construction, requirement of notice and the rule that exclusion of liability for negligence is void as against public policy. Discuss the distinction between exclusion clauses and reasonable risk allocation. Conclude with practical recommendations for hospital policy on patient valuables.

Q3. Compare and contrast the remedies available to a patient aggrieved by medical negligence under the Consumer Protection Act, 2019 and the Law of Torts. What are the advantages and disadvantages of each forum and what strategic considerations should guide the patient's choice?

Hints: Structure your answer as a comparative analysis. For the consumer forum: definition of service and deficiency, pecuniary and territorial jurisdiction, procedure, limitation period, nature of evidence, appeal mechanism, compensation principles, advantages of low cost, speed, no court fees and representative filing, disadvantages of pecuniary limits, summary procedure and limited discovery. For the civil court: jurisdiction under the Law of Torts, procedure under CPC, evidentiary rules, limitation period, appeal mechanism, compensation principles, advantages of unlimited pecuniary jurisdiction and developed procedures for complex evidence, disadvantages of expense, protracted timeline, court fees and strict pleading requirements. Discuss the possibility of concurrent proceedings and the doctrine of election. Conclude with a decision tree for patients based on claim quantum, complexity and urgency.

Q4. Analyse the provisions of the Right to Information Act, 2005 relating to access to medical records. To what extent are private hospitals subject to the Act and what remedies are available to patients whose requests for information are denied?

Hints: Explain the definition of public authority under Section 2 of the RTI Act. Discuss the direct application to government hospitals and institutions substantially financed by government. Analyse the application to private hospitals: decisions of Information Commissions applying the Act to treatment under government-sponsored insurance schemes; the Delhi High Court decision in Ramlal v. Government of NCT Delhi regarding hospitals

receiving government patronage; the distinction between information relating to public function and information relating to private treatment. Explain the patient's right to access their own medical records as inherent in the right to information. Discuss the procedure for filing an application, the time limits, the exemption provisions and the appeal mechanism to the First Appellate Authority and the Information Commission. Conclude with the strategic use of RTI applications in medical negligence litigation.

Q5. You are the Administrator of a three hundred bed corporate hospital. The hospital has been named as a respondent in a consumer complaint alleging that a patient's gold jewellery valued at four lakh fifty thousand rupees was stolen from the patient's room while she was in the intensive care unit. The patient claims she entrusted the jewellery to the ward nurse. The admission form signed by the patient contains a clause stating that the hospital is not responsible for loss of patient property. The hospital has no written policy on patient valuables. Draft a comprehensive response to the consumer complaint, addressing the issues of bailment, vicarious liability and the validity of the disclaimer clause, and propose a settlement strategy.

Hints: Structure your answer as a legal opinion addressed to the hospital board. Analyse the facts and identify the legal issues: whether a contract of bailment was created, whether the nurse had authority to accept the deposit, whether the hospital exercised reasonable care, whether the disclaimer clause is valid and enforceable, and whether the hospital is vicariously liable for the nurse's negligence. Assess the strength of the patient's case and the weaknesses of the hospital's defence. Evaluate the quantum of potential liability. Propose a settlement strategy including an apology, an offer of compensation and the implementation of a comprehensive patient valuables policy to prevent recurrence. Draft the key clauses of the proposed policy.

C. Analytical Multiple Choice Questions

1. Under the law of torts, which of the following is NOT an essential element of the tort of negligence?
a) The defendant owed a duty of care to the claimant
b) The defendant breached that duty of care
c) The defendant intended to cause harm to the claimant
d) The breach caused damage to the claimant
Correct Answer: c) The defendant intended to cause harm to the claimant

2. The doctrine of res ipsa loquitur applies to which of the following scenarios in a medical negligence case?
a) A patient develops an unexpected allergic reaction to a contrast agent
b) A surgeon removes the wrong kidney during a nephrectomy
c) A patient dies from a pulmonary embolism after prolonged bed rest
d) A doctor misinterprets an X-ray and delays diagnosis
Correct Answer: b) A surgeon removes the wrong kidney during a nephrectomy

3. Under the Indian Contract Act, 1872, the burden of proof in an action for loss of bailed goods is on:
a) The bailor to prove that the bailee was negligent
b) The bailee to prove that they took reasonable care of the goods
c) The bailor to prove that the goods were delivered to the bailee
d) The bailee to prove that the goods were not delivered to them

Correct Answer: b) The bailee to prove that they took reasonable care of the goods

4. Which of the following statements correctly states the legal position regarding the applicability of the Consumer Protection Act, 2019 to medical services?
a) All medical services, whether free or paid, are covered under the Act
b) Medical services rendered free of charge are excluded; paid services are covered
c) Government hospitals are completely exempt from the Act
d) Only services rendered by individual practitioners are covered; corporate hospitals are excluded
Correct Answer: b) Medical services rendered free of charge are excluded; paid services are covered

5. A patient files a consumer complaint against a private hospital alleging medical negligence. During the proceedings, the patient requests copies of the medical records. The hospital refuses, citing patient confidentiality. Which of the following is correct?
a) The hospital is entitled to refuse as medical records are confidential
b) The patient has no right to access medical records during consumer proceedings
c) The patient has a right to access their medical records under the RTI Act, 2005 and the consumer forum may direct production of the records
d) The patient must file a separate civil suit for discovery of documents
Correct Answer: c) The patient has a right to access their medical records under the RTI Act, 2005 and the consumer forum may direct production of the records

6. A patient undergoes surgery at a corporate hospital. The surgery is performed by a consultant surgeon who has a written contract with the hospital stating that he is an independent contractor and that the hospital is not vicariously liable for his negligence. The surgeon negligently injures the patient. Which of the following statements best describes the hospital's liability?
a) The hospital is automatically exempt from liability because of the independent contractor clause
b) The hospital may be liable under the doctrine of apparent agency if it held out the surgeon as its consultant and the patient reasonably relied on this representation
c) The hospital is never liable for the negligence of independent contractors
d) The hospital is liable only if the surgeon is also an employee of the hospital
Correct Answer: b) The hospital may be liable under the doctrine of apparent agency if it held out the surgeon as its consultant and the patient reasonably relied on this representation

7. Under the Consumer Protection Act, 2019, which of the following is NOT a ground for filing a complaint against a hospital?
a) Deficiency in service
b) Unfair trade practice
c) Restrictive trade practice
d) The hospital charges higher fees than another hospital for the same procedure
Correct Answer: d) The hospital charges higher fees than another hospital for the same procedure

6.14 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Wrong Side, The Missing Jewellery and The Denied Records

Sri Venkateswara Hospitals is a one hundred eighty bed multi-speciality corporate hospital located in Tirupati, Andhra Pradesh, registered as a private limited company under the Companies Act, 2013 and accredited by NABH. It employs forty-five full-time consultants on salary and engages thirty additional consultants under independent contractor service agreements. Dr. S. Raghavan is the Medical Superintendent.

Mrs. Lakshmamma, a fifty-eight year old farmer and widow, was admitted on 5 January 2026 with complaints of chronic right knee pain and deformity. She was diagnosed with severe osteoarthritis of the right knee and was advised total knee replacement surgery. She was accompanied by her son, Mr. Venkatesh, a thirty-two year old daily wage labourer, who had borrowed three lakh fifty thousand rupees from relatives and moneylenders to finance the surgery.

At the time of admission, Mrs. Lakshmamma was wearing her mangalsutra, a gold necklace approximately sixteen grams in weight and of significant sentimental value, and two gold earrings. She was also wearing a gold ring. Mr. Venkatesh asked the admission nurse whether the jewellery should be removed and deposited. The nurse stated that the hospital did not accept valuables for safekeeping and that the patient should remove the jewellery and hand it over to her relatives. Mr. Venkatesh had to return to his village to arrange additional funds and could not remain at the hospital. His mother was unwilling to remove her mangalsutra which she had worn continuously since her marriage thirty-six years earlier. Mr. Venkatesh requested the ward sister to take custody of the jewellery. The ward sister stated that she could not accept valuables but advised that the patient keep the jewellery in the bedside locker. The locker had a key, but the key was missing. Mr. Venkatesh locked the locker using his own padlock which he purchased from the hospital pharmacy and retained the single key. He instructed his mother to keep the key tied to her saree.

On 6 January 2026, Mrs. Lakshmamma was taken to the operation theatre for right total knee replacement. The surgery was performed by Dr. Krishna Mohan, a senior consultant orthopaedic surgeon engaged by the hospital under an independent contractor agreement. The agreement contained a clause stating that the consultant is an independent contractor and not an employee of the hospital, that the consultant shall be solely responsible for their own acts of negligence and that the hospital shall not be vicariously liable for any claim arising from the consultant's professional services. Dr. Mohan had been associated with the hospital for twelve years. He was listed on the hospital website as Senior Consultant Orthopaedic Surgeon, Sri Venkateswara Hospitals. His name was displayed on the departmental board. His outpatient clinic was held within the hospital premises. The hospital provided all operation theatre facilities, nursing staff, instruments and implants. Dr. Mohan billed patients directly and paid the hospital a facility fee of thirty per cent of his professional fees.

During the surgery, Dr. Mohan performed a left total knee replacement. The preoperative marking, verification of the surgical site and the surgical safety checklist were either not performed or not documented. The error was discovered on the first post-operative day when the patient complained of pain in the left knee and the dressing was removed. X-ray confirmed a left total knee prosthesis. The right knee remained unoperated.

On 7 January 2026, Mrs. Lakshmamma was transferred from the intensive care unit to the ward. Upon arrival, she discovered that the padlock on her bedside locker was missing and the locker was open. Her mangalsutra, earrings and ring were gone. The key was still tied to her saree. Mr. Venkatesh was informed and arrived at the hospital. The security office reviewed CCTV footage which showed an unidentified person entering the ward at 3:15 AM, tampering with the locker and leaving with a small cloth bag. The person's face was not clearly visible. The hospital lodged a First Information Report with the local police.

Mrs. Lakshmamma required a second surgery to correct the wrong-side error. The right total knee replacement was performed on 15 January 2026 by a different surgeon. Her hospitalisation was prolonged by twelve days. She experienced severe pain, psychological trauma and lost confidence in the treating team. Her total hospital bill, including both surgeries, extended stay and investigations, amounted to five lakh eighty-five thousand rupees. Mr. Venkatesh was unable to pay the full amount. The hospital insisted on payment and refused to discharge the patient until the outstanding bill of one lakh thirty-five thousand rupees was cleared.

Mr. Venkatesh filed a consumer complaint before the Andhra Pradesh State Consumer Disputes Redressal Commission against Sri Venkateswara Hospitals, Dr. Krishna Mohan and the ward matter alleging deficiency in service and medical negligence in performing wrong-side surgery, deficiency in service and negligence in the custody of patient property, and unfair trade practice in refusing discharge until payment of the outstanding bill.

The hospital filed its response through Dr. S. Raghavan. The defence on the wrong-side surgery was that Dr. Krishna Mohan was an independent contractor and the hospital was not vicariously liable for his negligence. The defence on the stolen jewellery was that the patient had declined to deposit the jewellery with the hospital, had retained possession through her own padlock and key and had signed an admission form containing a clause stating that the hospital shall not be responsible for loss or damage to patient property including jewellery, cash and valuables whether deposited or retained in the patient's possession. The defence on the discharge refusal was that the hospital was entitled to retain the discharge summary and to insist on payment before releasing the patient and that the patient had voluntarily remained in the hospital while arranging funds.

Mr. Venkatesh also filed an application under the Right to Information Act, 2005 before the State Public Information Officer of the Andhra Pradesh Health Department seeking copies of the inspection reports, registration documents and any disciplinary actions taken against Sri Venkateswara Hospitals under the Andhra Pradesh Private Medical Care Establishments Act, 2002. He also sought information on whether the hospital had been granted any government land, tax exemptions or other concessions. The information officer transferred the application to the hospital. The hospital refused to provide the information, stating that it was a private entity not subject to the RTI Act.

Questions for Analysis with Hints

Q1. Analyse the vicarious liability of Sri Venkateswara Hospitals for the negligence of Dr. Krishna Mohan in performing wrong-side surgery. Apply the doctrines of control, organisation, integration and apparent agency to the facts of this case. Is the hospital liable notwithstanding the independent contractor clause?

Hints: The hospital exercised significant de facto control over Dr. Mohan's practice by granting clinical privileges, determining his outpatient clinic schedule, providing all operation theatre facilities and support staff. Dr. Mohan's work was an integral part of the hospital's enterprise as the hospital held itself out to the public as providing orthopaedic surgical services. The doctrine of apparent agency applies as the hospital held out Dr. Mohan as its consultant through its website, departmental board and hospital letterhead. Mrs. Lakshmamma reasonably believed that Dr. Mohan was a hospital surgeon acting on behalf of the hospital. The independent contractor clause is not binding on the patient who is not a party to that contract. The wrong-side surgery is a never event and the doctrine of res ipsa loquitur applies. The hospital is jointly and severally liable with Dr. Mohan.

Q2. Evaluate the hospital's liability as bailee of Mrs. Lakshmamma's jewellery. Was a contract of bailment created? What was the duty of care and was it breached? Is the disclaimer clause in the admission form valid and enforceable against the patient?

Hints: A contract of bailment was created when Mrs. Lakshmamma through her son requested the ward sister to take custody of the jewellery. The ward sister's advice that the jewellery be kept in the bedside locker, in the context of the patient's vulnerability and the hospital's control over the premises, constituted an undertaking of responsibility. The duty of care under Section 151 required the hospital to take the same care as a person of ordinary prudence would take of their own goods. The hospital failed to meet this standard as the bedside locker had a missing key, there was no system for securing patient valuables, no safe custody facility, no documented procedure and the ward was accessible to unidentified persons at 3:15 AM. The disclaimer clause is void as against public policy, was printed in fine print, not specifically brought to the patient's attention and its effect was not explained. The clause is unconscionable and unenforceable.

Q3. Assess the legality and propriety of the hospital's refusal to discharge Mrs. Lakshmamma until the outstanding bill was paid. Does a hospital have a lien on the patient's body or a right to detain the patient for non-payment? What remedies are available to the patient for such conduct?

Hints: A hospital has no lien on the patient's body and no right to detain a patient for non-payment of bills. The patient's body is not security for the debt. The right to personal liberty under Article 21 of the Constitution prohibits unlawful detention. A patient who is medically fit for discharge must be discharged immediately regardless of the outstanding bill. The hospital's refusal to discharge constituted unlawful detention and a separate deficiency in service. The appropriate remedy for the patient is compensation for the mental agony and harassment caused by the unlawful detention. The hospital may pursue recovery of its legitimate charges through legal process including civil suit for recovery, but may not detain the patient's person.

Q4. Is Sri Venkateswara Hospitals subject to the Right to Information Act, 2005 in respect of the information sought by Mr. Venkatesh? What is the scope of the RTI Act's application to private hospitals receiving government patronage or performing public functions? What recourse does Mr. Venkatesh have against the refusal?

Hints: Sri Venkateswara Hospitals as a private limited company is not a public authority under Section 2 of the RTI Act in respect of its general operations. However, the Act applies to private hospitals in two specific contexts: where the hospital receives substantial financing from the

government including land at concessional rates, tax exemptions, subsidies or other forms of patronage, and where the hospital performs public functions such as treatment of patients under government-sponsored health insurance schemes. Mr. Venkatesh sought information on whether the hospital had received such benefits and information relating to regulation of the hospital under the AP Act which is held by the Health Department, a public authority. The State Public Information Officer erred in transferring the application to the hospital. Mr. Venkatesh may file a first appeal before the Appellate Authority of the Health Department against the deemed refusal or file a fresh RTI application before the State Public Information Officer, Health Department and pursue appeal to the Andhra Pradesh Information Commission.

Q5. As the Medical Superintendent of Sri Venkateswara Hospitals, you have been directed by the board of directors to prepare a comprehensive report on the lessons from this case and to recommend systemic reforms. Your report should address surgical safety protocols including preoperative site verification and the WHO Surgical Safety Checklist, patient valuables policy including safe custody, documentation and disclaimer clauses, patient discharge policy including financial counselling and prohibition of detention, vicarious liability risk management including review of independent contractor agreements and indemnity insurance requirements, and RTI compliance framework for responding to information requests.

Hints: Surgical safety reforms must mandate the WHO Surgical Safety Checklist for every surgical procedure with completion at three phases: sign in before induction of anaesthesia, time out before skin incision and sign out before patient leaves operating room. Preoperative site marking must be performed by the operating surgeon with the patient awake and participating, using an indelible marker and verified during time out. Patient valuables policy must require that at admission every patient be advised in writing to deposit all jewellery, cash exceeding one thousand rupees and other valuables in the hospital's safe custody. A secure safe custody facility must be established with tamper-proof sealed envelopes, central register and receipt system. Patients who decline to deposit valuables must sign an acknowledgment that they have been advised of the hospital's recommendation and that they assume the risk of loss or damage. Patient discharge policy must provide that no patient who is medically fit for discharge shall be detained for non-payment of bills. The hospital may offer payment plans, accept partial payment or pursue recovery through legal process after discharge. Vicarious liability risk management must require review and amendment of independent contractor agreements to delete clauses purporting to exclude vicarious liability and insert mandatory professional indemnity insurance requirements of not less than one crore rupees per occurrence. RTI compliance framework must require that all RTI applications be processed within forty-eight hours, that information relating to treatment under government-sponsored health insurance schemes be provided within thirty days, and that information relating to the hospital's receipt of government concessions be compiled and maintained in a dedicated register and provided upon request.

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The common law imposes a duty of care upon a hospital which it cannot escape by delegating performance to independent contractors. The patient who enters a hospital does so looking to the hospital for care, and the hospital's duty is non-delegable.

**— Adapted from Supreme Court of India judgments on vicarious

LESSON-7
HOSPITALS AS AN INDUSTRY AND LABOUR RELATIONS

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Explain the legal classification of hospitals as an industry under the Industrial Disputes Act, 1947 and trace its evolution through landmark Supreme Court judgments
2. Analyse the applicability of the Industrial Disputes Act, 1947 to hospitals including provisions relating to strikes, lock-outs, lay-offs, retrenchment and closure
3. Identify the principal causes of industrial unrest in hospitals including violence against healthcare workers, wage disparities, contractualisation and workload issues
4. Evaluate the dispute settlement mechanisms available under the Industrial Disputes Act including works committees, conciliation, arbitration and adjudication
5. Apply the principles of industrial relations to manage hospital workforce conflicts, develop preventive strategies and ensure compliance with labour laws

STRUCTURE OF THE LESSON

7.1 INTRODUCTION: THE INDUSTRIALISATION OF HEALTHCARE

The hospital of the twenty-first century bears little resemblance to its nineteenth-century predecessor. What was once a charitable institution, often religious-affiliated, staffed by religious sisters and philanthropic physicians, has transformed into a complex industrial

enterprise. Large corporate hospitals employ thousands of workers across dozens of occupational categories: doctors, nurses, technicians, pharmacists, administrative staff, engineers, cooks, cleaners, security personnel and others. They operate round the clock, seven days a week, with capital-intensive equipment and supply chains spanning continents. They generate revenue measured in crores and employ sophisticated management techniques. This transformation has profound legal consequences. The law of industrial relations, developed in the context of factories, mines and plantations, now applies to hospitals. The industrial worker, whose struggles gave birth to trade unionism and collective bargaining, now includes the nurse, the technician and the resident doctor. The industrial dispute, traditionally concerned with wages and working conditions in manufacturing, now encompasses the unique challenges of healthcare: violence against staff, emotional burnout, patient safety and the tension between professional autonomy and managerial control. For the hospital administrator, the law of industrial relations is not an optional specialisation. It is a daily operational reality. The administrator must navigate the complex web of statutes, regulations and judicial precedents that govern the relationship between the hospital as employer and its workforce. They must understand when a strike is lawful and when it is prohibited. They must know the procedure for retrenchment and the compensation payable upon closure. They must recognise the early warning signs of industrial unrest and deploy the dispute settlement mechanisms before conflict escalates. This lesson examines the industrial jurisprudence of healthcare. It begins with the foundational question: Is a hospital an industry? The answer, established by the Supreme Court in 1960 and reaffirmed repeatedly since, is yes. It then examines the key provisions of the Industrial Disputes Act, 1947 as they apply to hospitals. It analyses the causes of unrest that are distinctive to the healthcare sector. It surveys the statutory and non-statutory mechanisms for dispute resolution. It concludes with the contractual issues that arise in the employment of hospital staff, particularly the vexed question of permanent versus contractual employment.

7.2 INTRODUCTORY CASE STUDY: THE MAHARASHTRA NURSING STRIKE, 2024

In March 2024, the State of Maharashtra witnessed one of the largest and most sustained healthcare strikes in Indian history. Approximately forty-five thousand staff nurses employed across twenty-seven government medical colleges and district hospitals, as well as several hundred private corporate hospitals in Mumbai, Pune, Nagpur and Nashik, went on an indefinite strike. The strike was organised by the Maharashtra State Nursing Federation, an umbrella body representing multiple nursing unions.

The immediate trigger was the State Government's failure to implement the Seventh Pay Commission recommendations for nursing staff, which had been pending for over eighteen months. Nurses employed in government hospitals were receiving basic pay significantly lower than their counterparts in central government institutions and, in many cases, lower than nurses with comparable qualifications in private corporate hospitals. The disparity was most acute for senior nurses with fifteen to twenty years of service, who found themselves supervising staff earning salaries comparable to or higher than their own.

However, the dispute was not solely about wages. The nurses' charter of demands included regularisation of contract nurses who had been employed on temporary contracts for periods exceeding five years; enhancement of night shift allowances and risk allowances for those working in COVID-19 and infectious disease wards; provision of safe accommodation in or near hospital premises for nurses required to report for emergency duties; strengthening of security measures in hospitals following multiple incidents of violence against nursing staff;

and resolution of the chronic shortage of nursing staff which had resulted in mandated overtime and unsafe nurse-to-patient ratios.

The strike commenced on 12 March 2024. Within twenty-four hours, the impact was catastrophic. Outpatient departments in government hospitals were completely paralysed. Elective surgeries were cancelled. Intensive care units functioned with skeleton staff, with consultants and resident doctors attempting to perform nursing duties. In some districts, district hospitals declared a state of emergency and refused new admissions. Private corporate hospitals, though not the primary target of the strike, were affected as many nurses in the private sector joined in sympathy or in support of parallel demands for wage revision and contract regularisation.

The State Government initially adopted a confrontational posture. It issued orders declaring the strike illegal under the Maharashtra Recognition of Trade Unions and Prevention of Unfair Labour Practices Act, 1971 and invoked the Essential Services Maintenance Act to prohibit strikes in essential services. Notices were issued to striking nurses threatening disciplinary action, including termination of service and recovery of wages for the strike period. Several nurses were arrested for picketing and obstructing hospital entrances.

As the strike entered its fifth day, public pressure mounted. Patient families staged protests outside government hospitals. The media highlighted cases of patients who had died or suffered complications due to delayed care. The Bombay High Court took suo motu cognisance and directed the State Government and the striking unions to resume negotiations. A tripartite conciliation process was initiated under the chairmanship of the Additional Chief Secretary, Health. After four days of intensive negotiations, a settlement was reached on 19 March 2024. The State Government agreed to constitute a committee to implement the Seventh Pay Commission recommendations within three months, regularise all contract nurses who had completed three years of continuous service, enhance night shift allowances by twenty-five per cent, install CCTV cameras and deploy dedicated security personnel in all major hospitals, and initiate recruitment for eight thousand additional nursing posts to address the staffing shortage. The nurses agreed to resume duty immediately and not to initiate any further strike action while negotiations continued on the remaining demands.

Relevance to the Lesson: This case illustrates every major theme of this lesson. It demonstrates that hospitals, whether government or private, are industries within the meaning of industrial law. The dispute was an industrial dispute under Section 2 of the Industrial Disputes Act, 1947 involving collective demands by workmen against their employer. The strike, though arguably illegal under the Essential Services Maintenance Act, was a legitimate expression of collective bargaining. The conciliation process under the Industrial Disputes Act provided the framework for resolution. The underlying causes—wage disparity, contractualisation, workload, safety—are endemic to the healthcare sector and require systemic, not merely ad hoc, solutions.

7.3 HOSPITAL AS AN INDUSTRY: THE HOSPITAL MAZDOOR SABHA LEGACY

The Industrial Disputes Act, 1947: Definition of Industry

The Industrial Disputes Act, 1947 is the principal legislation governing the resolution of industrial disputes in India. Its jurisdiction is triggered by the existence of an industry. Section 2 of the Act originally defined industry as any business, trade, undertaking, manufacture or

calling of employers and includes any calling, service, employment, handicraft or industrial occupation or avocation of workmen. This definition, seemingly broad, became the subject of intense litigation for over five decades. The central question was whether hospitals, educational institutions, research institutes and other organisations not traditionally considered commercial enterprises fell within the definition. The answer, provided by the Supreme Court in a series of landmark judgments, has profound implications for hospital administration.

State of Bombay v. Hospital Mazdoor Sabha (1960)

The foundational judgment is State of Bombay v. Hospital Mazdoor Sabha, decided by a Constitution Bench of the Supreme Court in 1960. The dispute arose from the closure of the J.J. Hospital, a government-run hospital in Bombay, and the retrenchment of its employees. The employees challenged the retrenchment and the preliminary question was whether a government hospital was an industry under the Industrial Disputes Act. The Supreme Court held that it was. The Court rejected the argument that hospitals, being charitable or governmental in nature, were not industries. It held that the definition of industry is extremely broad and includes any activity systematically undertaken for the production or distribution of goods or services with the cooperation of employer and employee. The presence of profit motive is not essential. What matters is the nature of the activity, not the purpose for which it is carried on. The Court laid down the triple test for determining whether an entity is an industry. There must be systematic activity, organised by cooperation between employer and employee, for the production and distribution of goods and services calculated to satisfy human wants and wishes. A hospital, whether public or private, charitable or commercial, satisfies this test. It is a systematic activity organised by the cooperation of doctors, nurses, technicians and administrative staff for the provision of healthcare services to satisfy the human want of medical treatment.

Bangalore Water Supply and Sewerage Board v. A. Rajappa (1978)

The scope of industry was dramatically expanded by a seven-judge Constitution Bench in Bangalore Water Supply and Sewerage Board v. A. Rajappa. The Court overruled earlier decisions that had excluded charitable institutions, professional associations and public utilities from the definition of industry. It held that the definition is so broad as to include virtually every organised economic activity. The Court articulated the functional test. Where there is systematic activity, organised by cooperation between employer and employee, for the production and distribution of goods and services, and such goods and services are calculated to satisfy human wants and wishes, the activity constitutes an industry. The nature of the employer, whether government, charitable trust or commercial enterprise, is irrelevant. The presence or absence of profit motive is irrelevant. The sovereign functions of the State are excluded, but welfare activities, including the provision of healthcare, are not sovereign functions. Under this test, every hospital—government, charitable, trust or corporate—is an industry. The employees of such hospitals are workmen. The disputes between the hospital and its employees are industrial disputes. The provisions of the Industrial Disputes Act, 1947 relating to strikes, lock-outs, lay-off, retrenchment, closure and dispute resolution apply in full force.

The 1982 Amendment and Its Aftermath

In 1982, Parliament amended the Industrial Disputes Act to exclude hospitals and other institutions from the definition of industry. However, this amendment was never brought into

force. It remained on the statute book as a dormant provision for over four decades. The legal position throughout this period continued to be governed by the Bangalore Water Supply judgment.

The Industrial Relations Code, 2020

The Industrial Relations Code, 2020, which received presidential assent in September 2020 and was brought into force in 2021, replaces the Industrial Disputes Act, 1947, the Trade Unions Act, 1926 and the Industrial Employment Act, 1946. Section 2 of the Code defines industry as any systematic activity carried on by cooperation between an employer and workmen for the production, supply or distribution of goods or services with a view to satisfy human wants or wishes, whether or not any profit is gained from such activity. The definition specifically excludes hospitals, educational institutions and scientific research institutions from the definition of industry. This exclusion, unlike the 1982 amendment, is operative. The Industrial Relations Code, 2020 has been brought into force. However, the full implications of this exclusion are not yet settled. The Code has been challenged before the Supreme Court on multiple grounds, including that the exclusion of hospitals from the definition of industry is arbitrary and violative of Article 14. The challenge is pending. Moreover, State governments retain the power to declare any establishment as an industry for the purposes of State industrial relations legislation. Several States have exercised this power in respect of hospitals. The legal position is therefore in flux. Pending final resolution by the Supreme Court, the hospital administrator must assume that the Industrial Disputes Act, 1947 and the industrial relations framework thereunder continue to apply to hospitals. The Industrial Relations Code, 2020 is in force, but its provisions excluding hospitals have not been tested. Prudent administration requires compliance with the established industrial jurisprudence developed over six decades.

7.4 INDUSTRIAL DISPUTES ACT, 1947: KEY PROVISIONS FOR HOSPITALS

Definition of Industrial Dispute

Section 2 of the Industrial Disputes Act, 1947 defines an industrial dispute as any dispute or difference between employers and employers, or between employers and workmen, or between workmen and workmen, which is connected with the employment or non-employment or the terms of employment or with the conditions of labour of any person. The definition has three essential elements. The dispute must be connected with employment or non-employment or terms of employment or conditions of labour. The dispute must be between the specified parties. The dispute must be espoused by a substantial number of workmen or by a registered trade union. An individual grievance, unless espoused by the union or a substantial number of workmen, is not an industrial dispute; it is an individual dispute to be adjudicated under the general law or the relevant standing orders.

Definition of Workman

Section 2 defines workman as any person employed in any industry to do any manual, unskilled, skilled, technical, operational, clerical or supervisory work for hire or reward. The definition excludes persons employed mainly in a managerial or administrative capacity, persons employed in a supervisory capacity drawing wages exceeding ten thousand rupees per month, and persons employed in a confidential capacity. This definition is critical for hospitals. Nurses, technicians, pharmacists, laboratory assistants, ward attendants, cleaners, security guards and clerical staff are workmen. They are entitled to the protections of the Industrial

Disputes Act. Doctors, unless they are engaged in predominantly administrative or managerial work, are generally not workmen. Resident doctors and junior doctors engaged in clinical work have been held by some courts to be workmen, but the position is not uniform. Senior consultants and medical superintendents are clearly excluded.

Prohibition of Strikes and Lock-outs

Section 22 prohibits strikes and lock-outs in public utility services without giving notice of strike or lock-out within six weeks before commencing the strike, or within fourteen days of giving such notice, or before the expiry of the date of strike specified in the notice, or during the pendency of conciliation proceedings and seven days after the conclusion of such proceedings. Section 23 imposes a general prohibition on strikes and lock-outs during the pendency of conciliation proceedings, adjudication proceedings, arbitration proceedings or during the period of any settlement or award binding on the parties. Hospitals are public utility services under Section 2 of the Act, which includes any system of public conservancy, sanitation or medical service. A strike in a hospital without compliance with the notice requirements is illegal. An illegal strike invites disciplinary action against the workmen, including deduction of wages for the strike period and may render the strikers liable for damages.

Lay-off and Retrenchment

Chapter V-A of the Industrial Disputes Act imposes significant restrictions on the employer's right to lay-off or retrench workmen. Lay-off is defined as the failure, refusal or inability of an employer to give employment to a workman whose name is borne on the muster rolls of the industrial establishment and who has not been retrenched. Retrenchment is the termination by the employer of the service of a workman for any reason whatsoever, otherwise than as punishment inflicted by way of disciplinary action. Section 25F prescribes the conditions precedent to retrenchment of a workman who has been in continuous service for not less than one year. The employer must give one month's notice in writing indicating the reasons for retrenchment or pay wages in lieu of such notice; pay compensation equivalent to fifteen days' average pay for every completed year of continuous service; and serve notice on the appropriate government. Section 25N imposes additional restrictions on establishments employing more than one hundred workmen. Retrenchment of such workmen requires three months' notice and prior permission of the appropriate government. This provision applies to large corporate hospitals and government medical colleges. Section 25-O governs closure of industrial establishments. An employer intending to close down an undertaking must apply for prior permission of the appropriate government at least ninety days before the intended closure. The government may grant or refuse permission after giving the parties an opportunity of being heard. Unauthorised closure is punishable with imprisonment and fine.

Unfair Labour Practices

The Industrial Disputes Act, 1947 was amended in 1982 to add Chapter V-C, which prohibits unfair labour practices. Section 25-T declares that no employer or workman or trade union shall commit any unfair labour practice. Section 25-U prescribes punishment for unfair labour practices which may extend to imprisonment for six months and fine of one thousand rupees. The Fifth Schedule to the Act enumerates unfair labour practices on the part of employers and trade unions. For employers, these include interfering with the right of workmen to form or join trade unions, threatening workmen with discharge or dismissal if they join trade unions,

establishing employer-sponsored trade unions, indulging in acts of force or violence, showing favouritism or partiality to one set of workers, discharging or punishing workmen for filing complaints or participating in proceedings under the Act, and engaging in victimisation.

Victimisation

Victimisation is not defined in the Act but has been elaborated in judicial decisions. It refers to the punishment of a workman for activities which are legitimate trade union activities or for exercising rights under the industrial law. The Supreme Court has held that victimisation is an unfair labour practice and that where victimisation is established, the industrial tribunal may order reinstatement with full back wages. The essential elements of victimisation are: the workman must have been subjected to a punishment or adverse order; such punishment must be disproportionate to the misconduct alleged; and there must be evidence that the employer was actuated by malice or vindictiveness because of the workman's trade union activities or exercise of legal rights.

7.5 CAUSES OF UNREST IN HOSPITALS

Violence Against Healthcare Workers

The single most significant cause of industrial unrest in Indian hospitals is the escalating violence against doctors, nurses and other healthcare staff. The Indian Medical Association documented over one thousand two hundred incidents of physical assault on doctors between 2020 and 2024. The actual number is certainly higher, as many incidents go unreported. The violence ranges from verbal abuse and threats to physical assault, manhandling, vandalism of hospital property and, in extreme cases, murder. The causes of violence are multifactorial. Patient families, under immense emotional and financial stress, may react with anger when outcomes are unfavourable. Communication failures—inadequate explanation of the patient's condition, unrealistic expectations, insensitive disclosure of bad news—are frequent triggers. The perception that doctors are uncaring or that hospitals are commercially exploitative fuels hostility. Inadequate security infrastructure in many hospitals, particularly in government institutions, emboldens perpetrators. The impact of violence on the healthcare workforce is profound. Doctors and nurses report symptoms of post-traumatic stress, anxiety and depression. Many consider leaving the profession. Strikes and protests by medical associations demanding a central protection law have become routine. The fear of violence distorts clinical practice, encouraging defensive medicine and discouraging young doctors from pursuing high-risk specialties.

Contractualisation and Job Insecurity

The proliferation of contractual, temporary and outsourced employment in hospitals is a second major cause of unrest. Hospital administrators, seeking to reduce labour costs and increase numerical flexibility, have increasingly engaged staff nurses, technicians and paramedical workers on fixed-term contracts through third-party contractors. These workers perform the same duties as permanent employees, often side by side, but at substantially lower wages and with no job security, paid leave, provident fund, gratuity or other statutory benefits. The contractual workforce in Indian hospitals is disproportionately female. Nurses, who are predominantly women, are particularly affected. They are hired on eleven-month contracts, renewed annually at the discretion of the contractor, with no assurance of continuity. They are denied maternity benefits despite the statutory entitlement under the Maternity Benefit Act,

1961. They are often required to work overtime without compensation. The Maharashtra Nursing Strike of 2024 was substantially a protest against this contractualisation. The demand for regularisation of contract nurses who had worked for years in government hospitals was central to the dispute. Similar movements have emerged in Kerala, Tamil Nadu, Karnataka and West Bengal.

Wage Disparities and Pay Commission Anomalies

Wage disparities operate at multiple levels. There is disparity between central government health institutions and state government hospitals; between government hospitals and corporate hospitals; between corporate hospitals and small nursing homes; between permanent employees and contract workers; and between different categories of staff within the same institution. The failure to implement Pay Commission recommendations in a timely manner has been a recurring trigger for industrial action. State governments, facing fiscal constraints, often delay implementation or phase it in over several years. The resulting resentment is compounded when neighbouring states or central institutions implement the revisions earlier and more generously. In the private sector, the absence of a statutory wage fixation mechanism comparable to the Pay Commission leads to significant variation. Nurses in corporate hospitals in metropolitan cities may earn three to four times more than their counterparts in district-level nursing homes. This disparity fuels attrition, with better-trained and more experienced staff migrating to higher-paying employers, leaving smaller institutions chronically understaffed.

Workload and Staffing Shortages

India's nurse-to-population ratio and doctor-to-population ratio are substantially below World Health Organisation recommendations. This systemic shortage is acutely felt in hospitals, where patient loads far exceed the capacity of available staff. Overtime is mandatory, not voluntary. Breaks are skipped. Errors increase. Compassion fatigue sets in. The shortage is compounded by inequitable distribution. Rural and district hospitals are more severely affected than metropolitan tertiary care centres. Government hospitals are more severely affected than corporate hospitals. The resulting workload disparity fuels resentment and drives demand for enhanced allowances and accelerated recruitment.

Infrastructure Deficiencies and Safety Concerns

Healthcare workers in many government hospitals and smaller private nursing homes work in environments that are unsafe, unsanitary and inadequately equipped. Shortages of personal protective equipment, unsafe needle disposal systems, inadequate ventilation in infectious disease wards and poorly maintained electrical and fire safety systems are common. The COVID-19 pandemic exposed these deficiencies with devastating clarity. Thousands of healthcare workers were infected; several hundred died. The trauma of working through the pandemic, compounded by the failure of employers and governments to provide adequate protection, has left a legacy of anger and distrust.

Professional Autonomy and Managerial Control

Doctors, in particular, resent what they perceive as excessive managerial control over clinical decision-making. Corporate hospitals, driven by revenue targets and cost containment, may pressure doctors to increase patient throughput, reduce length of stay, avoid expensive investigations or prescribe from the hospital pharmacy. These pressures conflict with the

physician's ethical duty to act solely in the patient's best interest. The conflict between professional autonomy and managerial control is not easily resolved through conventional industrial dispute mechanisms. It is not a dispute over wages or working conditions; it is a dispute over the very purpose and values of the healthcare enterprise. It manifests in low morale, passive resistance and, in extreme cases, collective action by medical associations.

7.6 DISPUTE SETTLEMENT MECHANISMS

Works Committees

Section 3 of the Industrial Disputes Act, 1947 requires the appropriate government to require every industrial establishment employing one hundred or more workmen to constitute a Works Committee consisting of representatives of employers and workmen. The function of the Works Committee is to promote measures for securing and preserving amity and good relations between the employer and workmen and to comment upon matters of their common interest or concern. Works Committees are intended to function at the enterprise level, resolving disputes through discussion and negotiation before they escalate into formal industrial disputes. In the hospital context, Works Committees can address issues such as duty rosters, leave schedules, canteen facilities, transport arrangements and minor grievances. Their effectiveness depends on the commitment of both management and worker representatives to engage in good faith.

Grievance Redressal Machinery

The Industrial Relations Code, 2020 mandates the establishment of a Grievance Redressal Committee in every industrial establishment employing twenty or more workmen. The Committee consists of equal numbers of employer and workmen representatives, with a presiding officer selected from among the workmen representatives. The Committee is empowered to resolve disputes arising out of individual grievances relating to terms of employment, conditions of labour, unfair labour practices and victimisation. Its decision is binding on the parties. An appeal lies to the industrial tribunal or the appellate authority as prescribed.

Conciliation

Conciliation is the dominant dispute resolution mechanism under the Industrial Disputes Act. Section 4 empowers the appropriate government to appoint Conciliation Officers charged with the duty of mediating in and promoting the settlement of industrial disputes. Section 12 requires the Conciliation Officer to investigate the dispute and do all such things as they think fit for the purpose of inducing the parties to come to a fair and amicable settlement. Conciliation may be voluntary, initiated by the parties, or compulsory, initiated by the government. In practice, when a strike or lock-out is imminent or has commenced, the government typically refers the dispute to conciliation. The Conciliation Officer, drawn from the labour department, conducts meetings with the parties, explores settlement options and endeavours to broker a negotiated resolution. If a settlement is reached, it is recorded in a memorandum of settlement signed by the parties and the Conciliation Officer. Such a settlement is binding on all parties and remains in force for the period agreed upon. If no settlement is reached, the Conciliation Officer submits a failure report to the government, which may then refer the dispute for adjudication.

Arbitration

Section 10A of the Industrial Disputes Act permits the parties to refer an industrial dispute to arbitration by mutual agreement. The arbitration agreement must be in writing and must specify the arbitrator or arbitrators. The arbitrator is not bound by the Code of Civil Procedure or the Indian Evidence Act but must follow the principles of natural justice. Arbitration offers the advantage of party autonomy, confidentiality and potentially speedier resolution. However, it is rarely used in practice. Employers and trade unions are often reluctant to vest such authority in a private arbitrator and prefer the institutional framework of adjudication.

Adjudication: Labour Courts and Industrial Tribunals

The Industrial Disputes Act establishes a three-tier adjudicatory framework. Labour Courts constituted under Section 7 adjudicate disputes relating to the legality of orders passed by employers under standing orders, discharge or dismissal of workmen, grant of relief to workmen wrongfully dismissed and interpretation of standing orders. Industrial Tribunals constituted under Section 7A adjudicate a wider range of disputes including wages, compensatory allowances, hours of work, rest intervals, leave with wages, holidays, bonus, profit-sharing, provident fund, gratuity, retrenchment, closure and any other matter that may be prescribed. National Tribunals constituted under Section 7B adjudicate disputes of national importance or such nature that establishments in more than one state are likely to be interested in or affected by the dispute. The procedure before Labour Courts and Industrial Tribunals is governed by the Code of Civil Procedure, 1908 and the Indian Evidence Act, 1872, but the courts have considerable flexibility. They are not bound by the strict rules of pleading and evidence applicable to civil courts.

Voluntary Retirement Scheme and Separation

The Industrial Disputes Act does not directly regulate voluntary retirement schemes, which are contractual arrangements between employer and employee. However, where a voluntary retirement scheme is offered as an alternative to retrenchment, the protections of Section 25F and Section 25N apply. The employee must be given full information about the implications of the scheme and the consent must be free and voluntary. Courts have set aside voluntary retirement where it was found to be induced by coercion, undue influence or misrepresentation.

7.7 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES IN LABOUR RELATIONS

Permanent Employment versus Contractual Employment

The distinction between permanent employment and contractual employment is the most contested contractual issue in hospital labour relations. Permanent employees are entitled to the full panoply of statutory protections: notice and compensation upon retrenchment, provident fund, gratuity, paid leave, maternity benefit and access to the grievance redressal and adjudication machinery. Contractual employees, particularly those engaged through third-party contractors, are often denied these benefits. The Industrial Disputes Act does not prohibit fixed-term employment. The Industrial Relations Code, 2020 explicitly recognises fixed-term employment and permits employers to engage workmen on fixed-term contracts. However, the Code also provides that a fixed-term workman shall be entitled to the same statutory benefits, on a pro rata basis, as a permanent workman. It also provides that the workman shall not be discriminated against in matters of wages, hours of work and other conditions of service. The

challenge in hospitals is enforcement. Contract workers, often unaware of their rights, do not demand parity. Contractors, seeking to maximise their margins, do not voluntarily provide statutory benefits. Principal employers, the hospitals, disclaim responsibility, asserting that the contract worker is the employee of the contractor. The legal position, affirmed by the Supreme Court in several judgments, is that the principal employer cannot escape liability for the welfare of contract workers. The Contract Labour Act, 1970 imposes joint liability on the principal employer and the contractor. The Industrial Relations Code, 2020 strengthens this position.

Professional Indemnity Insurance and Vicarious Liability

The engagement of doctors as independent contractors rather than employees has significant implications for labour relations. Independent contractors are not workmen; they are not entitled to the protections of the Industrial Disputes Act. They are not covered by the employer's vicarious liability for torts committed in the course of employment. Hospitals that engage doctors as independent contractors typically require them to maintain their own professional indemnity insurance. The adequacy of this insurance is a recurring issue. Individual practitioners, particularly those in the early years of practice, often carry inadequate cover. When a catastrophic claim exceeds the policy limit, the patient is left with an unsatisfied award and the hospital, despite its contractual disclaimer, faces reputational damage and potential vicarious liability under the doctrine of apparent agency. A prudent contractual policy should prescribe minimum insurance limits based on specialty and risk profile. It should require annual verification of insurance and immediate reporting of any lapse. It should also provide that the independent contractor shall indemnify the hospital for any amount paid to a patient attributable to the contractor's negligence, up to the limit of the contractor's insurance cover.

Confidentiality, Restraint of Trade and Post-Employment Covenants

Employment contracts in hospitals often contain post-employment restrictive covenants. A non-compete clause may prohibit a departing doctor from practising within a specified geographical radius for a specified period. A non-solicitation clause may prohibit the doctor from soliciting the hospital's patients or staff. A confidentiality clause may restrict the use of the hospital's proprietary information, including patient lists, treatment protocols and business strategies. Section 27 of the Indian Contract Act, 1872 declares void any agreement by which anyone is restrained from exercising a lawful profession, trade or business. Non-compete clauses that operate after the termination of employment are generally unenforceable. The Supreme Court has consistently held that any restraint, even if partial and reasonable, is void unless it falls within the narrow exceptions recognised by judicial interpretation. Non-solicitation clauses and confidentiality clauses are more likely to be enforced. A departing doctor who uses the hospital's confidential patient list to solicit patients directly may be restrained. A doctor who joins a competing hospital and attempts to persuade colleagues to join them may be in breach of contract. However, generalised restraints that effectively prevent the doctor from practising altogether are unenforceable.

Disciplinary Proceedings and Standing Orders

The Industrial Employment Act, 1946 and the corresponding provisions of the Industrial Relations Code, 2020 require industrial establishments to define, with sufficient precision, the conditions of employment applicable to workmen. The standing orders must be certified by the appropriate authority and must cover matters such as classification of workmen, manner of intimating shifts, attendance and late-coming, leave and holidays, termination of employment

and disciplinary action. Hospitals are subject to these requirements. The standing orders constitute the statutory contract of employment between the hospital and its workmen. Any disciplinary action taken in violation of the standing orders is void. The principles of natural justice—notice of charges, opportunity to defend, reasoned order—are implied into the standing orders. Disciplinary proceedings in hospitals present unique challenges. The suspension of a nurse or technician pending inquiry disrupts patient care. The dismissal of a long-serving employee may provoke industrial action. The administrator must balance the imperative of maintaining discipline and accountability with the operational requirements of a twenty-four-hour service organisation and the legal requirements of due process.

Whistleblower Protection

The Whistle Blowers Protection Act, 2014 and the specific provisions of the Companies Act, 2013 require certain classes of companies to establish vigil mechanism for directors and employees to report genuine concerns. Listed companies and companies accepting deposits from the public are required to establish such a mechanism. For hospitals that are companies, this obligation applies. The vigil mechanism must provide adequate safeguards against victimisation of persons who use the mechanism. It must also provide direct access to the Chairperson of the Audit Committee or the Director in appropriate cases. Even where not statutorily mandated, a whistleblower policy is an essential component of a robust ethical culture in healthcare. Nurses and technicians are often the first to observe unsafe practices, medication errors or violations of patient safety protocols. They must be able to report these concerns without fear of retaliation.

7.8 STUDENT LEARNING ACTIVITIES

Activity 1: Hospital Industry Status Analysis

You are the Administrator of a one hundred fifty bed charitable trust hospital registered under Section 8 of the Companies Act, 2013. The hospital is managed by a board of trustees and does not distribute any profits to its members. It provides free treatment to thirty per cent of its patients and charges subsidised rates to the remainder. The hospital has one hundred eighty employees, including forty-five doctors, seventy-five nurses, twenty-five technicians and thirty-five administrative and support staff. The nursing staff have recently formed a union and have submitted a charter of demands seeking revision of pay scales, regularisation of contract nurses and enhancement of night shift allowances. The union has threatened to go on strike if the demands are not met within fifteen days. The hospital's legal counsel has advised that the hospital may not be an industry under the Industrial Relations Code, 2020 and that the union may not have the right to invoke the dispute resolution machinery under the Code. Prepare a comprehensive memorandum analysing the legal status of the hospital as an industry under the Industrial Disputes Act, 1947 and the Industrial Relations Code, 2020. Your memorandum should trace the evolution of the law from Hospital Mazdoor Sabha to Bangalore Water Supply to the 2020 Code, assess the impact of the pending constitutional challenge to the Code, evaluate the applicability of State industrial relations legislation and recommend a strategy for engaging with the union and addressing the charter of demands.

Activity 2: Strike Management and Crisis Response Plan

A private corporate hospital in your city is facing an indefinite strike by its nursing staff. The nurses are demanding immediate implementation of a revised pay scale comparable to central

government rates, regularisation of sixty-five contract nurses who have completed more than three years of continuous service, and installation of CCTV cameras in all patient care areas and deployment of dedicated security personnel in the emergency department. The strike has entered its third day. Elective surgeries have been cancelled. The intensive care unit is operating with skeleton staff, with resident doctors performing nursing duties. Two patients have been transferred to other hospitals. The hospital's reputation is being severely damaged by media coverage. As the Medical Superintendent, you have been directed by the board of directors to prepare a comprehensive strike management and crisis response plan. Your plan should address immediate operational measures to maintain patient safety, communication strategy for patients, families, media and regulatory authorities, negotiation strategy and settlement options, legal response to the strike including assessment of its legality and potential disciplinary action, and long-term measures to address the underlying causes of the dispute and prevent recurrence.

Activity 3: Contract Labour Audit and Regularisation Policy

Your hospital engages eighty-five contract workers, including forty-five staff nurses, twenty technicians and twenty housekeeping staff, through three different contractors. These workers have been engaged on eleven-month contracts for periods ranging from two to seven years. They perform the same duties as permanent employees, work the same shifts and are supervised by the same managers. However, they are paid substantially lower wages, receive no paid leave or maternity benefits and have no job security. The Labour Commissioner has issued a notice to the hospital under the Contract Labour Act, 1970 and the Industrial Relations Code, 2020 alleging that the engagement of contract labour is a sham and that the contract workers are, in substance, direct employees of the hospital. The notice requires the hospital to show cause why the contract workers should not be regularised and why prosecution should not be initiated. Prepare a detailed policy on contract labour and regularisation for the hospital. Your policy should establish the principles governing engagement of contract labour, specify the categories of work that may legitimately be outsourced, set limits on the duration of contract engagements, provide a transparent mechanism for regularisation of contract workers who have completed specified periods of continuous service, allocate responsibility for compliance with statutory benefits and establish monitoring and audit mechanisms.

Activity 4: Disciplinary Proceedings and Natural Justice

A senior staff nurse with fifteen years of service has been charged with gross negligence. The allegation is that she failed to monitor a post-operative patient's vital signs at the prescribed intervals, resulting in delayed recognition of internal bleeding and contributing to the patient's death. The nurse denies the allegation and claims that the ward was understaffed, that she was assigned sixteen patients against the standard ratio of one nurse to eight patients and that the hospital administration has made her a scapegoat for systemic failures. The hospital has issued a charge-sheet and proposes to hold a disciplinary inquiry. You have been appointed as the Inquiry Officer. Draft the charge-sheet to be issued to the nurse, the terms of reference for the disciplinary inquiry, a checklist of procedural safeguards to be observed during the inquiry to comply with the principles of natural justice, and a template for the final reasoned order structured to address each charge, evaluate the evidence and provide findings with reasons. Also prepare a briefing note for the management on the legal principles governing disciplinary inquiries, the distinction between minor and major misconduct and the range of punishments proportionate to the gravity of the misconduct.

7.9 SUMMARY

The classification of hospitals as an industry under industrial law is the foundational premise of healthcare labour relations. The Supreme Court in State of Bombay v. Hospital Mazdoor Sabha established that a hospital, whether public or private, charitable or commercial, is an industry because it involves systematic activity organised by cooperation between employer and employee for the production and distribution of services calculated to satisfy human wants. The Bangalore Water Supply and Sewerage Board v. A. Rajappa expanded this definition to its widest amplitude, holding that virtually every organised economic activity, including healthcare, constitutes an industry. The Industrial Relations Code, 2020 excludes hospitals from the definition of industry, but this exclusion is under constitutional challenge and has not been fully tested. Prudent hospital administration requires continued compliance with the established industrial jurisprudence.

The Industrial Disputes Act, 1947 is the principal legislation governing the resolution of industrial disputes. It applies to hospitals in full force. Key provisions include the definition of industrial dispute and workman; the prohibition of strikes and lock-outs in public utility services, which includes medical services; the conditions precedent to lay-off, retrenchment and closure; the prohibition of unfair labour practices; and the establishment of works committees, grievance redressal machinery, conciliation, arbitration and adjudication by labour courts and industrial tribunals.

The causes of industrial unrest in hospitals are multiple and interconnected. Violence against healthcare workers is the most visible and alarming cause, eroding morale and deterring entry into the profession. Contractualisation and job insecurity affect a large and growing segment of the hospital workforce, particularly nurses. Wage disparities, both within and between institutions, fuel resentment and attrition. Chronic staffing shortages result in excessive workload, mandatory overtime and unsafe nurse-to-patient ratios. Infrastructure deficiencies, inadequate safety measures and the trauma of the COVID-19 pandemic have compounded these grievances. The tension between professional autonomy and managerial control, particularly in corporate hospitals, adds a distinctive dimension to healthcare industrial relations.

The dispute settlement mechanisms under the Industrial Disputes Act provide a structured framework for resolving conflicts. Works committees promote dialogue at the enterprise level. Conciliation, conducted by officers of the labour department, is the primary mechanism for settling disputes without adjudication. Arbitration, though rarely used, offers party autonomy and confidentiality. Labour courts and industrial tribunals adjudicate disputes that cannot be resolved through conciliation, with appeals to High Courts and the Supreme Court.

Healthcare-specific contractual issues in labour relations include the distinction between permanent and contractual employment, the regulation of contract labour, professional indemnity insurance requirements for independent contractor doctors, post-employment restrictive covenants, disciplinary proceedings under standing orders and whistleblower protection. The hospital administrator must address these issues through clear policies, transparent procedures and compliance with statutory requirements.

The hospital administrator must recognise that industrial relations in healthcare are not merely a matter of legal compliance. They are integral to the quality and safety of patient care. A demoralised, overworked and insecure workforce cannot deliver compassionate, competent

care. A hospital riven by conflict between management and staff cannot fulfil its healing mission. The administrator's task is to build an organisational culture based on mutual respect, fair treatment and shared commitment to patient welfare. The law provides the minimum standards; leadership provides the vision.

7.10 KEY WORDS WITH EXPLANATIONS

Industry is defined under Section 2 of the Industrial Disputes Act, 1947 as any systematic activity carried on by cooperation between an employer and workmen for the production, supply or distribution of goods or services with a view to satisfy human wants or wishes, whether or not any profit is gained. Hospitals are industries. The Industrial Relations Code, 2020 excludes hospitals, but this exclusion is under challenge.

Industrial Dispute is any dispute or difference between employers and employers, or between employers and workmen, or between workmen and workmen, which is connected with the employment or non-employment or the terms of employment or with the conditions of labour of any person. The dispute must be espoused by a substantial number of workmen or by a registered trade union.

Workman is any person employed in any industry to do any manual, unskilled, skilled, technical, operational, clerical or supervisory work for hire or reward. It excludes persons employed mainly in managerial or administrative capacity, supervisory personnel drawing wages exceeding ten thousand rupees per month and persons employed in confidential capacity. Nurses, technicians, pharmacists and clerical staff are workmen; doctors generally are not.

Public Utility Service under Section 2 of the Industrial Disputes Act, 1947 includes any system of public conservancy, sanitation or medical service. Hospitals are public utility services. Strikes in hospitals without compliance with notice requirements are illegal.

Lay-off is the failure, refusal or inability of an employer to give employment to a workman whose name is borne on the muster rolls of the industrial establishment and who has not been retrenched. Lay-off compensation is payable under Section 25C.

Retrenchment is the termination by the employer of the service of a workman for any reason whatsoever, otherwise than as punishment inflicted by way of disciplinary action. Retrenchment requires one month's notice or wages in lieu thereof and compensation equivalent to fifteen days' average pay for every completed year of continuous service.

Closure is the permanent closing down of an industrial establishment. Closure of an establishment employing more than one hundred workmen requires prior permission of the appropriate government under Section 25-O.

Unfair Labour Practice comprises practices enumerated in the Fifth Schedule to the Industrial Disputes Act, 1947 including interference with the right to form trade unions, threats of discharge or dismissal for union activities, establishment of employer-sponsored unions, acts of force or violence, favouritism and victimisation.

Victimisation is the punishment of a workman for legitimate trade union activities or for exercising rights under industrial law. Essential elements are punishment disproportionate to

the misconduct alleged and evidence that the employer was actuated by malice or vindictiveness.

Conciliation is a dispute resolution mechanism wherein a Conciliation Officer appointed by the government mediates between the parties and promotes a fair and amicable settlement. If settlement is reached, it is binding on all parties. If not, a failure report is submitted and the dispute may be referred for adjudication.

Works Committee is a committee consisting of representatives of employers and workmen, required to be constituted in every industrial establishment employing one hundred or more workmen. Its function is to promote measures for securing and preserving amity and good relations between the employer and workmen.

Standing Orders are certified conditions of employment applicable to workmen in industrial establishments, required under the Industrial Employment Act, 1946 and the Industrial Relations Code, 2020. They cover classification of workmen, shifts, attendance, leave, termination and disciplinary action.

Contract Labour comprises workmen engaged through a contractor, as distinguished from workmen directly employed by the principal employer. The Contract Labour Act, 1970 regulates engagement of contract labour and imposes joint liability on the principal employer and contractor for welfare benefits.

Fixed-Term Employment is employment for a predetermined period, recognised under the Industrial Relations Code, 2020. Fixed-term workmen are entitled to the same statutory benefits, on a pro rata basis, as permanent workmen and shall not be discriminated against in matters of wages and conditions of service.

Non-Compete Clause is a contractual restriction on an employee's right to practise their profession after termination of employment. It is generally void under Section 27 of the Indian Contract Act, 1872 which declares void any agreement restraining a person from exercising a lawful profession, trade or business.

7.11 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What is the legal test for determining whether an entity is an industry under the Industrial Disputes Act, 1947 as established in Bangalore Water Supply and Sewerage Board v. A. Rajappa?

Ans. The Supreme Court laid down the functional test. There must be systematic activity, organised by cooperation between employer and employee, for the production and distribution of goods and services, and such goods and services must be calculated to satisfy human wants and wishes. The nature of the employer, the presence or absence of profit motive and the character of the activity as sovereign or non-sovereign are irrelevant. Every hospital satisfies this test.

Q2. What is the distinction between a permanent workman and a fixed-term workman under the Industrial Relations Code, 2020?

Ans. A permanent workman is employed on an open-ended basis with no predetermined date of termination. A fixed-term workman is engaged for a predetermined period. The Code provides that fixed-term workmen shall be entitled to the same statutory benefits, on a pro rata basis, as permanent workmen and shall not be discriminated against in matters of wages, hours of work and other conditions of service. However, fixed-term workmen are not entitled to notice and compensation upon retrenchment.

Q3. What are the conditions precedent to retrenchment of a workman under Section 25F of the Industrial Disputes Act, 1947?

Ans. The employer must give one month's notice in writing indicating the reasons for retrenchment or pay wages in lieu of such notice; pay compensation equivalent to fifteen days' average pay for every completed year of continuous service; and serve notice on the appropriate government. These conditions are mandatory; retrenchment effected without compliance is void ab initio.

Q4. What constitutes victimisation as an unfair labour practice?

Ans. Victimisation is the punishment of a workman for legitimate trade union activities or for exercising rights under industrial law. The essential elements are: the workman must have been subjected to punishment or an adverse order; the punishment must be disproportionate to the misconduct alleged; and there must be evidence that the employer was actuated by malice or vindictiveness because of the workman's trade union activities or exercise of legal rights.

Q5. What is the legal status of a non-compete clause in an employment contract under Section 27 of the Indian Contract Act, 1872?

Ans. Section 27 declares void any agreement by which anyone is restrained from exercising a lawful profession, trade or business. Non-compete clauses that operate after the termination of employment are generally unenforceable. The Indian rule against restraint of trade is stricter than the common law rule; all restraints, even if partial and reasonable, are void unless they fall within narrow exceptions recognised by judicial interpretation.

B. Essay Type Questions with Hints

Q1. Trace the evolution of the law relating to hospitals as an industry from State of Bombay v. Hospital Mazdoor Sabha to the Industrial Relations Code, 2020. Critically evaluate the exclusion of hospitals from the definition of industry under the Code and its implications for healthcare workers.

Hints: Begin with the Hospital Mazdoor Sabha judgment and the triple test. Analyse the expansion of the definition in Bangalore Water Supply. Discuss the 1982 amendment that was never brought into force. Explain the Industrial Relations Code, 2020 and its operative exclusion of hospitals. Evaluate the constitutional challenge to the exclusion on grounds of arbitrariness and violation of Article 14. Discuss the implications for healthcare workers: loss of protection against unfair labour practices, retrenchment and closure; exclusion from the adjudication framework; and dependence on State legislation and contractual remedies.

Conclude with the uncertainty in the current legal position and recommendations for hospital administrators.

Q2. Analyse the causes of industrial unrest in Indian hospitals with particular reference to violence against healthcare workers and contractualisation of the nursing workforce. What legal and administrative measures are necessary to address these causes?

Hints: Structure your answer around the two principal causes. For violence: discuss the inadequacy of the existing legal framework under the Indian Penal Code and the failure of several attempts to enact central protection legislation; analyse the role of communication failures, patient expectations and security deficiencies; evaluate the draft Healthcare Service Personnel and Clinical Establishments Bill; recommend both legal measures of stringent penalties and fast-track courts and administrative measures of CCTV, security personnel, de-escalation training and patient counselling. For contractualisation: analyse the extent of the practice in government and private hospitals; discuss the distinction between legitimate outsourcing and sham contracts; examine the provisions of the Contract Labour Act, 1970 and the Industrial Relations Code, 2020; recommend regularisation policies, joint liability enforcement and strengthening of contract labour inspection.

Q3. Discuss the dispute settlement mechanisms available under the Industrial Disputes Act, 1947. How do conciliation, arbitration and adjudication differ and what are the respective advantages and limitations of each?

Hints: Structure your answer around the three principal mechanisms. For conciliation: explain the role of the Conciliation Officer under Section 12; discuss the process of investigation, mediation and settlement; analyse the binding nature of settlements; evaluate the advantages of speed, cost and party autonomy and limitations of dependence on good faith and no binding determination if settlement fails. For arbitration: explain Section 10A; discuss party autonomy in selection of arbitrator and procedure; analyse the advantages of confidentiality and flexibility and limitations of rare use and reluctance of parties. For adjudication: explain the three-tier structure of Labour Courts, Industrial Tribunals and National Tribunals; discuss jurisdiction and procedure; analyse the advantages of binding precedent and enforceability and limitations of delay, cost and adversarial nature. Conclude with the importance of dispute prevention through works committees and grievance redressal machinery.

Q4. Critically examine the law relating to retrenchment and closure under the Industrial Disputes Act, 1947. What additional protections apply to establishments employing more than one hundred workmen and how do these provisions apply to large corporate hospitals?

Hints: Explain the conditions precedent to retrenchment under Section 25F: notice, compensation and government notice. Discuss the computation of continuous service and the fifteen days' average pay formula. Analyse the distinction between retrenchment and termination by way of disciplinary action. Explain Section 25N: three months' notice and prior permission of government for establishments employing more than one hundred workmen. Discuss the procedure for obtaining permission and the grounds on which permission may be granted or refused. Explain Section 25-O: prior permission for closure, application at least ninety days before intended closure and consequences of unauthorised closure. Apply these provisions to large corporate hospitals: thresholds, applicability and practical challenges. Conclude with the impact of the Industrial Relations Code, 2020 on retrenchment and closure provisions.

Q5. You are the Administrator of a three hundred bed corporate hospital. The hospital engages one hundred twenty nurses, of whom forty-five are employed on fixed-term contracts through a third-party contractor. These contract nurses have been agitating for regularisation and have recently formed a union. The management is considering disciplinary action against the leaders of the union. Draft a comprehensive advisory note on the legal framework governing trade union formation, unfair labour practices and victimisation, and recommend a strategy for constructive engagement with the union.

Hints: Structure your advisory note in four parts. Part one: explain the right to form trade unions under the Trade Unions Act, 1926 and Article 19 of the Constitution; clarify that contract workers are entitled to form and join unions; analyse the prohibition on employer interference with this right as an unfair labour practice. Part two: define victimisation and its elements; explain that disciplinary action against union leaders, particularly where it is disproportionate or actuated by malice, constitutes victimisation and is an unfair labour practice; warn of the consequences including reinstatement with back wages and prosecution. Part three: recommend a strategy for constructive engagement; recognise the union, establish regular dialogue, address the regularisation demand through a transparent policy, ensure wage parity and statutory benefits for contract workers and utilise the grievance redressal machinery. Part four: conclude with the principle that respecting trade union rights is not a concession but a legal obligation and a sound management practice.

C. Analytical Multiple Choice Questions

1. Which of the following Supreme Court judgments authoritatively established that a government hospital is an industry under the Industrial Disputes Act, 1947?
a) Bangalore Water Supply and Sewerage Board v. A. Rajappa
b) State of Bombay v. Hospital Mazdoor Sabha
c) Workmen of Dimakuchi Tea Estate v. Management
d) Indian Medical Association v. V.P. Shantha
Correct Answer: b) State of Bombay v. Hospital Mazdoor Sabha

2. Under the Industrial Disputes Act, 1947, which of the following categories of hospital employees is generally NOT considered a workman?
a) Staff nurse employed in the intensive care unit
b) Laboratory technician with a diploma in medical laboratory technology
c) Senior consultant cardiologist drawing a monthly salary of two lakh fifty thousand rupees
d) Ward attendant employed on a fixed-term contract
Correct Answer: c) Senior consultant cardiologist drawing a monthly salary of two lakh fifty thousand rupees

3. A private corporate hospital proposes to retrench fifty nurses due to financial losses. The hospital employs a total of three hundred fifty workmen. Under the Industrial Disputes Act, 1947, which of the following statements is correct?
a) The hospital may retrench the nurses by giving one month's notice and paying fifteen days' compensation per year of service
b) The hospital must obtain prior permission of the appropriate government before effecting retrenchment
c) The hospital may retrench the nurses without any notice or compensation because the retrenchment is due to financial losses

d) The hospital must first lay off the nurses for a period of six months before retrenchment
Correct Answer: b) The hospital must obtain prior permission of the appropriate government before effecting retrenchment

4. Which of the following constitutes an unfair labour practice under the Fifth Schedule to the Industrial Disputes Act, 1947?
a) An employer requiring workmen to work overtime during a public health emergency
b) An employer discharging a workman for participating in an illegal strike
c) An employer threatening workmen with discharge if they join a trade union
d) An employer refusing to grant leave to a workman during peak admission season
Correct Answer: c) An employer threatening workmen with discharge if they join a trade union

5. Under the Industrial Relations Code, 2020, a fixed-term workman is entitled to:
a) The same wages and statutory benefits as a permanent workman, on a pro rata basis
b) Lower wages than a permanent workman, as specified in the contract
c) No statutory benefits, only the benefits specified in the contract
d) Preference in appointment to permanent vacancies
Correct Answer: a) The same wages and statutory benefits as a permanent workman, on a pro rata basis

6. A staff nurse has been dismissed from service for allegedly administering the wrong medication to a patient, resulting in the patient's death. The nurse claims that the dismissal is an act of victimisation because she had recently filed a complaint against the ward sister for harassment. The burden of proving that the dismissal was not an act of victimisation lies on:
a) The nurse, who must prove that the dismissal was actuated by malice
b) The hospital, which must prove that the dismissal was for good cause and not by way of victimisation
c) The trade union, which must espouse the nurse's grievance
d) The Labour Commissioner, who must investigate the complaint
Correct Answer: b) The hospital, which must prove that the dismissal was for good cause and not by way of victimisation

7. A hospital administrator receives information that a group of employees is planning to go on strike from the following Monday. The hospital is a public utility service under the Industrial Disputes Act, 1947. What is the minimum notice period required for a lawful strike?
a) No notice is required; strikes in public utility services are always illegal
b) Six weeks notice before commencing the strike
c) Fourteen days notice before commencing the strike
d) Twenty-four hours notice before commencing the strike
Correct Answer: b) Six weeks notice before commencing the strike

7.12 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Contract Nurses' Agitation and the Hospital's Response

Vijayashree Superspeciality Hospital is a three hundred fifty bed corporate hospital located in Visakhapatnam, Andhra Pradesh, registered as a private limited company under the Companies Act, 2013 and accredited by NABH and NABL. The hospital employs one hundred eighty-five permanent staff nurses and engages an additional one hundred ten staff nurses through three

different contractors. These contract nurses work alongside permanent nurses in all clinical areas, including intensive care units, emergency department, operation theatres and general wards. They perform identical duties, work identical shifts and are supervised by the same nursing superintendents. However, their wages are significantly lower: a contract nurse with five years of experience earns approximately eighteen thousand rupees per month, while a permanent nurse with equivalent experience earns thirty-two thousand rupees per month. Contract nurses receive no paid leave, no maternity benefits, no provident fund contributions from the contractor and no gratuity.

In September 2024, a group of forty-five contract nurses formed an association, the Vijayashree Contract Nurses Welfare Association, and submitted a charter of demands to the hospital administration. The demands included regularisation of all contract nurses who have completed three years of continuous service; parity in wages and statutory benefits with permanent nurses; payment of arrears on account of wage disparity for the preceding two years; enhancement of night shift allowance; and provision of safe, subsidised accommodation within or near the hospital campus. The hospital administration responded that the contract nurses were employees of the respective contractors and that the hospital had no direct employment relationship with them. The contractors, when approached, stated that they were bound by the terms of their contracts with the hospital and could not unilaterally revise wages or benefits.

On 10 January 2025, the association organised a peaceful demonstration outside the hospital main gate during the lunch hour. Approximately eighty contract nurses participated, holding placards and chanting slogans. The demonstration did not disrupt patient care and dispersed after two hours. The hospital administration issued a memorandum to all contract nurses warning that any further protest during working hours would be treated as misconduct and would result in termination of their services through the contractors. On 15 January 2025, the association organised a one-day relay fast in the hospital cafeteria. The fast was attended by sixty contract nurses and was supported by the Andhra Pradesh Government Nurses and Midwives Union. The hospital administration called the police, who dispersed the gathering and removed the nurses from the premises. Five nurses were arrested for unlawful assembly and were released on bail the same evening.

On 20 January 2025, the hospital administration issued termination notices to twelve nurses who were identified as the leaders of the association. The notices, issued through the contractors, stated that the nurses had violated the terms of their contracts by engaging in activities prejudicial to the interests of the hospital and that their services were no longer required. The termination was effective immediately and the nurses were escorted out of the hospital premises by security personnel. The termination of the twelve nurses provoked a strong response. The association called for an indefinite strike commencing 25 January 2025. The strike was joined by approximately ninety contract nurses and, in a show of solidarity, by thirty-five permanent nurses who were members of the Government Nurses and Midwives Union. The strike severely impacted hospital operations. The emergency department was forced to divert ambulances to other hospitals. The intensive care units operated with reduced bed capacity. Two elective surgeries were cancelled and three patients were transferred to other hospitals at family request.

On 28 January 2025, the Deputy Commissioner of Labour, Visakhapatnam, initiated conciliation proceedings under the Industrial Disputes Act, 1947. Notices were issued to the hospital, the contractors and the association. The hospital contested the jurisdiction of the Conciliation Officer, arguing that the dispute was not an industrial dispute because the contract

nurses were not workmen of the hospital and because the hospital was not an industry under the Industrial Relations Code, 2020. The hospital also argued that the association was not a registered trade union and therefore had no standing to represent the nurses. The Conciliation Officer rejected the hospital's preliminary objections. He held that the hospital was an industry under the Industrial Disputes Act, 1947 and that the Industrial Relations Code, 2020 had not been fully tested. He held that the contract nurses were workmen and that the dispute was an industrial dispute because it related to conditions of employment. He held that the association, though not registered, could represent the nurses in conciliation proceedings.

After four rounds of conciliation meetings, the following terms of settlement were negotiated: the hospital agreed to regularise sixty-five contract nurses who had completed three years of continuous service as of 31 January 2025, effective from 1 April 2025, with incremental credit for past service; the hospital agreed to ensure that all contract nurses engaged through contractors would be paid wages equivalent to the minimum wages prescribed for the scheduled employment of nursing with effect from 1 February 2025 and further agreed to ensure that contractors would make provident fund contributions and pay gratuity in accordance with law; the hospital agreed to reinstate the twelve terminated nurses with continuity of service but without back wages for the period of termination; the hospital agreed to constitute a Joint Grievance Redressal Committee consisting of equal representatives of management and nursing staff, including contract nurses, to address future disputes; and the association agreed to call off the strike immediately and to refrain from any strike action while the settlement was being implemented.

The settlement was reduced to writing and signed by the hospital, the contractors, the association and the Conciliation Officer on 3 February 2025. However, implementation proved problematic. By 31 March 2025, only forty-five of the sixty-five eligible nurses had been regularised. The hospital cited administrative delays and the need to verify service records. The contractors continued to pay wages below the agreed rates, claiming that the hospital had not revised the contract rates accordingly. The twelve terminated nurses who were reinstated reported hostile treatment by their supervisors and were assigned to night shifts disproportionately. On 15 April 2025, the association filed a complaint with the Conciliation Officer alleging breach of settlement.

Questions for Analysis with Hints

Q1. Analyse the legal status of the contract nurses. Are they workmen under the Industrial Disputes Act, 1947? Are they employees of the hospital or of the contractors? What is the hospital's liability for their wages and statutory benefits under the Contract Labour Act, 1970 and the Industrial Relations Code, 2020?

Hints: The contract nurses are workmen under Section 2 of the Industrial Disputes Act, 1947 as they are employed to do skilled technical work for hire or reward. The determination of whether they are employees of the hospital or of the contractors requires examination of the substance of the relationship, not merely the form of the contract. The facts strongly indicate that the engagement of contract nurses is a sham intended to evade the obligations of an employer. The nurses work alongside permanent employees, perform identical duties, work identical shifts and are supervised by the hospital's nursing superintendents. The contractors merely process payroll and have no independent supervisory role. The prolonged duration of engagement demonstrates that the work is not temporary, casual or intermittent. The hospital is, in substance, the employer. The hospital's liability for wages and statutory benefits is joint

and several with the contractors under Section 21 of the Contract Labour Act, 1970 and Section 45 of the Industrial Relations Code, 2020.

Q2. Evaluate the hospital's response to the nurses' agitation. Was the termination of the twelve nurses lawful? Does it constitute victimisation and an unfair labour practice? What remedies are available to the terminated nurses?

Hints: The termination of the twelve nurses was unlawful and constitutes victimisation and an unfair labour practice. The termination was directly connected to the nurses' legitimate trade union activities. The nurses had formed an association, submitted a charter of demands and engaged in peaceful protest. These activities are protected under Article 19 of the Constitution and the Trade Unions Act, 1926. The termination was disproportionately severe; the alleged misconduct of participation in a peaceful demonstration did not warrant dismissal. The timing of the termination immediately following the nurses' leadership of the agitation strongly indicates that the employer was actuated by malice and vindictiveness. The termination constitutes an unfair labour practice under Items 1 and 5 of the Fifth Schedule to the Industrial Disputes Act, 1947. Remedies available to the terminated nurses are reinstatement with continuity of service and full back wages, compensation for the period of unemployment and mental agony, and prosecution of the employer for unfair labour practice under Section 25-U.

Q3. Assess the legality of the strike under the Industrial Disputes Act, 1947. Was it a strike in a public utility service? Were the notice requirements complied with? Was the strike protected or illegal? What are the consequences for the striking nurses and the hospital?

Hints: The strike was illegal under Section 22 of the Industrial Disputes Act, 1947. Vijayashree Superspeciality Hospital, being a hospital, is a public utility service under Section 2. A strike in a public utility service is illegal unless notice of strike is given within six weeks before commencing the strike. No such notice was given. The consequences of an illegal strike are that the strikers are liable to disciplinary action including deduction of wages for the strike period and dismissal; the strike is not protected and the employer is not obligated to reinstate the strikers; and the employer may claim damages from the union or the strikers for losses caused by the illegal strike. However, the Supreme Court has held that while participation in an illegal strike may be misconduct, the punishment of dismissal is disproportionately severe unless the strike was violent or the participation was aggravated by other misconduct. In this case, the strike was peaceful and did not involve violence, obstruction or intimidation. The appropriate disciplinary response would be deduction of wages for the strike period, not dismissal.

Q4. Discuss the binding nature of the settlement reached in conciliation proceedings. Is the hospital in breach of the settlement? What remedies are available to the nurses for enforcement of the settlement? Can the nurses resort to strike action to enforce the settlement?

Hints: The settlement reached in conciliation proceedings under Section 12 of the Industrial Disputes Act, 1947 is binding on all parties to the settlement under Section 18. The hospital is in breach of the settlement. It has failed to regularise all eligible nurses within the agreed timeframe. It has failed to ensure that contractors pay wages equivalent to minimum wages. The reinstated nurses have been subjected to hostile treatment and discriminatory assignment of night shifts. The remedies available to the nurses for enforcement of the settlement are: a complaint to the Conciliation Officer, who may initiate further conciliation proceedings or refer the dispute for adjudication; an application to the Industrial Tribunal or Labour Court for

enforcement of the settlement as an award; and a writ petition under Article 226 of the Constitution before the High Court for enforcement of the settlement as a binding obligation. The nurses cannot resort to strike action to enforce the settlement. The settlement itself is a binding obligation and breach of settlement is to be remedied through the statutory dispute resolution machinery, not through self-help. Moreover, any strike in a public utility service without notice would be illegal, regardless of the grievance that provoked it.

Q5. As the newly appointed Medical Superintendent of Vijayashree Superspeciality Hospital, you have been directed by the board of directors to prepare a comprehensive policy on contract labour and regularisation to prevent recurrence of such disputes. Your policy should address the principles governing engagement of contract labour, the categories of work that may be legitimately outsourced, the maximum duration of contract engagements, the criteria and process for regularisation, the mechanism for ensuring wage parity and statutory compliance by contractors, and the grievance redressal framework for contract workers.

Hints: The policy must establish that the hospital shall engage contract labour only for work that is genuinely temporary, seasonal or intermittent; peripheral to the core clinical activities of the hospital; or requiring specialised skills not available within the permanent workforce. Core clinical activities, including nursing care in intensive care units, emergency departments and operation theatres, shall be performed by permanent employees of the hospital. The categories of work that may be legitimately outsourced are housekeeping and sanitation, security services, laundry and linen services, cafeteria and food services, biomedical waste collection and transportation, maintenance of plant and equipment, and gardening and horticulture. No contract worker shall be engaged for a period exceeding one year and no contract worker shall be engaged for more than three consecutive years. A contract worker who has completed three years of continuous service shall be regularised as a permanent employee of the hospital with incremental credit for past service. All contractors shall be required as a condition of contract to pay wages at rates not less than the minimum wages prescribed and not less than the wages paid to permanent employees performing similar work, and to make provident fund contributions, pay gratuity, provide paid leave and provide maternity benefit. The hospital shall deduct from the contractor's bills any amounts required to ensure compliance with these obligations. A Joint Grievance Redressal Committee shall be constituted consisting of equal representatives of management and contract workers.

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A hospital is an industry, not because it makes profit, but because it is an organised activity in which capital and labour cooperate for the production of services calculated to satisfy human wants. The patient is the consumer; the doctor and nurse are the workmen; the hospital is the employer. The law of industrial relations applies to this relationship as it applies to any other.

** Supreme Court of India, State of Bombay v. Hospital Mazdoor Sabha (1960)**

LESSON-8
TRADE UNIONS, DISCIPLINE AND SERVICE CONDITIONS

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Explain the statutory framework governing trade unions in India under the Trade Unions Act, 1926 and the role of trade unions in the healthcare sector
2. Analyse the concept of unfair labour practices and victimisation and identify specific employer actions that constitute such practices
3. Evaluate the legal requirements for a valid disciplinary enquiry including the principles of natural justice, charge-sheet, evidence and reasoned order
4. Distinguish between the various components of service conditions and retiral benefits applicable to hospital employees
5. Apply the principles of social security legislation to ensure compliance and protect employee welfare in healthcare establishments

STRUCTURE OF THE LESSON

8.1 INTRODUCTION: THE COLLECTIVE VOICE OF HEALTHCARE WORKERS

The hospital is a complex social organisation. Within its walls, hundreds or thousands of individuals—doctors, nurses, technicians, administrators and support staff—cooperate in the shared endeavour of patient care. Yet this cooperation is not spontaneous. It is structured by

hierarchy, mediated by contract and animated by the divergent interests of employer and employee. The trade union is the institutional expression of the employee's collective voice. It is the mechanism through which individual workers, who would be powerless in isolation, aggregate their bargaining power and negotiate with the employer on terms of relative equality. The right to form and join trade unions is a fundamental right under Article 19 of the Constitution, and its exercise in the healthcare sector has transformed the employment relationship. This transformation has not been without conflict. Employers, particularly in the private corporate sector, have resisted unionisation. They have dismissed union leaders, imposed punitive transfers and outsourced work to non-unionised contract labour. The law has responded by declaring such practices unfair and by providing remedies for victimisation. Disciplinary proceedings represent the other face of the employment relationship. The employer has the right to maintain discipline and to punish misconduct. This right, however, is not absolute. It is hedged by the requirements of natural justice, by the standing orders certified under the Industrial Employment Act, 1946 and by the oversight of labour courts and industrial tribunals. A dismissal effected without a valid enquiry is void. This lesson examines the legal framework governing trade unions, unfair labour practices, disciplinary proceedings, service conditions and social security. It traces the rights and obligations of both employer and employee, the procedures that must be followed and the remedies available when those procedures are breached. For the hospital administrator, this is not abstract jurisprudence. It is the daily reality of managing a workforce in a highly regulated, emotionally charged and legally complex environment.

8.2 INTRODUCTORY CASE STUDY: DR. REDDY'S FOUNDATION – THE DISMISSAL THAT SHOOK A HOSPITAL

Dr. Reddy's Foundation Hospital is a two hundred bed multi-speciality charitable trust hospital located in Hyderabad, established in 1995, providing subsidised treatment to patients from economically weaker sections. The hospital employs one hundred eighty nurses, forty-five technicians and sixty-five administrative and support staff. The nurses are organised under the Dr. Reddy's Foundation Nurses Union, registered under the Trade Unions Act, 1926.

In June 2022, the union submitted a charter of demands to the hospital administration including revision of pay scales to bring them in line with government hospital scales, payment of night shift allowance at double the normal rate, provision of free transport for nurses required to report for emergency duties during night hours, and regularisation of thirty-five contract nurses who had been employed for more than three years. The hospital administration did not respond to the charter for six weeks. On 10 August 2022, the union organised a peaceful demonstration outside the hospital main gate during the lunch hour. Approximately sixty nurses participated. The demonstration lasted ninety minutes and did not disrupt patient care. The hospital administration issued a memorandum to all nurses warning that any further protest would be treated as misconduct.

On 15 September 2022, the union called for a one-day relay fast in the hospital cafeteria. The fast was attended by forty-five nurses. The hospital administration called the police, who dispersed the gathering and removed the nurses from the premises. Three nurses—Smt. Lakshmi, the union president; Smt. Sarala, the union secretary; and Smt. Kavitha, a member of the executive committee—were identified as the leaders. On 20 September 2022, the hospital issued show-cause notices to these three nurses alleging that they had engaged in acts of indiscipline, had instigated other nurses to participate in an illegal strike and had made baseless

allegations against the management. The nurses were directed to submit their explanations within seven days.

The nurses submitted their explanations, denying the allegations and asserting that their activities were legitimate trade union activities protected by law. Without considering their explanations, the hospital appointed a retired district judge as an Enquiry Officer. The enquiry was conducted ex parte. The nurses were not permitted to cross-examine the management witnesses. Their requests for representation by a union office-bearer were denied on the ground that the union was not recognised by the hospital. The Enquiry Officer submitted a report finding the nurses guilty of misconduct. The report was not shared with the nurses before the disciplinary authority passed its order. On 15 November 2022, the hospital issued orders dismissing the three nurses from service with immediate effect. The dismissal orders stated that the nurses had lost the confidence of the management and that their continued employment was prejudicial to the interests of the hospital.

The dismissal of the three nurses provoked widespread outrage. The union called for an indefinite strike joined by one hundred twenty nurses and twenty-five technicians. The union filed a complaint before the Industrial Tribunal-cum-Labour Court, Hyderabad, challenging the dismissal and alleging unfair labour practice and victimisation. The Tribunal issued notice to the hospital and stayed the operation of the dismissal orders pending final adjudication. The hospital challenged the Tribunal's jurisdiction before the High Court, arguing that a charitable trust hospital was not an industry under the Industrial Disputes Act, 1947. The High Court dismissed the petition, holding that the hospital was an industry under the law settled in Hospital Mazdoor Sabha and Bangalore Water Supply. After eighteen months of litigation the matter was settled through conciliation. The hospital agreed to reinstate the three nurses with full back wages and continuity of service, recognise the union for the purposes of collective bargaining and constitute a Joint Grievance Redressal Committee.

Relevance to the Lesson: This case illustrates every major theme of this lesson. It demonstrates the right of healthcare workers to form and join trade unions and the protection of that right against employer interference. It exemplifies the elements of victimisation: punishment for legitimate trade union activities, disproportionate sanction and malice evidenced by procedural irregularities. It exposes the deficiencies in the disciplinary enquiry: denial of cross-examination, ex parte proceedings, non-supply of enquiry report and absence of a reasoned order. It underscores the importance of social security as the dismissed nurses were without income for eighteen months. It demonstrates the ultimate futility of resisting legitimate trade union activity through unlawful means.

8.3 TRADE UNIONS IN HEALTHCARE: LEGAL FRAMEWORK AND ROLE

The Constitutional and Statutory Foundation

The right to form and join trade unions is a fundamental right under Article 19 of the Constitution of India. This right is available to all citizens, including healthcare workers employed in government hospitals, corporate hospitals and charitable institutions. The right is not absolute; reasonable restrictions may be imposed under Article 19 in the interests of public order, morality or sovereignty and integrity of India. However, mere inconvenience to the employer or disruption of work is not a ground for restricting the right. The Trade Unions Act, 1926 provides the statutory framework for the registration and regulation of trade unions. Any seven or more members of a trade union may apply for registration by subscribing their names

to the rules of the trade union and otherwise complying with the provisions of the Act. Upon registration, the trade union becomes a body corporate with perpetual succession and a common seal, with power to acquire and hold property and to contract. Registered trade unions enjoy certain immunities. Section 17 provides immunity from criminal conspiracy in respect of any agreement or combination of two or more persons to do or procure to be done any act in furtherance of a trade dispute. Section 18 provides immunity from civil suit in respect of any act done in contemplation or furtherance of a trade dispute, provided the act is not done with the intention of causing injury or to intimidate another person.

Trade Unions in Government and Private Hospitals

Employees of government hospitals are public servants under Section 21 of the Indian Penal Code. Their service conditions are governed by the Civil Services Rules or analogous State rules. They have the right to form associations for the purpose of representing their legitimate service interests, but such associations are not registered under the Trade Unions Act, 1926. They are governed by the Central Civil Services Conduct Rules which prohibit government servants from participating in strikes and from engaging in any activity that is prejudicial to the interests of the government. Employees of private hospitals, including corporate hospitals, trust hospitals and nursing homes, have the full right to form and join trade unions registered under the Trade Unions Act, 1926. This right extends to all categories of workmen including nurses, technicians, pharmacists and clerical and support staff. It does not extend to persons employed in managerial or administrative capacity to persons employed in supervisory capacity drawing wages above the statutory threshold. The employer cannot refuse to recognise a registered trade union merely because it is not a party to any collective bargaining agreement or because it is not the majority union. The duty to recognise a union for the purposes of collective bargaining arises when the union represents a substantial number of workmen.

Role of Trade Unions in Healthcare

Trade unions in healthcare perform multiple functions. They negotiate with employers on wages, allowances and other conditions of service. They represent individual workmen in disciplinary proceedings and grievance redressal. They monitor compliance with labour laws and social security legislation. They articulate the collective voice of healthcare workers on issues of patient safety, staffing ratios and professional autonomy. They mobilise public opinion and political support for legislative reform. The legitimate functions of trade unions must be distinguished from activities that exceed the bounds of lawful trade union activity. Peaceful demonstrations, relay fasts and even strikes, when conducted in compliance with the statutory notice requirements, are lawful. Violence, gherao, intimidation of patients and obstruction of hospital entrances are unlawful and expose the participants to disciplinary action and criminal prosecution.

Recognition of Trade Unions under the Industrial Relations Code, 2020

The Industrial Relations Code, 2020 introduces a statutory mechanism for the recognition of trade unions. In establishments where there is only one registered trade union functioning, that union shall be recognised as the sole negotiating union. In establishments where there are multiple registered trade unions, the union with the greatest membership, verified through a check-off system or a secret ballot, shall be recognised as the sole negotiating union. Unions representing at least twenty per cent of the workmen but not securing the status of sole negotiating union shall constitute the negotiating council. Recognition confers upon the trade

union the exclusive right to represent workmen in collective bargaining and to enter in settlements binding on all workmen. It also imposes upon the recognised union the duty to maintain industrial peace and to comply with the terms of settlements.

8.4 UNFAIR LABOUR PRACTICES AND VICTIMISATION

The Statutory Prohibition

Chapter V-C of the Industrial Disputes Act, 1947, inserted by the Industrial Disputes Amendment Act, 1982, prohibits unfair labour practices. Section 25-T declares that no employer or workman or trade union shall commit any unfair labour practice. Section 25-U prescribes punishment for unfair labour practices which may extend to imprisonment for six months and fine of one thousand rupees. The Fifth Schedule to the Act enumerates specific practices which are declared to be unfair labour practices. These are divided into five categories: practices on the part of employers and trade unions of employers, practices on the part of workmen and trade unions of workmen, and practices common to both.

Unfair Labour Practices on the Part of Employers

Item 1 of the Fifth Schedule prohibits threatening workmen with discharge or dismissal if they join a trade union. This is the most fundamental protection of the right to organise. An employer who warns a nurse that her services will be terminated if she joins the union commits an unfair labour practice, regardless of whether the threat is carried out. Item 2 prohibits threatening a lock-out or closure if a trade union is organised. Item 3 prohibits granting wage increases to workmen at critical periods of trade union organisation with a view to undermining the union. Item 4 prohibits the establishment of employer-sponsored trade unions. Item 5 prohibits discharging or punishing workmen for filing complaints or participating in proceedings under the Act. Item 6 prohibits discriminating against workmen in the matter of employment and conditions of employment on the ground of union activities. Item 7 prohibits recruiting workmen during a strike which is not an illegal strike. Item 8 prohibits the employment of workmen as badges of favouritism. Item 9 prohibits acts of force or violence or intimidation against workmen and their families. Item 10 prohibits refusing collective bargaining in good faith with the recognised trade union.

Victimisation: Judicial Definition

Victimisation is not defined in the Industrial Disputes Act, 1947 but has been elaborately defined in judicial decisions. The Supreme Court in Bharat Iron Works v. Bhanubhai Balubhai Patel held that victimisation means the exercise of the employer's right of discharge or dismissal mala fide, or by way of imposing punishment which is not warranted by the facts and circumstances of the case, or by way of adopting unfair labour practice. The essential elements of victimisation are: the workman must have been subjected to a punishment or adverse order; such punishment must be disproportionate to the misconduct alleged; and there must be evidence that the employer was actuated by malice or vindictiveness because of the workman's trade union activities or exercise of legal rights.

Burden of Proof

Where victimisation is alleged, the burden of proof shifts to the employer. The employer must satisfy the court or tribunal that the dismissal was for good cause and was not actuated by any

improper motive. This shift in burden is a well-established principle in industrial jurisprudence, designed to protect workmen from victimisation. The employer must produce evidence to show that there was a valid reason for the dismissal, that the workman was guilty of the misconduct alleged, that the punishment was proportionate to the misconduct, and that other workmen guilty of similar misconduct were similarly punished. If the employer fails to discharge this burden, the court or tribunal will presume that the dismissal was an act of victimisation.

Remedies for Victimisation

A workman who has been victimised is entitled to reinstatement with full back wages and continuity of service. Reinstatement is the normal rule and back wages are the normal consequence. The court or tribunal may, in exceptional circumstances, award compensation in lieu of reinstatement or deny back wages for the period of unemployment, but such departure from the normal rule must be justified by reasons. The workman is also entitled to compensation for the mental agony and harassment caused by the victimisation. Additionally, the employer is liable for prosecution under Section 25-U and may be directed to pay costs.

8.5 DISCIPLINARY ACTIONS AND VALID ENQUIRY PROCEDURES

The Right to Punish and the Duty to Enquire

The employer has the right to maintain discipline and to punish misconduct. This right is an inherent incident of the employment relationship. However, the exercise of this right is subject to two fundamental limitations. First, the punishment must be proportionate to the gravity of misconduct. Second, the decision to punish must be preceded by a fair enquiry consistent with the principles of natural justice. A disciplinary enquiry conducted without observing the principles of natural justice is void. A dismissal order passed on the basis of such an enquiry is a nullity. The court or tribunal will ignore the enquiry and afford the employer an opportunity to adduce evidence for the first time before it. If the employer fails to adduce such evidence, the dismissal will be set aside.

Principles of Natural Justice

The principles of natural justice are not codified in any statute but are derived from the common law. They are two-fold: nemo judex in causa sua, meaning no person shall be a judge in their own cause, and audi alteram partem, meaning hear the other side. In the context of disciplinary enquiries, these principles are elaborated into specific procedural requirements. The rule against bias requires that the Enquiry Officer be impartial and independent. The Enquiry Officer must not be the complainant, a witness or a person with a personal interest in the outcome of the enquiry. The test for bias is whether there is a real likelihood of bias, not whether bias actually existed. The rule of fair hearing requires that the workman be given notice of the charges, an opportunity to submit an explanation, an opportunity to cross-examine the witnesses produced by the employer, an opportunity to lead defence evidence and an opportunity to make submissions on the evidence and the penalty.

The Charge-Sheet

The disciplinary process commences with the issuance of a charge-sheet. The charge-sheet must contain a clear statement of the specific charges and allegations against the workman, the facts and circumstances constituting the misconduct, the relevant standing order or service rule

alleged to have been violated, and a direction to the workman to submit a written explanation within a specified period. The charge-sheet must be precise and specific. Vague or generalised charges do not enable the workman to defend themselves effectively and vitiate the enquiry. Charges framed in the alternative are permissible, but each charge must be specific and capable of being met. The workman must be given sufficient time to submit an explanation. What constitutes sufficient time depends on the facts of each case, but twenty-four hours is generally insufficient. Seven to fourteen days is the norm.

The Enquiry Officer

The Enquiry Officer must be a person who is impartial and independent. The employer may appoint an officer of the establishment as Enquiry Officer, provided that officer is not biased against the workman and has no personal interest in the outcome. The employer may also appoint an external person, such as a retired judicial officer or an advocate, as Enquiry Officer. The Enquiry Officer is not a prosecutor. Their function is to hold the scales evenly between the employer and the workman, to ensure that the enquiry is conducted fairly and to submit a findings report based on the evidence adduced. The Enquiry Officer cannot themselves adduce evidence or assume the role of the presenting officer.

The Enquiry Proceedings

The employer must appoint a Presenting Officer to present the case against the workman. The Presenting Officer may be an officer of the establishment or an external advocate. The workman has the right to be represented by a fellow workman, an office-bearer of the trade union or, where the standing orders so permit, a legal practitioner. The enquiry must be conducted in the presence of the workman. Ex parte proceedings are permissible only if the workman, after due notice, fails to appear without sufficient cause. However, the Enquiry Officer must record the reasons for proceeding ex parte and must give the workman an opportunity to participate if they appear at a later stage. The employer must lead evidence to prove the charges. The witnesses must be examined in the presence of the workman, and the workman must be given an opportunity to cross-examine them. Documents relied upon by the employer must be disclosed to the workman and proved in the manner required by the Indian Evidence Act, 1872. Hearsay evidence is inadmissible. The workman has the right to lead defence evidence. The Enquiry Officer must give the workman an opportunity to produce witnesses and documents in support of their defence. If the workman requests the employer to produce any document or witness, the Enquiry Officer must consider the request and, if satisfied that the document or witness is relevant, direct the employer to produce it.

The Enquiry Report

Upon the conclusion of the enquiry, the Enquiry Officer must prepare a report setting out the charges and the workman's explanation, a summary of the evidence adduced by the employer, a summary of the evidence adduced by the workman, findings on each charge with reasons, and a recommendation on the penalty if the terms of appointment so require. The enquiry report must be based solely on the evidence adduced during the enquiry. The Enquiry Officer cannot rely on their personal knowledge or on information not disclosed to the workman. The findings must be supported by reasons; a bare statement that the charges are proved is insufficient. The enquiry report must be supplied to the workman before the disciplinary authority passes its final order. The Supreme Court in Managing Director, ECIL v. B. Karunakar held that non-

supply of the enquiry report to the workman constitutes a violation of natural justice and vitiates the dismissal order.

The Disciplinary Authority

The disciplinary authority is the employer or the officer authorised by the employer to impose punishment. The disciplinary authority is not bound by the findings of the Enquiry Officer. It may accept the findings, reject them or remit the matter for further enquiry. However, if the disciplinary authority disagrees with the findings of the Enquiry Officer, it must record its tentative disagreement and give the workman an opportunity to show cause why the proposed punishment should not be imposed. The disciplinary authority must pass a speaking order setting out the charges, the findings of the Enquiry Officer, the disciplinary authority's own findings, the reasons for the punishment and the punishment imposed. The order must be communicated to the workman.

Range of Punishments

The punishments that may be imposed on a workman found guilty of misconduct are censure or warning, fine, withholding of increment or promotion, suspension, reduction in rank, demotion, removal from service and dismissal from service. Dismissal is the gravest punishment and should be imposed only for the gravest misconduct. The punishment must be proportionate to the gravity of the misconduct. A punishment that is shockingly disproportionate to the misconduct is liable to be set aside by the court or tribunal. In determining whether the punishment is proportionate, the court or tribunal will consider the nature of the misconduct, the circumstances in which it was committed, the past record of the workman and the consistency of punishment as between different workmen guilty of similar misconduct.

8.6 SERVICE CONDITIONS AND EMPLOYMENT RIGHTS

Sources of Service Conditions

The service conditions of hospital employees are derived from multiple sources. For employees of government hospitals, service conditions are governed by the Civil Services Rules or analogous State rules, read with the applicable Pay Commission recommendations. For employees of private hospitals, service conditions are governed by the contract of employment, the certified standing orders under the Industrial Employment Act, 1946 and the applicable provisions of the Industrial Disputes Act, 1947 and the Industrial Relations Code, 2020. The certified standing orders constitute the statutory contract of employment. They define the classification of workmen, the shifts and hours of work, the attendance and leave rules, the termination and disciplinary procedure and the grievance redressal mechanism. The standing orders are binding on both employer and workmen and cannot be unilaterally altered by the employer.

Classification of Employees

Hospital employees may be classified into several categories. Permanent employees are those who have completed the probationary period and whose employment is continuous. Probationers are those who are on trial for a specified period. Temporary employees are those engaged for work of a temporary or intermittent nature. Casual employees are those engaged

on a daily wage basis. Fixed-term employees are those engaged for a predetermined period. The classification determines the entitlement to notice and compensation upon termination. Permanent employees are entitled to the protections of Section 25F of the Industrial Disputes Act, 1947. Fixed-term employees are not entitled to notice and compensation upon the expiry of the term but are entitled to the same wages and statutory benefits as permanent employees on a pro rata basis.

Hours of Work and Overtime

The Factories Act, 1948, which applies to hospitals in many States, prescribes the maximum hours of work and the minimum overtime rates. No adult worker shall be required or allowed to work in a factory for more than forty-eight hours in any week and for more than nine hours in any day. Where a worker works for more than nine hours in any day or for more than forty-eight hours in any week, they shall be entitled to overtime wages at twice the ordinary rate of wages. Nurses and other hospital employees are frequently required to work overtime. The employer must maintain a register of overtime and pay overtime wages in accordance with law. Failure to pay overtime wages is a contravention of the Factories Act and also constitutes a deficiency in service under the Consumer Protection Act, 2019.

Leave and Holidays

The Factories Act, 1948 and the corresponding State Shops and Establishments Acts prescribe the minimum leave entitlements. An adult worker who has worked for a period of two hundred forty days or more in a calendar year is entitled to annual leave with wages at the rate of one day for every twenty days of work. The worker is also entitled to casual leave, sick leave and public holidays as prescribed by the applicable State legislation. Nurses and other hospital employees who are required to work on public holidays are entitled to compensatory leave or additional wages. The employer cannot compel a worker to forgo their leave entitlement.

Maternity Benefit

The Maternity Benefit Act, 1961 applies to every establishment being a factory, mine, plantation or shop or establishment in which ten or more persons are employed. Most hospitals satisfy this threshold and are covered by the Act. Every woman who has actually worked in an establishment for a period of not less than eighty days in the twelve months immediately preceding the date of her expected delivery is entitled to maternity benefit at the rate of the average daily wage for the period of her actual absence, up to a maximum of twenty-six weeks. The benefit is payable for a further period of up to one month in case of illness arising out of pregnancy, delivery, premature birth or miscarriage. The Act also prohibits the employment of women in any establishment during the six weeks immediately following the day of her delivery or her miscarriage. It prohibits the discharge or dismissal of a woman during her absence on maternity leave and prohibits any discrimination in the matter of employment on the ground of pregnancy.

Equal Remuneration

The Equal Remuneration Act, 1976 mandates the payment of equal remuneration to men and women workers for the same work or work of a similar nature. No employer shall pay to any worker remuneration at rates less favourable than those at which remuneration is paid by the employer to workers of the opposite sex for performing the same work or work of a similar

nature. The Act also prohibits discrimination against women in the matter of recruitment and promotion. No employer shall, while making recruitment for the same work or work of a similar nature, discriminate against women except where the employment of women in such work is prohibited or restricted by law.

8.7 RETIRAL BENEFITS AND SOCIAL SECURITY

Employees' Provident Fund

The Employees' Provident Funds and Miscellaneous Provisions Act, 1952 is the principal social security legislation for organised sector workers. The Act applies to every establishment in which twenty or more persons are employed. Most hospitals satisfy this threshold and are covered by the Act. Every employee who has completed one year of continuous service or who has actually worked for one hundred twenty days in a year is entitled to become a member of the provident fund. The employee contributes twelve per cent of their basic wages, dearness allowance and retaining allowance. The employer contributes an equal amount. The entire contribution, together with interest, is payable to the employee upon retirement, resignation or death. The Act also establishes the Employees' Pension Scheme 1995. The employer contributes eight point three three per cent of the employee's wages to the pension fund. Upon superannuation, the employee is entitled to a monthly pension calculated on the basis of their pensionable service and pensionable salary.

Employees' State Insurance

The Employees' State Insurance Act, 1948 provides for medical care, cash benefits in sickness, maternity and employment injury, and pension to dependants of deceased workers. The Act applies to every establishment in which ten or more persons are employed. Most hospitals satisfy this threshold and are covered by the Act. Every employee whose wages do not exceed the prescribed ceiling is entitled to ESI benefits. Both employer and employee contribute to the ESI fund. In return, the employee and their family members are entitled to full medical care at ESI dispensaries and hospitals. The employee is also entitled to sickness benefit, maternity benefit, disablement benefit and dependants' benefit.

Payment of Gratuity

The Payment of Gratuity Act, 1972 provides for payment of gratuity to employees engaged in factories, mines, oilfields, plantations, ports, railway companies, shops and other establishments. The Act applies to every establishment in which ten or more persons are employed. Most hospitals satisfy this threshold and are covered by the Act. Every employee who has rendered continuous service for five years or more is entitled to gratuity upon superannuation, retirement, resignation or death. The amount of gratuity is calculated at the rate of fifteen days' wages based on the rate of wages last drawn by the employee for every completed year of service or part thereof in excess of six months. The maximum amount of gratuity payable is twenty lakh rupees.

National Pension System

Employees of central government hospitals and many state government hospitals appointed on or after 1 January 2004 are covered by the National Pension System. Under the NPS, the employee contributes ten per cent of their basic wages and dearness allowance and the

employer contributes an equivalent amount. The contributions are invested in pension funds regulated by the Pension Fund Regulatory and Development Authority. Upon retirement, the employee may withdraw up to sixty per cent of the corpus as a lump sum and must annuitise the remaining forty per cent to receive a monthly pension.

Employees' Compensation

The Employees' Compensation Act, 1923, formerly known as the Workmen's Compensation Act, provides for payment of compensation to workmen and their dependants in case of injury or death arising out of and in the course of employment. The Act applies to workmen employed in factories, mines, plantations, construction and other hazardous occupations. A workman who suffers personal injury by accident arising out of and in the course of employment is entitled to compensation from the employer. The amount of compensation is calculated on the basis of the workman's wages and the nature of the injury. In case of death, the dependants are entitled to compensation ranging from one lakh twenty thousand rupees to five lakh rupees depending on the wages of the deceased.

8.8 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES

Recognition and Collective Bargaining

The refusal to recognise a registered trade union is a common source of industrial conflict in the healthcare sector. Employers argue that recognition is voluntary and that they are not obliged to negotiate with every union that claims to represent workmen. The law, however, imposes a duty to bargain collectively in good faith with the recognised union. Refusal to bargain collectively is an unfair labour practice under Item 10 of the Fifth Schedule. The Industrial Relations Code, 2020 provides a statutory mechanism for determining the sole negotiating union. In the absence of such determination, the employer should recognise the union that commands the support of a majority of workmen. Verification of membership may be done through a check-off system or a secret ballot conducted by the labour department.

Contract Labour and Regularisation

The engagement of contract labour in core healthcare activities is a persistent issue. Hospitals engage nurses, technicians and even resident doctors through contractors to reduce labour costs and avoid the obligations of a permanent employer. This practice, where it is a sham intended to evade the obligations of an employer, is an unfair labour practice. The Supreme Court in Steel Authority of India Ltd. v. National Union Waterfront Workers held that contract labour working in the establishment of the principal employer, where the work is perennial and is done through regular workmen in other establishments of the same industry, is entitled to regularisation. The Industrial Relations Code, 2020 provides that contract labour engaged for more than one year in work of a perennial nature shall be deemed to be directly employed by the principal employer.

Professional Indemnity Insurance for Employees

Hospitals have a duty to ensure that their employees are adequately insured against professional liability claims. While individual practitioners may be required to maintain their own insurance, employees of hospitals are entitled to be indemnified by the employer for acts done

in the course of employment. The employer's vicarious liability extends to all employees, and the prudent employer will maintain institutional indemnity insurance to cover this liability.

Post-Employment Covenants

Employment contracts for senior medical professionals often contain post-employment restrictive covenants. A non-compete clause may prohibit the departing doctor from practising within a specified geographical radius for a specified period. A non-solicitation clause may prohibit the doctor from soliciting the hospital's patients or staff. Non-compete clauses that operate after the termination of employment are generally void under Section 27 of the Indian Contract Act, 1872. Non-solicitation clauses are enforceable only to the extent that they protect the employer's legitimate business interests and are reasonable in scope and duration. A blanket prohibition on treating any patient who was ever treated at the hospital is unreasonable and unenforceable.

Confidentiality and Patient Data

Employees of hospitals have access to confidential patient information. The duty of confidentiality is both an ethical duty and a contractual duty. Employment contracts should contain a confidentiality clause clearly defining the employee's obligations and the consequences of breach. The Digital Personal Data Protection Act, 2023 imposes statutory obligations on data fiduciaries to protect personal data. Employees who process patient data must be trained in data protection principles and must be subject to contractual obligations of confidentiality. Breach of confidentiality may expose the employee to disciplinary action and the employer to penalties under the Act.

Whistleblower Protection

Healthcare employees are often the first to observe unsafe practices, medication errors, fraud or violations of patient safety protocols. They must be able to report these concerns without fear of retaliation. The Companies Act, 2013 requires certain classes of companies to establish a vigil mechanism for directors and employees to report genuine concerns. Even where not statutorily mandated, hospitals should adopt a whistleblower policy that provides a secure and confidential channel for reporting concerns, assures the whistleblower of protection against victimisation and establishes a mechanism for independent investigation of complaints. Victimisation of a whistleblower is an unfair labour practice and may also constitute a criminal offence under the Whistle Blowers Protection Act, 2014.

8.9 STUDENT LEARNING ACTIVITIES

Activity 1: Trade Union Recognition and Collective Bargaining

You are the Administrator of a two hundred fifty bed corporate hospital. A group of eighty-five nurses has formed a registered trade union and has submitted a request for recognition. The hospital also has a staff association, which is not a registered trade union but has been in existence for ten years and has the support of sixty nurses. The management is opposed to unionisation and prefers to deal with the staff association. Prepare a comprehensive advisory note for the board of directors analysing the legal right of nurses to form and join trade unions, the consequences of refusing recognition, the distinction between a registered trade union and a staff association, the mechanism for determining the sole negotiating union under the

Industrial Relations Code, 2020 and the strategic considerations in engaging with the union. Recommend a course of action that is legally compliant and consistent with sound industrial relations practice.

Activity 2: Disciplinary Enquiry Simulation

A senior staff nurse with twelve years of service has been charged with gross negligence. The allegation is that she failed to monitor a post-operative patient's vital signs at the prescribed intervals, resulting in delayed recognition of internal bleeding and contributing to the patient's death. The nurse denies the allegation and claims that the ward was understaffed and that she was assigned sixteen patients against the standard ratio of one nurse to six patients. You have been appointed as the Enquiry Officer. Draft the charge-sheet to be issued to the nurse, the terms of reference for the disciplinary enquiry, a checklist of procedural safeguards to be observed during the enquiry and a template for the final reasoned order. Also prepare a briefing note for the management on the legal principles governing disciplinary enquiries and the consequences of non-compliance with natural justice.

Activity 3: Social Security Compliance Audit

Your hospital employs three hundred twenty permanent employees and eighty-five contract workers. The permanent employees include forty-five doctors, one hundred eighty-five nurses, fifty-five technicians and thirty-five administrative and support staff. The contract workers include sixty-five nurses and twenty housekeeping staff engaged through three different contractors. The Employees' Provident Fund Organisation has issued a notice to the hospital alleging non-compliance with the Employees' Provident Funds and Miscellaneous Provisions Act, 1952. The notice alleges that the hospital has not enrolled all eligible employees as members of the provident fund, has not deducted and remitted provident fund contributions for contract workers and has not paid administrative charges. Conduct a comprehensive compliance audit of the hospital's social security obligations covering provident fund, employees' state insurance, gratuity, maternity benefit and employees' compensation. Identify the areas of non-compliance, assess the potential liability and penalty and prepare a corrective action plan with specific timelines and responsible persons.

Activity 4: Whistleblower Policy Design

A junior doctor in your hospital has reported that a senior consultant is routinely performing unnecessary invasive procedures on patients covered by government health insurance schemes to generate revenue. The junior doctor is anxious about retaliation and has requested anonymity. The hospital has no whistleblower policy. Draft a comprehensive whistleblower policy for the hospital addressing the scope of concerns that may be reported, the persons who may make a report, the procedure for making a report including anonymous reporting, the mechanism for investigation, the protection against victimisation and the disciplinary consequences for false and malicious complaints. Also prepare a training module to sensitise employees on the policy and on their ethical duty to report concerns.

8.10 SUMMARY

The right of healthcare workers to form and join trade unions is a fundamental right under Article 19 of the Constitution. The Trade Unions Act, 1926 provides the statutory framework for registration and regulation of trade unions. Registered trade unions enjoy immunity from

criminal conspiracy and civil suit in respect of acts done in furtherance of a trade dispute. The Industrial Relations Code, 2020 introduces a statutory mechanism for recognition of trade unions and collective bargaining.

Unfair labour practices are prohibited under Chapter V-C of the Industrial Disputes Act, 1947. The Fifth Schedule enumerates specific practices declared to be unfair, including threatening workmen with discharge for joining a trade union, discriminating against workmen on the ground of union activities and refusing to bargain collectively in good faith. Victimisation is the mala fide punishment of a workman for legitimate trade union activities or exercise of legal rights. Where victimisation is alleged, the burden of proof shifts to the employer.

The employer has the right to maintain discipline and to punish misconduct, but this right must be exercised in accordance with the principles of natural justice. A valid disciplinary enquiry requires a clear and specific charge-sheet, sufficient opportunity to the workman to submit an explanation, an impartial Enquiry Officer, full opportunity to the workman to cross-examine the employer's witnesses and to lead defence evidence, an enquiry report based solely on the evidence adduced, supply of the enquiry report to the workman, a speaking order by the disciplinary authority and a punishment proportionate to the gravity of the misconduct.

Service conditions of hospital employees are governed by the contract of employment, the certified standing orders and applicable labour laws. Permanent employees are entitled to the protections of Section 25F of the Industrial Disputes Act, 1947. Fixed-term employees are entitled to the same wages and statutory benefits as permanent employees on a pro rata basis. Employees are entitled to overtime wages, leave with wages, maternity benefit and equal remuneration.

Retiral benefits and social security are governed by a comprehensive statutory framework. The Employees' Provident Funds and Miscellaneous Provisions Act, 1952 mandates provident fund and pension contributions. The Employees' State Insurance Act, 1948 provides for medical care and cash benefits. The Payment of Gratuity Act, 1972 provides for gratuity upon completion of five years of service. The Employees' Compensation Act, 1923 provides for compensation for employment injury.

Healthcare-specific contractual issues include the recognition of trade unions, the regularisation of contract labour, professional indemnity insurance for employees, post-employment restrictive covenants, confidentiality and patient data protection and whistleblower protection. The hospital administrator must address these issues through clear policies, transparent procedures and compliance with statutory requirements.

8.11 KEY WORDS WITH EXPLANATIONS

Trade Union is any combination, whether temporary or permanent, formed primarily for the purpose of regulating the relations between workmen and employers or between workmen and workmen, or between employers and employers, or for imposing restrictive conditions on the conduct of any trade or business. Registered trade unions are bodies corporate with perpetual succession and common seal.

Unfair Labour Practice comprises practices enumerated in the Fifth Schedule to the Industrial Disputes Act, 1947 which are declared to be unfair. These include interference with

the right to form trade unions, threats of discharge or dismissal for union activities, discrimination on the ground of union activities and refusal to bargain collectively.

Victimisation is the mala fide punishment of a workman for legitimate trade union activities or for exercising rights under industrial law. Essential elements are punishment disproportionate to the misconduct alleged and evidence that the employer was actuated by malice or vindictiveness.

Principles of Natural Justice are two fundamental rules of fair procedure: nemo judex in causa sua meaning no person shall be judge in their own cause and audi alteram partem meaning hear the other side. In disciplinary enquiries, these principles require an impartial Enquiry Officer, notice of charges, opportunity to cross-examine witnesses, opportunity to lead defence evidence and a reasoned order.

Charge-Sheet is the document initiating disciplinary proceedings. It must contain a clear and specific statement of the charges, the facts and circumstances constituting the misconduct, the relevant standing order or service rule alleged to have been violated and a direction to submit an explanation within a specified period.

Enquiry Officer is the person appointed to conduct the disciplinary enquiry and submit findings on the charges. Must be impartial and independent. Cannot be the complainant, a witness or a person with a personal interest in the outcome.

Standing Orders are certified conditions of employment applicable to workmen in industrial establishments, required under the Industrial Employment Act, 1946 and the Industrial Relations Code, 2020. They cover classification of workmen, shifts, attendance, leave, termination and disciplinary procedure.

Permanent Employee is an employee who has completed the probationary period and whose employment is continuous. Entitled to the protections of Section 25F of the Industrial Disputes Act, 1947 including notice and compensation upon retrenchment.

Fixed-Term Employee is an employee engaged for a predetermined period. Entitled to the same wages and statutory benefits as permanent employees on a pro rata basis. Not entitled to notice and compensation upon expiry of the term.

Employees' Provident Fund is a statutory social security scheme under the Employees' Provident Funds and Miscellaneous Provisions Act, 1952. Employee and employer each contribute twelve per cent of wages. The accumulated corpus with interest is payable upon retirement, resignation or death.

Employees' State Insurance is a statutory social security scheme under the Employees' State Insurance Act, 1948. Provides medical care, sickness benefit, maternity benefit, disablement benefit and dependants' benefit to employees whose wages do not exceed the prescribed ceiling.

Gratuity is a lump sum payment under the Payment of Gratuity Act, 1972 payable to an employee who has rendered continuous service for five years or more upon superannuation, retirement, resignation or death. Calculated at fifteen days' wages for every completed year of service.

Non-Compete Clause is a contractual restriction on an employee's right to practise their profession after termination of employment. Generally void under Section 27 of the Indian Contract Act, 1872.

Whistleblower is an employee who reports misconduct, fraud or illegal activity within the organisation. Protected against victimisation under the Whistle Blowers Protection Act, 2014 and the Companies Act, 2013.

8.12 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What is the legal status of a registered trade union under the Trade Unions Act, 1926?

Ans. A registered trade union is a body corporate by the name under which it is registered, with perpetual succession and a common seal. It has the power to acquire and hold both movable and immovable property and to contract. It may sue and be sued in its registered name. The registration confers upon the trade union immunity from criminal conspiracy under Section 17 and immunity from civil suit under Section 18 in respect of acts done in contemplation or furtherance of a trade dispute.

Q2. What constitutes victimisation in industrial jurisprudence?

Ans. Victimisation is the mala fide punishment of a workman for legitimate trade union activities or for exercising rights under industrial law. The essential elements are: the workman must have been subjected to a punishment or adverse order; such punishment must be disproportionate to the misconduct alleged; and there must be evidence that the employer was actuated by malice or vindictiveness. Where victimisation is alleged, the burden of proof shifts to the employer to prove that the dismissal was for good cause and not by way of victimisation.

Q3. What are the minimum requirements of a valid disciplinary enquiry under the principles of natural justice?

Ans. The minimum requirements are: a clear and specific charge-sheet; sufficient opportunity to the workman to submit an explanation; an impartial Enquiry Officer; full opportunity to the workman to cross-examine the employer's witnesses; full opportunity to the workman to lead defence evidence; an enquiry report based solely on the evidence adduced; supply of the enquiry report to the workman; a speaking order by the disciplinary authority; and a punishment proportionate to the gravity of the misconduct.

Q4. What is the distinction between a permanent employee and a fixed-term employee under the Industrial Relations Code, 2020?

Ans. A permanent employee is employed on an open-ended basis with no predetermined date of termination and is entitled to the protections of Section 25F of the Industrial Disputes Act, 1947 including notice and compensation upon retrenchment. A fixed-term employee is engaged for a predetermined period and is not entitled to notice and compensation upon the expiry of the term. However, a fixed-term employee is entitled to the same wages, hours of

work and other conditions of service as a permanent employee doing the same or similar nature of work and to the same statutory benefits on a pro rata basis.

Q5. What are the eligibility conditions and calculation method for gratuity under the Payment of Gratuity Act, 1972?

Ans. Every employee who has rendered continuous service for five years or more is entitled to gratuity upon superannuation, retirement, resignation or death. In case of death, the condition of five years' continuous service is waived. Gratuity is calculated at the rate of fifteen days' wages based on the rate of wages last drawn by the employee for every completed year of service or part thereof in excess of six months. The maximum amount of gratuity payable is twenty lakh rupees.

B. Essay Type Questions with Hints

Q1. Trace the legal framework governing trade unions in India under the Trade Unions Act, 1926 and the Industrial Relations Code, 2020. What are the rights and immunities of registered trade unions, and how are these rights balanced against the employer's right to maintain discipline and ensure uninterrupted patient care in hospitals?

Hints: Begin with the constitutional foundation under Article 19. Explain the registration process under the Trade Unions Act, 1926. Discuss the immunities under Sections 17 and 18. Analyse the concept of trade dispute and its boundaries. Explain the recognition mechanism under the Industrial Relations Code, 2020. Discuss the duty to bargain collectively in good faith. Address the tension between trade union rights and the employer's right to maintain discipline: distinguish between legitimate trade union activity and misconduct; discuss the prohibition of strikes in public utility services without notice; analyse the concept of illegal strikes and the consequences. Conclude with the importance of social dialogue and collective bargaining as alternatives to conflict.

Q2. Critically examine the law relating to unfair labour practices and victimisation under the Industrial Disputes Act, 1947. What remedies are available to a workman who has been victimised, and what is the burden of proof?

Hints: Explain the statutory prohibition under Section 25-T and the punishment under Section 25-U. Enumerate the unfair labour practices specified in the Fifth Schedule with particular emphasis on Items 1, 5 and 10. Define victimisation through judicial decisions. Discuss the shift in burden of proof where victimisation is alleged. Explain the remedies: reinstatement with full back wages and continuity of service is the normal rule; exceptions must be justified by reasons. Discuss the factors that courts consider in determining whether to award reinstatement or compensation in lieu. Analyse the consequences of non-compliance with the statutory provisions.

Q3. Discuss the essential requisites of a valid disciplinary enquiry in an industrial establishment. What are the consequences of non-compliance with the principles of natural justice?

Hints: Structure your answer around the chronological sequence of a disciplinary enquiry. Begin with the charge-sheet: requirements of specificity and clarity; time for submission of explanation. Discuss the appointment of Enquiry Officer: impartiality and independence;

distinction between Enquiry Officer and Presenting Officer. Explain the enquiry proceedings: right to cross-examination; right to lead defence evidence; ex parte proceedings. Discuss the enquiry report: requirement of reasons; based solely on evidence; supply to workman. Explain the disciplinary authority's order: speaking order; proportionality of punishment. Discuss the consequences of non-compliance: the enquiry is void; the court or tribunal will ignore the enquiry and afford the employer an opportunity to adduce evidence; if the employer fails to adduce evidence, the dismissal is set aside.

Q4. Examine the social security framework applicable to hospital employees in India. Your answer should cover the Employees' Provident Funds and Miscellaneous Provisions Act, 1952, the Employees' State Insurance Act, 1948 and the Payment of Gratuity Act, 1972.

Hints: Structure your answer around each of the three statutes. For the EPF Act: applicability threshold of twenty employees; eligibility for membership; contribution rates; Employees' Pension Scheme, 1995; withdrawal and transfer; administrative machinery. For the ESI Act: applicability threshold of ten employees; wage ceiling; contributions; medical benefits; sickness benefit; maternity benefit; disablement benefit; dependants' benefit. For the Gratuity Act: applicability; eligibility conditions; calculation method; maximum limit; nomination; recovery of gratuity. Discuss the interrelationship between these statutes and the employer's obligations. Conclude with the importance of compliance and the consequences of non-compliance.

Q5. You are the Administrator of a two hundred bed corporate hospital. A senior nurse with fifteen years of unblemished service has been dismissed following a disciplinary enquiry. The nurse was charged with administering the wrong medication to a patient, resulting in the patient's death. The nurse alleges that the dismissal is an act of victimisation because she had recently filed a complaint against the nursing superintendent for harassment and had been actively organising her colleagues to form a trade union. The disciplinary enquiry was conducted by the hospital's Human Resources Manager, who is also the complainant. The nurse was not permitted to cross-examine the nursing superintendent, and the enquiry report was not supplied to her before the dismissal order was passed. Advise the management on the legal validity of the dismissal, the potential consequences and the appropriate course of action.

Hints: Structure your answer as a legal opinion. Analyse the deficiencies in the disciplinary enquiry: Enquiry Officer is the complainant, violating the rule against bias; denial of right to cross-examination, violating audi alteram partem; non-supply of enquiry report, violating the requirement in ECIL v. Karunakar. Conclude that the enquiry is void and the dismissal is a nullity. Analyse the allegation of victimisation: the nurse was engaged in legitimate trade union activity; the punishment of dismissal is disproportionately severe; the burden shifts to the employer to prove that the dismissal was for good cause and not by way of victimisation. Advise the management to reinstate the nurse with immediate effect, conduct a fresh enquiry by an independent Enquiry Officer, afford the nurse full opportunity to defend herself and consider the proportionality of the punishment. Warn of the consequences of non-compliance: reinstatement with full back wages, compensation for mental agony and prosecution for unfair labour practice.

C. Analytical Multiple Choice Questions

1. Under the Trade Unions Act, 1926, which of the following is a consequence of registration of a trade union?

a) The trade union becomes exempt from all taxation
b) The trade union becomes a body corporate with perpetual succession and a common seal
c) The trade union acquires immunity from all criminal and civil proceedings
d) The trade union is entitled to automatic recognition by the employer
Correct Answer: b) The trade union becomes a body corporate with perpetual succession and a common seal

2. Which of the following constitutes an unfair labour practice under the Fifth Schedule to the Industrial Disputes Act, 1947?
a) An employer requiring workmen to work overtime during a public health emergency
b) An employer discharging a workman for participating in an illegal strike
c) An employer discriminating against workmen on the ground of their union activities
d) An employer refusing to grant leave to a workman during peak admission season
Correct Answer: c) An employer discriminating against workmen on the ground of their union activities

3. In a disciplinary enquiry, the burden of proof regarding the charges rests on:
a) The workman, who must prove their innocence
b) The employer, who must prove the workman's guilt
c) The Enquiry Officer, who must investigate the facts
d) The trade union, which must espouse the workman's defence
Correct Answer: b) The employer, who must prove the workman's guilt

4. Under the Payment of Gratuity Act, 1972, an employee who has completed five years of continuous service is entitled to gratuity upon:
a) Superannuation only
b) Superannuation, retirement, resignation or death
c) Resignation only
d) Termination for misconduct
Correct Answer: b) Superannuation, retirement, resignation or death

5. The maximum amount of gratuity payable under the Payment of Gratuity Act, 1972 as of 2025 is:
a) ₹10,00,000
b) ₹20,00,000
c) ₹25,00,000
d) ₹35,00,000
Correct Answer: b) ₹20,00,000

6. A fixed-term employee under the Industrial Relations Code, 2020 is entitled to:
a) Lower wages than a permanent employee doing the same work
b) The same wages and statutory benefits as a permanent employee, on a pro rata basis
c) Preference in appointment to permanent vacancies
d) Notice and compensation upon expiry of the fixed term
Correct Answer: b) The same wages and statutory benefits as a permanent employee, on a pro rata basis

7. Under the Employees' State Insurance Act, 1948, the wage ceiling for coverage is:
a) ₹15,000 per month
b) ₹21,000 per month

c) ₹25,000 per month
d) There is no wage ceiling
Correct Answer: b) ₹21,000 per month

8.13 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Union, The Dismissal and The Enquiry That Never Was

St. Theresa's Mission Hospital is a one hundred fifty bed charitable trust hospital located in a district town in Kerala, established in 1965 by a Catholic religious congregation and registered under the Travancore-Cochin Literary, Scientific and Charitable Societies Registration Act, 1955. The hospital provides affordable healthcare to the local population with a significant proportion of patients receiving free or subsidised treatment. The hospital employs eighty-five nurses, twenty-five technicians, thirty-five administrative and support staff and twelve doctors. The hospital has never had a registered trade union. In 2022, a group of nurses formed an informal association to discuss common concerns. The management did not object to the association but declined to engage in any collective negotiation with it.

In January 2024, following the national nurses' strike in Maharashtra, the nurses at St. Theresa's decided to formalise their association. They approached the Registrar of Trade Unions and on 15 March 2024 registered the St. Theresa's Mission Hospital Nurses Union under the Trade Unions Act, 1926. The union had fifty-two members out of eighty-five nurses. Smt. Gracy Thomas, a senior staff nurse with eighteen years of service, was elected President. Smt. Anjali Krishnan, a staff nurse with twelve years of service, was elected Secretary.

On 25 March 2024, the union submitted a charter of demands to the management including revision of pay scales to bring them in line with government hospital scales, payment of night shift allowance at one point five times the normal rate, provision of free transport for nurses required to report for emergency duties between 10 PM and 6 AM, regularisation of twenty-five contract nurses who had been employed for more than three years and recognition of the union for the purposes of collective bargaining. The management did not respond to the charter. On 10 April 2024, the union organised a peaceful demonstration outside the hospital chapel after Sunday mass. Approximately forty nurses participated. The demonstration lasted thirty minutes and did not disrupt patient care.

On 15 April 2024, Smt. Gracy Thomas was summoned to the office of the Medical Superintendent and informed that the management had received complaints from patients that she was rude and unprofessional in her behaviour. She was issued a memorandum of censure and warned that any further complaint would result in disciplinary action. On 20 April 2024, Smt. Anjali Krishnan was transferred from the intensive care unit to the general ward. She had worked in the ICU for eight years and had received consistently positive performance appraisals. The management did not provide any reason for the transfer. When she inquired, she was told that the transfer was administrative and not subject to appeal. On 5 May 2024, the union submitted a complaint to the management alleging victimisation. The management did not respond.

On 15 May 2024, Smt. Gracy Thomas was issued a charge-sheet alleging that she had instigated nurses to participate in an illegal demonstration, made false and defamatory statements against the management and committed breach of trust by disclosing confidential patient information to unauthorised persons. The charge-sheet did not provide any particulars of the alleged

defamatory statements or the alleged breach of confidentiality. She was directed to submit her explanation within forty-eight hours. Smt. Thomas submitted her explanation on 17 May 2024 denying all charges. She stated that the demonstration was a peaceful and lawful expression of legitimate trade union demands, denied making any defamatory statements and demanded particulars, and denied any breach of confidentiality demanding that the management provide the details of the alleged unauthorised disclosure.

Without considering her explanation, the management appointed the hospital's Human Resources Manager as the Enquiry Officer. The enquiry commenced on 25 May 2024. Smt. Thomas requested that she be permitted to be represented by Smt. Anjali Krishnan, the union secretary. The request was denied on the ground that the union was not recognised by the hospital. Smt. Thomas was not offered any alternative representation. The management presented two witnesses: the Medical Superintendent who testified that he had received complaints about Smt. Thomas's behaviour but did not produce any written complaints or identify any complainants; and a staff nurse who testified that she had heard Smt. Thomas speaking critically of the management to other nurses. Smt. Thomas was not permitted to cross-examine either witness. When she attempted to ask questions, the Enquiry Officer directed her to remain silent. Smt. Thomas requested that she be permitted to call three witnesses: the ward sister of the ICU who could testify to her professional competence and two fellow nurses who had been present during the conversations referred to by the management witness. The Enquiry Officer denied the request on the ground that the witnesses were not relevant.

The enquiry concluded on 28 May 2024. The Enquiry Officer submitted his report on 30 May 2024 finding Smt. Thomas guilty of all charges. The report did not contain any discussion of the evidence or any reasons for the findings. It merely stated that the charges are proved. The enquiry report was not supplied to Smt. Thomas. On 5 June 2024, the Medical Superintendent issued an order dismissing Smt. Gracy Thomas from service with immediate effect. The order stated that the Enquiry Officer had found the charges proved and that the management had lost confidence in the nurse. The order did not contain any discussion of the evidence or any reasons for the punishment. Smt. Thomas was escorted out of the hospital premises by security personnel. She was fifty-two years old, had eighteen years of unblemished service and was five years away from superannuation.

The dismissal provoked outrage among the nursing staff. On 10 June 2024, the union called for an indefinite strike. The strike was joined by sixty-five nurses and fifteen technicians. The hospital's operations were severely impacted. The emergency department was forced to divert ambulances. The intensive care unit operated with reduced bed capacity. Elective surgeries were cancelled. The union filed a complaint before the Industrial Tribunal-cum-Labour Court, Kozhikode, challenging the dismissal and alleging unfair labour practice and victimisation. The union also filed a separate complaint before the Regional Provident Fund Commissioner alleging non-payment of provident fund contributions for contract nurses. The hospital contested the jurisdiction of the Industrial Tribunal, arguing that a charitable trust hospital is not an industry under the Industrial Disputes Act, 1947. The Tribunal rejected the preliminary objection, holding that the hospital is an industry under the law settled by the Supreme Court. After six months of litigation, the matter was referred to conciliation. The Conciliation Officer brokered a settlement on 15 December 2024. The hospital agreed to reinstate Smt. Gracy Thomas with full back wages and continuity of service, recognise the St. Theresa's Mission Hospital Nurses Union for the purposes of collective bargaining, regularise all contract nurses who had completed three years of continuous service and constitute a Joint Grievance Redressal Committee with equal representation of management and union.

Questions for Analysis with Hints

Q1. Analyse the actions of the management against Smt. Gracy Thomas and Smt. Anjali Krishnan in light of the provisions relating to unfair labour practices and victimisation under the Industrial Disputes Act, 1947. Do these actions constitute unfair labour practices? What remedies are available to the nurses?

Hints: The issuance of a memorandum of censure to Smt. Thomas immediately following her leadership of the peaceful demonstration is discrimination on the ground of union activities prohibited by Item 6 of the Fifth Schedule. The transfer of Smt. Krishnan from the ICU to the general ward without any reason, immediately following her role as union secretary, is also discrimination on the ground of union activities and constitutes victimisation. The refusal to respond to the union's charter of demands and the refusal to recognise the union constitute refusal to bargain collectively in good faith prohibited by Item 10. The dismissal of Smt. Thomas is an act of victimisation: she was subjected to the gravest punishment; the punishment is grossly disproportionate to the alleged misconduct; and the timing and circumstances clearly indicate that the management was actuated by malice and vindictiveness because of her trade union activities. Remedies available are reinstatement with full back wages and continuity of service, compensation for mental agony and harassment, and prosecution of the employer for unfair labour practice under Section 25-U.

Q2. Evaluate the validity of the disciplinary enquiry conducted against Smt. Gracy Thomas. Identify each procedural deficiency and explain how it violates the principles of natural justice. What is the legal effect of an enquiry conducted in violation of natural justice?

Hints: The charge-sheet was vague and lacking in particulars, not specifying the alleged defamatory statements or the alleged breach of confidentiality, rendering Smt. Thomas incapable of defending herself. The Enquiry Officer was not impartial as the Human Resources Manager reported directly to the Medical Superintendent who was both the complainant and the disciplinary authority, creating a real likelihood of bias. Smt. Thomas was denied the right to representation by a fellow workman or union office-bearer on the arbitrary ground that the union was not recognised. Smt. Thomas was denied the right to cross-examine the management's witnesses, the most fundamental violation of audi alteram partem. Smt. Thomas was denied the right to lead defence evidence as the Enquiry Officer arbitrarily rejected her request to call witnesses. The enquiry report was not based on the evidence and contained no reasons; a bare statement that the charges are proved is not a valid finding. The enquiry report was not supplied to Smt. Thomas before the dismissal order was passed in violation of ECIL v. Karunakar. The legal effect is that the enquiry is void and the dismissal order based on it is a nullity. The court or tribunal will ignore the enquiry and afford the employer an opportunity to adduce evidence for the first time before it. If the employer fails to adduce such evidence, the dismissal will be set aside and the workman will be entitled to reinstatement with full back wages.

Q3. Discuss the legality of the strike called by the union. Was the strike in a public utility service? Were the notice requirements complied with? What are the consequences of an illegal strike for the strikers and for the union?

Hints: The strike called by the union was illegal under Section 22 of the Industrial Disputes Act, 1947. St. Theresa's Mission Hospital, being a hospital, is a public utility service under

Section 2. A strike in a public utility service is illegal unless notice of strike is given within six weeks before commencing the strike. No such notice was given. The consequences of an illegal strike are: the strikers are liable to disciplinary action including deduction of wages for the strike period and dismissal; the strike is not protected and the employer is not obligated to reinstate the strikers; the employer may claim damages from the union or the strikers for losses caused by the illegal strike; and the strike may be restrained by injunction. However, the Supreme Court has held that while participation in an illegal strike may be misconduct, the punishment of dismissal is disproportionately severe unless the strike was violent or the participation was aggravated by other misconduct. In this case, the strike was peaceful and did not involve violence, obstruction or intimidation. The appropriate disciplinary response would be deduction of wages for the strike period, not dismissal.

Q4. Examine the jurisdiction of the Industrial Tribunal to adjudicate the dispute. Is a charitable trust hospital an industry under the Industrial Disputes Act, 1947? What is the effect of the exclusion of hospitals from the definition of industry under the Industrial Relations Code, 2020?

Hints: The Industrial Tribunal has jurisdiction to adjudicate the dispute. St. Theresa's Mission Hospital, though a charitable trust hospital, is an industry under the Industrial Disputes Act, 1947 as interpreted by the Supreme Court in State of Bombay v. Hospital Mazdoor Sabha and Bangalore Water Supply and Sewerage Board v. A. Rajappa. The presence of profit motive is not essential; what matters is the nature of the activity. A hospital, whether public or private, charitable or commercial, is a systematic activity organised by cooperation between employer and employee for the production of services calculated to satisfy human wants. It is an industry. The Industrial Relations Code, 2020 excludes hospitals from the definition of industry. However, the Code is under constitutional challenge and its provisions have not been fully tested. The exclusion has been challenged as arbitrary and violative of Article 14. The challenge is pending before the Supreme Court. In the meantime, many High Courts have continued to apply the Industrial Disputes Act, 1947 to hospitals, and the Industrial Tribunal was correct in rejecting the preliminary objection.

Q5. As the newly appointed Administrator of St. Theresa's Mission Hospital, you have been directed by the Board of Trustees to prepare a comprehensive policy on trade union recognition, disciplinary proceedings and grievance redressal to prevent recurrence of such disputes. Your policy should address the procedure for recognition of trade unions, the code of conduct for maintaining industrial harmony, the disciplinary procedure compliant with principles of natural justice, the grievance redressal mechanism for individual workmen and the social security compliance framework.

Hints: The policy must recognise the right of employees to form and join trade unions under Article 19 and the Trade Unions Act, 1926. Any registered trade union with membership of at least thirty per cent of the workmen shall be entitled to recognition verified through check-off system or secret ballot. The recognised union shall have the right to represent workmen in disciplinary proceedings, negotiate on wages and conditions of service, enter into settlements and hold meetings on hospital premises with prior permission. No strike or lock-out shall be resorted to without complying with notice requirements under the Industrial Disputes Act, 1947. The disciplinary procedure must mandate that no employee shall be punished except after a disciplinary enquiry conducted in accordance with natural justice. The charge-sheet shall contain specific statement of charges and the employee shall be given not less than seven days to submit an explanation. The Enquiry Officer shall be impartial and independent, not the

complainant or a witness. The employee shall have the right to be represented by a fellow workman or union office-bearer, the right to cross-examine management witnesses and the right to lead defence evidence. The enquiry report shall contain findings on each charge with reasons based on evidence and shall be supplied to the employee before the disciplinary authority passes its final order. The disciplinary authority shall pass a speaking order with reasons for the punishment, which shall be proportionate to the gravity of the misconduct. A Joint Grievance Redressal Committee consisting of equal representatives of management and the recognised union shall meet monthly to address individual and collective grievances. The hospital shall comply with all social security legislation including the EPF Act, ESI Act and Payment of Gratuity Act, and all employees including contract workers shall be enrolled as members of the provident fund.

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The principles of natural justice are those fundamental rules which have been developed over the centuries to ensure that justice is not only done but is seen to be done. They require that no person shall be condemned unheard and that no person shall be judge in their own cause. These principles apply with full force to disciplinary proceedings in industrial establishments, for the dismissal of a workman is the civil death of his employment.

** Supreme Court of India, Managing Director, ECIL v. B. Karunakar (1993)**

LESSON-9

PATIENT RIGHTS AND MEDICAL NEGLIGENCE

53

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Explain the charter of patient rights recognised under Indian law including constitutional, statutory and judicial foundations
2. Analyse the distinction between patient rights and patient responsibilities in the therapeutic relationship
3. Define medical malpractice and distinguish it from medical negligence, adverse events and complications
4. Evaluate the medico-legal framework governing impotence, sterility and mental health including consent, confidentiality and evidentiary issues
5. Apply the principles of patient rights and medical negligence to real-world hospital administration scenarios through case-based analysis

STRUCTURE OF THE LESSON

9.1 INTRODUCTION: THE PATIENT AS RIGHTS-HOLDER

For the greater part of medical history, the patient was the object, not the subject, of healthcare. The physician possessed knowledge; the patient lacked it. The physician made decisions; the patient complied. The relationship was paternalistic, not participatory. The patient's role was to trust, not to question. This conception has been fundamentally displaced. The patient is no longer a passive recipient of care but an active rights-holder. The right to informed consent, the right to access medical records, the right to confidentiality, the right to emergency care and the right to redressal for negligence are now firmly established in constitutional jurisprudence, statutory law and professional ethics. The patient is a consumer of services, a bearer of fundamental rights and a participant in shared decision-making. The transformation of the patient from object to subject is one of the most significant developments in modern healthcare law. It has profound implications for the hospital administrator. Every admission form, every consent form, every disclosure of information and every response to a complaint must be informed by an appreciation of the patient's rights. The administrator who disregards these rights does so at the peril of litigation, regulatory sanction and reputational damage. This lesson examines the legal framework of patient rights and the corresponding responsibilities of patients as active participants in their own care. It analyses the tort of medical malpractice, distinguishing it from mere complications and adverse events. It explores the medico-legal issues arising in the specialised contexts of impotence, sterility and mental health. It concludes with the contractual dimensions of the patient-provider relationship, including the enforceability of disclaimer clauses and the patient's right to refuse treatment.

9.2 INTRODUCTORY CASE STUDY: SAMIRA KOHLI v. PRABHA MANCHANDA – THE UNCONSENTED STERILISATION

Mrs. Samira Kohli, a forty-four year old woman, consulted Dr. Prabha Manchanda, a gynaecologist, at a hospital in New Delhi. She complained of prolonged menstrual bleeding and was advised to undergo a diagnostic laparoscopy to determine the cause. She consented to the procedure. She did not consent to any surgical removal of organs or any permanent sterilisation procedure. During the laparoscopy, the doctor discovered that Mrs. Kohli's ovaries were grossly abnormal and, in her clinical judgment, required removal. She proceeded to perform a bilateral oophorectomy and salpingectomy, removing both ovaries and fallopian tubes. The patient was not consulted. Her consent was not obtained. The procedure rendered her permanently sterile and precipitated premature menopause.

Mrs. Kohli filed a consumer complaint alleging medical negligence and deficiency in service. She claimed that the doctor had performed an entirely different procedure than the one to which she had consented, without any emergency justifying the deviation and without obtaining her consent. The doctor defended her actions on the ground that the procedure was medically necessary and that she had acted in the patient's best interest.

The Supreme Court held that consent to a diagnostic procedure does not imply consent to therapeutic intervention. Consent must be specific to the procedure performed. A doctor who performs an act beyond the scope of the patient's consent is liable for negligence and for the tort of battery. The Court laid down the following principles regarding consent. Consent is the voluntary agreement of a patient to undergo a particular medical intervention. It must be obtained after the patient has been informed of the nature of the procedure, its purpose, its material risks and the available alternatives. The consent must be free from coercion, fraud or undue influence. In the case of a major surgical procedure, consent must be obtained in writing

and must be specific to the procedure. A general consent to treatment is not sufficient to authorise a major surgical intervention. In an emergency, where the patient is incapable of giving consent and no authorised representative is immediately available, the doctor may proceed with life-saving treatment without consent. However, the emergency must be real and imminent, and the treatment must be limited to what is immediately necessary to preserve life or prevent serious deterioration. The Court held that no emergency existed in Mrs. Kohli's case. The condition of her ovaries did not pose an immediate threat to her life. The doctor could have closed the abdomen, obtained proper consent and performed the procedure at a later date. By proceeding without consent, she violated the patient's right to autonomy and self-determination. The Court awarded compensation of ten lakh rupees to Mrs. Kohli.

Relevance to the Lesson: This case is the foundational authority on informed consent in India. It establishes that patient autonomy is paramount and that the doctor's judgment, however sound clinically, cannot override the patient's right to decide what shall be done with their own body. It distinguishes between diagnostic and therapeutic procedures, between general and specific consent, and between genuine emergencies and clinical convenience. It affirms that the patient is the ultimate decision-maker and that the doctor's role is to inform, advise and obtain consent, not to decide unilaterally.

9.3 PATIENT RIGHTS: CONSTITUTIONAL AND STATUTORY FRAMEWORK

The Constitutional Foundation

The right to health is not expressly enumerated as a fundamental right in the Constitution of India. However, the Supreme Court has read the right to health into Article 21, which guarantees the right to life and personal liberty. In a series of landmark judgments, the Court has held that the right to life includes the right to live with human dignity, and that the right to live with human dignity includes the right to health and access to medical care. In State of Punjab v. Mohinder Singh Chawla, the Supreme Court held that the right to health is a fundamental right of citizens and that the State has a constitutional obligation to provide medical facilities to preserve human life. In Paschim Banga Khet Mazdoor Samity v. State of West Bengal, the Court held that denial of emergency medical treatment in government hospitals constitutes a violation of Article 21 and that the State is liable to pay compensation for such violation. The right to health under Article 21 is enforceable against the State. Private hospitals are not directly subject to constitutional obligations unless they are performing delegated governmental functions or are regulated by law to such an extent that their actions are attributable to the State. However, the constitutional values inform the interpretation of statutory and contractual duties owed by private hospitals to their patients.

The Charter of Patient Rights

In 2018, the Ministry of Health and Family Welfare, in consultation with the National Human Rights Commission, released a Charter of Patient Rights. The Charter is not a statute but a policy document intended to guide healthcare providers and to empower patients. It enumerates seventeen rights organised under seven headings. The right to information includes the right to know the identity of the treating doctors, the diagnosis, the proposed treatment, the expected costs and the anticipated outcomes. The hospital must display this information prominently and must provide it to patients in a language they understand. The right to records and reports includes the right to access medical records and to obtain copies of investigation reports, discharge summaries and operation notes. The hospital must provide these documents within

seventy-two hours of request and must retain records for the period prescribed by the National Medical Commission regulations. The right to emergency care is absolute and non-negotiable. No patient shall be denied emergency medical care for any reason, including inability to pay, lack of bed availability or medico-legal formalities. This right is derived from Parmanand Katara v. Union of India and is reinforced by the National Medical Commission Code of Conduct. The right to informed consent is the cornerstone of patient autonomy. Every patient has the right to be fully informed about the nature, purpose, risks and alternatives of any proposed medical intervention and to give or withhold consent freely. Consent must be obtained without coercion, fraud or undue influence. The right to confidentiality and privacy protects the patient's personal and medical information from unauthorised disclosure. The hospital must maintain the confidentiality of patient records and must disclose information only with the patient's consent or as required by law. The right to second opinion entitles the patient to seek consultation from another doctor without fear of discrimination or abandonment by the treating doctor. The hospital must facilitate access to second opinion and must not penalise patients who exercise this right. The right to grievance redressal requires the hospital to establish an internal complaint mechanism and to display the contact details of the appropriate consumer forum and medical council. The patient has the right to file a complaint and to receive a timely response.

Statutory Recognition of Patient Rights

The Clinical Establishments Act, 2010 requires every clinical establishment to display its rates, to maintain medical records and to provide a copy of the medical records to the patient on request. The Act also requires the establishment to obtain informed consent in the prescribed form. The Mental Healthcare Act, 2017 is the most comprehensive statutory recognition of patient rights in India. It confers upon persons with mental illness the right to access mental healthcare, the right to community living, the right to confidentiality, the right to information, the right to free legal aid and the right to make advance directives. It also prohibits cruel, inhuman and degrading treatment, including solitary confinement, chaining and electroconvulsive therapy without anaesthesia. The Consumer Protection Act, 2019 treats patients as consumers and medical services as service. It confers upon patients the right to file complaints for deficiency in service and to seek compensation. The consumer forum is the primary adjudicatory body for medical negligence claims.

The Right to Die with Dignity

In Common Cause v. Union of India, the Supreme Court held that the right to life under Article 21 includes the right to die with dignity. The Court recognised the validity of advance directives, commonly known as living wills, whereby a person can specify the medical treatment they would or would not receive if they become terminally ill and incapable of making decisions. The Court laid down detailed procedural safeguards for the execution and implementation of advance directives. The right to die with dignity is not a right to euthanasia. Active euthanasia, the intentional administration of lethal substances to end life, remains illegal. Passive euthanasia, the withdrawal or withholding of life-sustaining treatment in accordance with the patient's advance directive or the decision of the surrogate decision-maker, is lawful when the procedure prescribed by the Supreme Court is followed.

9.4 PATIENT RESPONSIBILITIES: THE RECIPROCAL OBLIGATIONS

The Concept of Reciprocal Obligations

Patient rights are not absolute. They are accompanied by reciprocal responsibilities. The patient is not merely a passive recipient of care but an active participant in the therapeutic relationship. The success of treatment depends substantially on the patient's cooperation, honesty and compliance with medical advice. The Charter of Patient Rights issued by the Ministry of Health and Family Welfare also enumerates patient responsibilities. These responsibilities are not legally enforceable in the same manner as rights, but they inform the standard of care and may affect the quantum of damages in cases of contributory negligence.

Disclosure of Accurate Information

The patient has a responsibility to provide accurate and complete information about their medical history, current symptoms, medications, allergies and lifestyle factors. Incomplete or inaccurate information may lead to misdiagnosis, incorrect treatment or adverse drug reactions. A patient who conceals relevant information and suffers harm as a result may be found contributorily negligent, and the damages may be reduced proportionately.

Compliance with Treatment

The patient has a responsibility to comply with the prescribed treatment regimen, including taking medications as directed, attending follow-up appointments and adhering to dietary and lifestyle modifications. Non-compliance that results in treatment failure or deterioration of condition may break the chain of causation between the doctor's negligence and the patient's damage.

Respect for Healthcare Providers

The patient and their attendants have a responsibility to treat healthcare providers with courtesy and respect. Verbal abuse, threats and physical violence are not only violations of patient responsibility but also criminal offences. Hospitals are entitled to refuse treatment to violent patients, except in emergencies, and may discharge patients who persistently engage in abusive behaviour.

Observance of Hospital Rules

The patient has a responsibility to observe the reasonable rules and regulations of the hospital regarding visiting hours, smoking, noise levels and use of facilities. Violation of hospital rules may result in discharge or denial of non-emergency services.

Financial Responsibility

The patient has a responsibility to pay the agreed fees for services rendered within the stipulated time. While inability to pay cannot be a ground for denial of emergency care, patients who avail of non-emergency services are contractually obligated to pay reasonable charges.

9.5 MEDICAL MALPRACTICE: DEFINITION AND ESSENTIAL ELEMENTS

Definition and Distinction

Medical malpractice is a sub-species of negligence. It is the failure of a medical professional to exercise the degree of care and skill that is expected of a reasonably competent practitioner in the same field, resulting in injury or loss to the patient. Medical malpractice must be distinguished from medical negligence. The terms are often used interchangeably, but malpractice implies a broader range of professional misconduct, including not only negligence but also breach of confidentiality, failure to obtain informed consent and abandonment of the patient. Negligence is a specific tort; malpractice is a professional fault. Medical malpractice must also be distinguished from adverse events and complications. An adverse event is an injury caused by medical management rather than by the underlying disease. A complication is a known and accepted risk of a properly performed procedure. Not every adverse event is caused by negligence; not every complication is evidence of malpractice. The distinction is determined by the standard of care.

Essential Elements

To establish medical malpractice, the patient must prove four essential elements: duty, breach, causation and damage. Duty is the legal obligation of the medical professional to conform to a standard of care. The duty arises from the undertaking of treatment. Once a doctor accepts a patient for treatment, a duty of care attaches and continues until the relationship is lawfully terminated. Breach is the failure of the medical professional to meet the standard of care. The standard of care is not the highest possible skill but the ordinary skill of a competent practitioner in the same field. Breach is established by expert evidence that the doctor's conduct deviated from accepted practice. Causation is the link between the breach and the damage. The patient must prove that the negligence caused the injury or loss. Causation is established by the but for test: but for the negligence, would the injury have occurred? If the injury would have occurred regardless, the negligence is not the cause. Damage is the injury or loss suffered by the patient. Damage may be physical injury, psychiatric illness or economic loss consequential upon physical injury. Negligence without damage is not actionable.

The Bolam Test

The standard of care in medical negligence cases is determined by the Bolam test, derived from Bolam v. Friern Hospital Management Committee. A doctor is not negligent if their actions are in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art, even if other practitioners adopt a different practice. The Bolam test was approved by the Supreme Court in Indian Medical Association v. V.P. Shantha and applied in Samira Kohli v. Prabha Manchanda. However, the Court in Samira Kohli modified the Bolam test to require that the practice be reasonable and logical. A practice that is not supported by logic or science cannot be defended merely because it is accepted by a body of medical opinion.

Res Ipsa Loquitur

In exceptional cases, the patient may rely on the doctrine of res ipsa loquitur, meaning the thing speaks for itself. The doctrine applies where the instrumentality causing the injury was under the exclusive control of the defendant, and the accident is such that in the ordinary course of

events would not occur if proper care were used. In such cases, the court may infer negligence without direct evidence. The classic applications of res ipsa loquitur in medical negligence cases are: a surgical instrument or sponge left in the patient's body; a wrong-side or wrong-site surgery; a patient burned by an uninsulated electrical cautery; and a healthy part of the body injured during surgery on another part. In these cases, the burden shifts to the defendant to rebut the inference of negligence.

9.6 STANDARDS OF CARE AND THE BOLAM TEST

The General Standard

The law does not require a doctor to possess the highest degree of skill or to guarantee a successful outcome. Medicine is an inexact science. Complications are inherent in treatment. Adverse outcomes may occur despite the exercise of reasonable care and skill. The standard is that of an ordinary competent practitioner in the same field. The standard is objective, not subjective. It is not measured by what the particular doctor was capable of doing but by what a reasonably competent doctor would have done in the same circumstances. A doctor who lacks the skill to treat a particular condition has a duty to refer the patient to a specialist.

The Specialist Standard

A doctor who holds themselves out as a specialist is judged by the standard of an ordinary competent specialist in that field. A neurosurgeon is not judged by the standard of a general surgeon; a cardiologist is not judged by the standard of a general physician. Specialisation implies a higher level of knowledge and skill, and the standard of care is correspondingly higher.

The Locality Rule

The Bolam test does not incorporate a locality rule. The standard of care is not determined by the resources available in a particular geographic area. A doctor practising in a rural area is not entitled to a lower standard of care than a doctor practising in a metropolitan city. However, the resources available may be relevant to whether the doctor acted reasonably in referring the patient or in providing treatment with available facilities.

Error of Judgment

An error of judgment is not necessarily negligence. Medicine requires constant decision-making under conditions of uncertainty. A doctor who makes a reasonable judgment based on available information, even if that judgment later proves to be incorrect, is not negligent. The distinction is between an error of judgment and a failure to exercise reasonable care in arriving at that judgment.

9.7 CAUSATION AND REMOTENESS OF DAMAGE

The But For Test

Causation is established by the but for test. The patient must prove that, but for the defendant's negligence, the injury would not have occurred. If the injury would have occurred regardless of the negligence, the negligence is not the cause. In medical negligence cases, causation is

often the most contested element. Patients who suffer adverse outcomes frequently have severe pre-existing illness. The question is whether the negligence materially contributed to the outcome or whether the outcome was inevitable regardless of the quality of care.

Loss of Chance

The Supreme Court has not definitively resolved whether loss of chance is compensable in medical negligence cases. Loss of chance refers to the situation where the patient had a statistical probability of survival or recovery that was reduced by the defendant's negligence, even if the overall probability was less than fifty per cent. In some common law jurisdictions, loss of chance is compensable. In India, the courts have awarded compensation where the negligence deprived the patient of a substantial chance of survival, even if the chance was less than even. The principle is that the patient should not be required to prove causation with certainty where the defendant's negligence has made such proof impossible.

Remoteness of Damage

The defendant is liable only for damage that is reasonably foreseeable. Damage that is too remote is not compensable. In medical negligence cases, the patient is entitled to compensation for all damage that is a direct consequence of the negligence. Psychiatric injury consequential upon physical injury is compensable; pure psychiatric injury not consequent upon physical injury may be compensable only if it was reasonably foreseeable.

Contributory Negligence

The patient's own negligence may reduce the compensation payable. Contributory negligence is the patient's failure to take reasonable care for their own safety, which contributes to the damage. A patient who fails to disclose relevant medical history, who refuses recommended treatment or who fails to attend follow-up appointments may be found contributorily negligent. The damages are reduced proportionately to the patient's degree of fault. The burden of proof is on the defendant to establish contributory negligence.

9.8 MEDICO-LEGAL ISSUES: IMPOTENCE AND STERILITY

Impotence: Definition and Distinction

Impotence, or erectile dysfunction, is the inability of a male to achieve or maintain an erection sufficient for satisfactory sexual intercourse. It must be distinguished from sterility, which is the inability to procreate. A man may be impotent but fertile; he may be sterile but potent. The distinction is critical in law because impotence, not sterility, is a ground for annulment of marriage under the Hindu Marriage Act, 1955 and the Special Marriage Act, 1954.

Impotence and Nullity of Marriage

Under Section 12 of the Hindu Marriage Act, 1955, a marriage is voidable and may be annulled if the marriage has not been consummated owing to the impotence of the respondent. The impotence must exist at the time of the marriage and must continue until the institution of proceedings. The petitioner must not have, with knowledge of the facts, induced the respondent to undergo impotence treatment and waived the right to annulment. The courts have held that impotence includes both physical incapacity and psychological incapacity, including invincible

repugnance to sexual intercourse. The incapacity must be incurable. However, the respondent is not required to undergo dangerous or humiliating treatment to cure the impotence.

Medical Examination and Consent

The court may direct a medical examination of the respondent to determine impotence. However, such examination cannot be ordered without the respondent's consent. The court cannot compel a person to submit to medical examination against their will. If the respondent refuses to submit to examination, the court may draw an adverse inference. The medical examination must be conducted with dignity and respect for the respondent's privacy. The examining doctor must obtain informed consent, explain the nature and purpose of the examination and maintain confidentiality of the findings.

Sterility and Assisted Reproductive Technology

Sterility, the inability to procreate, is not a ground for annulment of marriage. However, it may be a ground for divorce if it is accompanied by other factors constituting cruelty. A husband who discovers that his wife is sterile and was not informed of this fact before marriage may seek divorce on the ground of fraud. The Assisted Reproductive Technology (Regulation) Act, 2021 regulates the use of assisted reproductive technology for the treatment of sterility. The Act requires that every ART clinic and bank be registered, that written informed consent be obtained from all parties, that donors be screened for communicable and hereditary diseases, and that the child born through ART be deemed the legitimate child of the commissioning parents. The Act prohibits the commercial sale or purchase of gametes and prohibits sex-selective ART procedures. It also prohibits the use of sperm from a relative or friend and requires that gametes be obtained from anonymous donors through registered ART banks.

Medical Negligence in Sterilisation Procedures

Medical negligence in sterilisation procedures gives rise to claims for compensation. The most common claim is for failed sterilisation resulting in unwanted pregnancy. The courts have awarded compensation for the pain, suffering and economic loss associated with an unplanned pregnancy and the birth of an unplanned child. In State of Haryana v. Santra, the Supreme Court held that the State is liable for the negligence of doctors in government hospitals who performed failed sterilisation procedures. The Court awarded compensation for the cost of rearing the child. In subsequent decisions, the Court has limited compensation to the cost of the failed procedure and the pain and suffering of the unwanted pregnancy, excluding the cost of rearing a healthy child.

9.9 MEDICO-LEGAL ISSUES: PSYCHIATRIC AND MENTAL HEALTH

The Mental Healthcare Act, 2017

The Mental Healthcare Act, 2017 is a transformative legislation that replaces the Mental Health Act, 1987. It adopts a rights-based approach to mental health, recognising the autonomy and dignity of persons with mental illness. The Act decriminalises suicide, prohibits electroconvulsive therapy without anaesthesia and bans the use of chaining and solitary confinement.

Right to Access Mental Healthcare

Section 18 of the Act confers upon every person the right to access mental healthcare and treatment from mental health services run or funded by the appropriate government. The government has a duty to provide affordable, accessible and quality mental healthcare, including acute care, rehabilitation and half-way homes.

Right to Confidentiality

Section 23 provides that a person with mental illness has the right to confidentiality in respect of their mental health, treatment and physical healthcare. Information may be disclosed only with the person's consent, or where necessary to protect the health and safety of the person or others, or to a nominated representative, or as required by court order.

Right to Make Advance Directives

Sections 5 to 13 empower any person who is not a minor to make an advance directive in writing specifying how they wish to be cared for and treated for a mental illness, and how they do not wish to be cared for and treated. The advance directive may also appoint a nominated representative to make decisions on their behalf when they lack capacity. The advance directive must be certified by a medical practitioner and registered with the Mental Health Board. It becomes operative when the person loses capacity to make mental healthcare decisions. The medical practitioner must determine capacity in accordance with the principles set out in Section 4.

Right to Nominated Representative

Sections 14 to 17 confer upon every person with mental illness the right to appoint a nominated representative to make decisions on their behalf when they lack capacity. The nominated representative may be a relative, a caregiver, a friend or a suitable person appointed by the Mental Health Board. The nominated representative has the duty to consider the past and present wishes of the person, to promote the person's recovery and to protect the person's rights. The representative may consent to or refuse treatment on behalf of the person, but must act in the person's best interest.

Informed Consent in Mental Healthcare

Section 89 of the Act requires that every person with mental illness shall have the right to make an informed decision about their treatment. The medical practitioner must explain the nature of the treatment, its purpose, its likely effects and side-effects, the probability of success and the consequences of refusal. If the person lacks capacity to give consent, the nominated representative may give consent. However, the nominated representative cannot consent to electroconvulsive therapy without anaesthesia, sterilisation for the purpose of treating mental illness, or chaining or seclusion.

Criminal Responsibility and Insanity Defence

Section 84 of the Indian Penal Code provides that nothing is an offence which is done by a person who, at the time of doing it, by reason of unsoundness of mind, is incapable of knowing the nature of the act, or that the act is wrong or contrary to law. This is the insanity defence,

based on the M'Naghten rules. The burden of proof is on the accused to establish unsoundness of mind. The defence must show that at the time of the act, the accused was labouring under such a defect of reason as not to know the nature and quality of the act or, if they did know it, not to know that it was wrong.

Fitness to Stand Trial

A person who is mentally ill may be unfit to stand trial. The court must determine whether the accused is capable of understanding the proceedings and of defending themselves. If the accused is found unfit, the court may postpone the trial, release the accused on bail or order admission to a mental health facility.

9.10 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES

The Nature of the Patient-Provider Contract

The relationship between the patient and the healthcare provider is contractual. The patient agrees to pay fees; the provider agrees to render professional services with reasonable care and skill. The contract may be express or implied, written or oral. The terms of the contract are derived from multiple sources. The admission form contains express terms regarding payment, discharge and patient responsibilities. The consent form contains terms regarding the specific procedure and its risks. The hospital's published policies regarding visiting hours, discharge procedures and grievance redressal are incorporated by reference. The law implies certain terms into every contract for medical services. The most important is the implied term that the provider will exercise reasonable care and skill. This term is implied by law and cannot be excluded by agreement.

Disclaimer Clauses and Exclusion of Liability

Hospitals frequently include disclaimer clauses in admission forms purporting to exclude or limit their liability. A clause may state that the hospital is not responsible for the negligence of its doctors, or that the patient assumes all risks of treatment, or that the hospital's liability is limited to a specified amount. Such clauses are strictly construed by courts. Any ambiguity is resolved against the hospital as the drafting party. A clause purporting to exclude liability for death or personal injury caused by negligence is void as against public policy. A hospital cannot, by any contractual term, absolve itself of the duty of care it owes to its patients. A clause that reasonably allocates risk, such as requiring patients to deposit valuables in safe custody and limiting liability for items retained in the patient's possession, may be enforceable if it is clearly communicated and fairly balances the interests of both parties.

The Right to Refuse Treatment

A competent adult patient has the right to refuse medical treatment, even if that refusal appears irrational to the doctor and even if it results in the patient's death. This right is an incident of the right to autonomy and self-determination. It is also a statutory right under the Mental Healthcare Act, 2017 for persons with mental illness. The right to refuse treatment is not absolute. It may be overridden in an emergency where the patient is incapable of making a decision and no authorised representative is immediately available. It may also be overridden where the treatment is necessary to protect the health and safety of others, as in the case of compulsory vaccination or quarantine for communicable diseases.

The Right to Access Medical Records

The patient has a right to access their medical records. This right is recognised by the National Medical Commission Code of Conduct, the Clinical Establishments Act, 2010 and the Consumer Protection Act, 2019. It is also a right under the Right to Information Act, 2005 for patients in government hospitals and in private hospitals receiving government funding. The hospital must provide copies of medical records within seventy-two hours of request. The patient may be charged reasonable photocopying fees. The hospital cannot refuse access on the ground that the records are confidential; the duty of confidentiality is owed to the patient, and the patient can waive it.

The Right to Continuity of Care

The patient has a right to continuity of care. The doctor cannot abandon the patient without giving adequate notice and making reasonable arrangements for the transfer of care to another qualified practitioner. Abandonment is a breach of contract and may also constitute negligence if it results in injury to the patient.

9.11 STUDENT LEARNING ACTIVITIES

Activity 1: Informed Consent Audit and Redesign

You are the Administrator of a two hundred bed corporate hospital. A patient has filed a consumer complaint alleging that she underwent a hysterectomy without her informed consent. The patient had consented to a diagnostic laparoscopy for investigation of chronic pelvic pain. During the procedure, the surgeon discovered extensive endometriosis and, in his clinical judgment, performed a hysterectomy. The patient was thirty-four years old and had not completed her family. Audit the hospital's current informed consent forms and procedures. Identify deficiencies in the consent process. Draft a revised comprehensive informed consent policy that addresses the distinction between diagnostic and therapeutic procedures, the requirement of specific consent for major surgical interventions, the procedure for obtaining consent in emergencies, the documentation requirements and the training of medical and nursing staff in the consent process.

Activity 2: Patient Rights and Responsibilities Brochure

The National Accreditation Board for Hospitals has flagged that your hospital does not have a patient rights and responsibilities charter displayed or distributed to patients. The board has directed that such a charter be developed and implemented within three months. Draft a patient-friendly brochure explaining the rights and responsibilities of patients at your hospital. The brochure should be written in plain language, avoiding legal jargon, and should be suitable for patients with limited literacy. It should cover the right to information, the right to consent, the right to confidentiality, the right to emergency care, the right to grievance redressal and the patient's responsibilities regarding disclosure of information, compliance with treatment and respect for staff. Also prepare a one-page summary suitable for display in patient areas.

Activity 3: Mental Healthcare Act Compliance Audit

A patient with bipolar disorder was admitted to your hospital's psychiatric unit. She was placed in seclusion for eight hours without any documentation of the clinical justification or the required periodic reviews. She was administered electroconvulsive therapy without anaesthesia on three occasions. Her nominated representative was not consulted. The patient's family has filed a complaint with the State Mental Health Authority alleging violation of the Mental Healthcare Act, 2017. Conduct a comprehensive compliance audit of your hospital's psychiatric services against the requirements of the Mental Healthcare Act, 2017. Your audit should cover the procedure for determining capacity, the process for obtaining informed consent, the use of advance directives and nominated representatives, the restrictions on electroconvulsive therapy, seclusion and restraint, and the maintenance of medical records. Identify areas of non-compliance, assess the potential liability and prepare a corrective action plan.

Activity 4: Medical Negligence Case Analysis

A fifty-five year old patient underwent elective laparoscopic cholecystectomy at your hospital. During the procedure, the surgeon inadvertently transected the common bile duct. The injury was recognised intra-operatively, and the surgeon performed a primary repair over a T-tube. The patient developed a bile leak post-operatively, required re-operation by a gastrointestinal surgeon and suffered prolonged hospitalisation. The patient has filed a consumer complaint alleging medical negligence. Analyse the facts against the essential elements of medical negligence: duty, breach, causation and damage. Apply the Bolam test to the surgeon's decision to perform laparoscopic cholecystectomy in a patient with previous abdominal surgery, the recognition and repair of the injury and the post-operative management. Assess whether the patient has a sustainable claim for negligence. Draft a response to the consumer complaint on behalf of the hospital.

9.12 SUMMARY

Patient rights in India are founded on the constitutional right to life under Article 21, which has been expansively interpreted to include the right to health, the right to emergency medical care and the right to die with dignity. The Charter of Patient Rights issued by the Ministry of Health and Family Welfare enumerates seventeen rights organised under seven headings, including the right to information, the right to records, the right to emergency care, the right to informed consent, the right to confidentiality, the right to second opinion and the right to grievance redressal.

The Mental Healthcare Act, 2017 is the most comprehensive statutory recognition of patient rights in India. It confers upon persons with mental illness the right to access mental healthcare, the right to community living, the right to confidentiality, the right to information, the right to free legal aid, the right to make advance directives and the right to appoint a nominated representative. The Act decriminalises suicide, prohibits electroconvulsive therapy without anaesthesia and bans chaining and solitary confinement.

Patient rights are accompanied by reciprocal responsibilities. The patient has a responsibility to provide accurate and complete information, to comply with prescribed treatment, to respect healthcare providers, to observe hospital rules and to pay agreed fees. Non-compliance may constitute contributory negligence and reduce the damages payable by the provider.

Medical malpractice is the failure of a medical professional to exercise the degree of care and skill expected of a reasonably competent practitioner in the same field, resulting in injury or loss to the patient. The essential elements are duty, breach, causation and damage. The standard of care is determined by the Bolam test: a doctor is not negligent if their actions are in accordance with a practice accepted as proper by a responsible body of medical opinion, even if other practitioners adopt a different practice.

The doctrine of res ipsa loquitur permits the court to infer negligence from the mere occurrence of an accident where the instrumentality was under the exclusive control of the defendant and the accident is such that in the ordinary course of events would not occur if proper care were used. The classic applications in medical negligence are retained surgical instruments, wrong-site surgery and unexplained burns.

Impotence, the inability to achieve or maintain an erection sufficient for satisfactory sexual intercourse, is a ground for annulment of marriage. It must be distinguished from sterility, the inability to procreate, which is not a ground for annulment. The court may direct medical examination of the respondent to determine impotence, but cannot compel such examination without consent.

The Assisted Reproductive Technology (Regulation) Act, 2021 regulates the treatment of sterility through ART. The Act requires registration of ART clinics and banks, written informed consent from all parties, screening of donors and prohibition of commercial sale or purchase of gametes. A child born through ART is deemed the legitimate child of the commissioning parents.

The patient-provider relationship is contractual. The contract includes express terms from admission and consent forms and implied terms, including the implied undertaking to exercise reasonable care and skill. Disclaimer clauses purporting to exclude liability for negligence are void as against public policy. The patient has the right to refuse treatment, the right to access medical records and the right to continuity of care.

9.13 KEY WORDS WITH EXPLANATIONS

Informed Consent is the voluntary agreement of a patient to undergo a medical intervention after being informed of the nature, purpose, material risks and alternatives of the procedure. Consent must be free from coercion, fraud or undue influence. For major surgical procedures, consent must be specific and in writing.

Patient Autonomy is the right of a competent adult patient to make informed decisions about their own medical care, including the right to accept or refuse treatment. Autonomy is the ethical foundation of informed consent.

Bolam Test is the standard for determining breach of duty in medical negligence cases. A doctor is not negligent if their actions are in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art, even if other practitioners adopt a different practice. The test was modified in Samira Kohli to require that the practice be reasonable and logical.

Res Ipsa Loquitur is a Latin maxim meaning the thing speaks for itself. It is a rule of evidence permitting the court to infer negligence from the mere occurrence of an accident where the instrumentality was under the exclusive control of the defendant and the accident is such that in the ordinary course of events would not occur if proper care were used.

Medical Malpractice is professional negligence by a healthcare provider that results in injury or loss to the patient. It includes not only negligent treatment but also failure to obtain informed consent, breach of confidentiality and abandonment.

Causation is the link between the defendant's breach of duty and the claimant's damage. The but for test asks whether the damage would have occurred regardless of the breach. The claimant must prove causation on a balance of probabilities.

Contributory Negligence is the claimant's failure to take reasonable care for their own safety, which contributes to the damage. Damages are reduced proportionately to the claimant's degree of fault.

Advance Directive is a written document in which a person specifies how they wish to be cared for and treated for a mental illness, or how they do not wish to be cared for and treated, if they become incapable of making decisions. It is recognised under the Mental Healthcare Act, 2017.

Nominated Representative is a person appointed by a person with mental illness to make decisions on their behalf when they lack capacity. The nominated representative must act in the person's best interest and consider their past and present wishes.

Impotence is the inability of a male to achieve or maintain an erection sufficient for satisfactory sexual intercourse. It is a ground for annulment of marriage under the Hindu Marriage Act, 1955 and the Special Marriage Act, 1954.

Sterility is the inability to procreate. It is not a ground for annulment of marriage but may be a ground for divorce if accompanied by fraud or cruelty.

Assisted Reproductive Technology comprises medical procedures used to achieve pregnancy by artificial or partially artificial means, including in vitro fertilisation, intracytoplasmic sperm injection and gamete donation. It is regulated by the Assisted Reproductive Technology (Regulation) Act, 2021.

Disclaimer Clause is a contractual term purporting to exclude or limit liability for breach of contract or negligence. It is strictly construed by courts. Clauses excluding liability for death or personal injury caused by negligence are void as against public policy.

9.14 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What are the essential elements of a valid informed consent under Indian law?

Ans. The essential elements of a valid informed consent are: the patient must have the capacity to consent; the consent must be voluntary and free from coercion, fraud or undue

influence; the patient must be informed of the nature of the procedure, its purpose, the material risks and the available alternatives; and the consent must be specific to the procedure. For major surgical procedures, consent must be in writing. Consent to a diagnostic procedure does not imply consent to therapeutic intervention.

Q2. What is the Bolam test and how is it applied in medical negligence cases?

Ans. The Bolam test, derived from Bolam v. Friern Hospital Management Committee, provides that a doctor is not negligent if their actions are in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art, even if other practitioners adopt a different practice. The test was approved by the Supreme Court in Indian Medical Association v. V.P. Shantha and modified in Samira Kohli v. Prabha Manchanda to require that the practice be reasonable and logical.

Q3. What is the distinction between impotence and sterility, and what are the legal consequences of each?

Ans. Impotence is the inability of a male to achieve or maintain an erection sufficient for satisfactory sexual intercourse. Sterility is the inability to procreate. A man may be impotent but fertile or sterile but potent. Impotence, if existing at the time of marriage and incurable, is a ground for annulment of marriage under Section 12 of the Hindu Marriage Act, 1955. Sterility is not a ground for annulment but may be a ground for divorce if accompanied by fraud or cruelty.

Q4. What are the rights of a person with mental illness under the Mental Healthcare Act, 2017?

Ans. The Mental Healthcare Act, 2017 confers upon persons with mental illness the right to access mental healthcare, the right to community living, the right to confidentiality, the right to information, the right to free legal aid, the right to make advance directives and the right to appoint a nominated representative. The Act prohibits electroconvulsive therapy without anaesthesia, chaining and solitary confinement. It decriminalises suicide and requires that every person with mental illness be treated with dignity and respect.

Q5. What is the legal effect of a disclaimer clause in a hospital admission form purporting to exclude liability for medical negligence?

Ans. A disclaimer clause purporting to exclude liability for death or personal injury caused by negligence is void as against public policy. The hospital cannot, by any contractual term, absolve itself of the duty of care it owes to its patients. Such clauses are strictly construed by courts, and any ambiguity is resolved against the hospital as the drafting party. A clause that reasonably allocates risk, such as limiting liability for patient property, may be enforceable if it is clearly communicated and fairly balances the interests of both parties.

B. Essay Type Questions with Hints

Q1. Trace the evolution of the right to health under Article 21 of the Constitution of India through landmark Supreme Court judgments. To what extent is this right enforceable against private hospitals?

Hints: Begin with the text of Article 21 and the narrow interpretation in A.K. Gopalan. Discuss the transformation in Maneka Gandhi and the expansion to include the right to dignity. Analyse the judgments specifically on the right to health: State of Punjab v. Mohinder Singh Chawla, Parmanand Katara v. Union of India and Paschim Banga Khet Mazdoor Samity v. State of West Bengal. Discuss the State's obligation to provide emergency medical care and the liability for denial. Analyse the enforceability against private hospitals: the doctrine of State action under Article 12, the functional test and the effect of government regulation and funding. Conclude with the role of the right to health as a constitutional value informing statutory and contractual duties of private hospitals.

Q2. Critically examine the doctrine of informed consent in Indian medical jurisprudence with reference to Samira Kohli v. Prabha Manchanda. What are the exceptions to the requirement of informed consent?

Hints: Begin with the facts and issues in Samira Kohli. Explain the distinction between diagnostic and therapeutic procedures, between general and specific consent, and between battery and negligence. Discuss the essential elements of informed consent: capacity, voluntariness, information and specificity. Analyse the Supreme Court's holding that consent to a diagnostic procedure does not imply consent to therapeutic intervention. Discuss the exceptions to informed consent: emergency where the patient is incapable of consenting and no authorised representative is available; therapeutic privilege where disclosure would cause serious psychological harm to the patient; and waiver where the patient voluntarily waives the right to information. Conclude with the importance of documentation and the need for institutional consent policies.

Q3. Analyse the legal framework governing assisted reproductive technology in India under the Assisted Reproductive Technology (Regulation) Act, 2021. What are the rights of a child born through ART, and what are the obligations of ART clinics and banks?

Hints: Explain the need for legislation in the context of unregulated ART practice. Discuss the key provisions of the ART Act, 2021: registration of clinics and banks; informed consent from commissioning parents, donors and surrogates; donor anonymity and screening; prohibition of commercial sale of gametes; prohibition of sex selection; and the single donor rule to prevent consanguinity. Discuss the legal status and rights of the child born through ART: deemed legitimate child of commissioning parents; entitled to all rights and privileges of a naturally conceived child; birth certificate records names of commissioning parents. Discuss the obligations of ART clinics and banks: maintenance of records, reporting to the National Registry, adherence to quality standards and prohibition of certain practices. Conclude with the gaps in the legislation and the need for complementary surrogacy regulation.

Q4. Discuss the rights of persons with mental illness under the Mental Healthcare Act, 2017. How does the Act balance the patient's right to autonomy with the need for treatment and protection from harm?

Hints: Structure your answer around the rights-based approach of the Act. Explain the presumption of capacity and the functional test for determining incapacity. Discuss the right to make advance directives and the procedure for their registration and implementation. Discuss the right to appoint a nominated representative and the duties of the representative. Explain the restrictions on electroconvulsive therapy, seclusion and restraint. Discuss the prohibition of inhuman and degrading treatment. Analyse the provisions for supported admission and

independent admission. Discuss the role of the Mental Health Review Boards in protecting the rights of persons admitted to mental health establishments. Conclude with an assessment of whether the Act achieves the balance between autonomy and protection.

Q5. You are the Administrator of a one hundred fifty bed hospital. A patient has filed a consumer complaint alleging that she was discharged prematurely and against medical advice because she was unable to pay the outstanding bill. The patient was twenty-eight weeks pregnant and presented with preterm premature rupture of membranes. She was admitted, managed conservatively and after seventy-two hours, the treating doctor determined that inpatient care was no longer medically necessary. The patient's family requested continued hospitalisation until delivery, citing their inability to manage the pregnancy at home. The hospital refused and discharged the patient. The patient delivered at home two days later with complications. Advise the management on the legal validity of the discharge, the patient's rights and the appropriate response to the complaint.

Hints: Structure your answer as a legal opinion. Analyse the patient's right to emergency care and the hospital's duty under Parmanand Katara. Distinguish between emergency care and elective care. Discuss the patient's right to refuse treatment and the correlative right to be discharged when treatment is not accepted. Discuss the hospital's right to discharge a patient who is medically fit and to refuse non-emergency services to patients who are unable to pay. Analyse whether the patient was medically fit for discharge. Assess whether the hospital had any obligation to continue inpatient care for the patient's convenience. Evaluate the causation issues: were the complications caused by the discharge or by the underlying condition? Advise the management on the legal defence and on a compassionate settlement strategy.

C. Analytical Multiple Choice Questions

1. Under the principles laid down in Samira Kohli v. Prabha Manchanda, consent to a diagnostic laparoscopy:
a) Impliedly consents to any therapeutic intervention that the doctor considers medically necessary
b) Does not imply consent to a therapeutic intervention, even if the intervention is minor
c) Implies consent to a therapeutic intervention if the patient is unconscious
d) Is valid only if obtained in writing
Correct Answer: b) Does not imply consent to a therapeutic intervention, even if the intervention is minor

2. The doctrine of res ipsa loquitur in medical negligence cases applies to which of the following scenarios?
a) A patient develops an unexpected allergic reaction to a contrast agent
b) A surgeon removes the wrong kidney during a nephrectomy
c) A patient dies from a pulmonary embolism after prolonged bed rest
d) A doctor misinterprets an X-ray and delays diagnosis
Correct Answer: b) A surgeon removes the wrong kidney during a nephrectomy

3. Under the Mental Healthcare Act, 2017, electroconvulsive therapy (ECT):
a) May be administered to any patient with informed consent
b) May be administered without anaesthesia in emergency situations
c) May not be administered without anaesthesia and muscle relaxants
d) May be administered to minors with parental consent

Correct Answer: c) May not be administered without anaesthesia and muscle relaxants

4. A patient undergoes a sterilisation procedure at a government hospital. The procedure fails, and the patient conceives and delivers a healthy child. The patient files a claim for compensation. Which of the following correctly states the legal position?
a) The patient is entitled to full compensation for the cost of rearing the child
b) The patient is entitled to compensation for the failed procedure and the pain and suffering of the unwanted pregnancy, but not for the cost of rearing a healthy child
c) The patient is not entitled to any compensation because the birth of a healthy child is a blessing
d) The patient is entitled to punitive damages because the failure constitutes gross negligence
Correct Answer: b) The patient is entitled to compensation for the failed procedure and the pain and suffering of the unwanted pregnancy, but not for the cost of rearing a healthy child

5. Under the Assisted Reproductive Technology (Regulation) Act, 2021, a child born through ART using donor gametes is deemed to be:
a) The illegitimate child of the commissioning mother
b) The biological child of the donor, with the commissioning parents as guardians
c) The legitimate child of the commissioning parents, entitled to all rights and privileges of a naturally conceived child
d) Entitled to know the identity of the donor upon attaining majority
Correct Answer: c) The legitimate child of the commissioning parents, entitled to all rights and privileges of a naturally conceived child

6. A sixty-five year old patient with terminal cancer has executed an advance directive stating that she does not wish to receive artificial nutrition and hydration if she becomes permanently unconscious. She is now in a persistent vegetative state. Her son, who is her nominated representative, demands that the hospital provide artificial nutrition and hydration. Under the Mental Healthcare Act, 2017:
a) The hospital must comply with the son's demand as the nominated representative
b) The hospital must comply with the advance directive and withhold artificial nutrition and hydration
c) The hospital must apply to the Mental Health Review Board for a decision
d) The hospital must continue all life-sustaining treatment regardless of the advance directive
Correct Answer: b) The hospital must comply with the advance directive and withhold artificial nutrition and hydration

7. A patient suffers an injury during surgery. The patient alleges negligence. The burden of proof in a medical negligence case is on:
a) The patient, who must prove negligence on a balance of probabilities
b) The doctor, who must prove that they were not negligent
c) The hospital, which must prove that it exercised reasonable care
d) The consumer forum, which must appoint an expert to determine negligence
Correct Answer: a) The patient, who must prove negligence on a balance of probabilities

9.15 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Unwanted Pregnancy and the Undisclosed Sterilisation

Sree Chitra Health City is a three hundred bed multi-speciality corporate hospital located in Thiruvananthapuram, Kerala, registered as a private limited company under the Companies Act, 2013 and accredited by NABH. The hospital has a well-established department of obstetrics and gynaecology with four full-time consultants, six resident doctors and forty-five nursing staff. It is empanelled under the Ayushman Bharat PM-JAY scheme and the Kerala Karunya Health Scheme.

Mrs. Meera Nair, a thirty-two year old school teacher, presented to the outpatient department on 15 January 2025 with complaints of heavy, prolonged menstrual bleeding for the preceding eight months. She was examined by Dr. Asha Krishnan, Senior Consultant Gynaecologist. Clinical examination and ultrasound revealed multiple uterine fibroids, the largest measuring six centimetres. Mrs. Nair was advised to undergo a hysteroscopic myomectomy for removal of the fibroids. Mrs. Nair was admitted on 20 January 2025. She signed the hospital's standard admission form and a separate consent form for hysteroscopic myomectomy. The consent form described the procedure as removal of uterine fibroids under anaesthesia. It listed the potential risks as bleeding, infection, perforation of the uterus and damage to adjacent organs. It did not mention the possibility of hysterectomy or sterilisation. It did not contain any statement that consent to the myomectomy did not imply consent to any other procedure.

On 21 January 2025, Dr. Krishnan performed the hysteroscopic myomectomy. During the procedure, she encountered multiple submucous fibroids that were not visualised on preoperative imaging. The uterine cavity was distorted, and the bleeding was profuse. Dr. Krishnan was unable to control the bleeding hysteroscopically. She converted the procedure to an open laparotomy. At laparotomy, she found that the uterus was extensively involved with fibroids and that conservative surgery was not feasible. She performed a subtotal hysterectomy, removing the uterus but preserving the ovaries and fallopian tubes. The patient was not consulted before the hysterectomy. Her husband, who was waiting in the visitors' area, was not informed. No emergency was documented that would have precluded obtaining consent. The operating notes recorded that the hysterectomy was performed because of uncontrollable haemorrhage and that the patient's condition was stable throughout the procedure.

Mrs. Nair recovered uneventfully from the surgery. She was discharged on 26 January 2025 with a discharge summary that described the procedure as hysteroscopic myomectomy converted to open myomectomy. The discharge summary did not mention that a hysterectomy had been performed. Mrs. Nair returned for her follow-up appointment on 10 February 2025. She reported that she was feeling well but had not yet resumed menstruation. She asked Dr. Krishnan when she could expect her next period. Dr. Krishnan informed her that she would not menstruate again because her uterus had been removed.

Mrs. Nair was devastated. She was thirty-two years old. She and her husband had planned to have a second child after the myomectomy. Her son was four years old. She had not consented to the loss of her fertility. She had not been informed that a hysterectomy was a possibility. She had not been given the opportunity to consider alternatives, to seek a second opinion or to prepare herself psychologically.

On 15 February 2025, Mrs. Nair filed a consumer complaint before the Kerala State Consumer Disputes Redressal Commission against Sree Chitra Health City and Dr. Asha Krishnan alleging medical negligence and deficiency in service in performing a hysterectomy without informed consent, failure to disclose material information that hysterectomy was a possible outcome and that alternative treatments were available, and deficiency in service in preparing a misleading discharge summary that concealed the nature of the surgery performed. The complaint claimed compensation of fifty lakh rupees including five lakh rupees for the cost of surgery and hospitalisation, twenty-five lakh rupees for loss of fertility and the opportunity to bear another child, ten lakh rupees for pain, suffering and mental agony, five lakh rupees for loss of consortium to the husband and five lakh rupees for punitive damages.

The hospital and Dr. Krishnan filed their response denying negligence and deficiency. The defence was that the hysterectomy was medically necessary as the bleeding was profuse and could not be controlled by conservative means, and that continuing with myomectomy would have endangered the patient's life. The consent form was a general consent for surgery and implied consent to such additional procedures as were necessary to preserve the patient's life and health. The patient suffered no physical injury; she recovered uneventfully and was relieved of her symptoms. The discharge summary was not deliberately misleading but was prepared by a junior resident who was not fully aware of the operative details.

The State Consumer Commission referred the complaint for expert opinion to the Kerala State Medical Council. The board of three senior gynaecologists opined that the preoperative counselling was inadequate. The patient should have been informed that hysterectomy was a possible outcome of surgery for multiple fibroids and should have been given the opportunity to consent to or refuse hysterectomy in advance. The consent form was deficient; it did not mention the possibility of hysterectomy and did not contain any statement about the limits of consent. No emergency existed that justified proceeding without consent. The patient's vital signs were stable. The bleeding, though profuse, was controlled by packing and compression. The surgeon could have closed the abdomen, obtained proper consent and performed the hysterectomy at a later date. The decision to proceed without consent was a violation of the patient's autonomy, not a medical necessity. The board concluded that Dr. Krishnan's conduct constituted professional negligence and a breach of the Code of Medical Ethics Regulations, 2002.

The State Consumer Commission referred the matter to conciliation. After three rounds of conciliation, the parties reached a settlement on 30 July 2025. The hospital and Dr. Krishnan agreed to pay Mrs. Nair a lump sum compensation of twenty-eight lakh rupees apportioned as five lakh rupees for the cost of surgery and hospitalisation, fifteen lakh rupees for loss of fertility and the opportunity to bear another child, six lakh rupees for pain, suffering and mental agony, and two lakh rupees for the husband's loss of consortium. The hospital agreed to revise its informed consent policy to require that all consent forms for gynaecological surgery specifically address the possibility of hysterectomy and the patient's right to refuse consent. The hospital agreed to implement a mandatory training programme on informed consent for all medical and nursing staff. Dr. Krishnan agreed to undergo continuing medical education on medical ethics and to issue a written apology to Mrs. Nair.

Questions for Analysis with Hints

Q1. Analyse the validity of Mrs. Nair's consent to the hysterectomy. Did Dr. Krishnan obtain valid consent? Apply the principles laid down in Samira Kohli v. Prabha Manchanda to the facts of this case. Was there an emergency that justified proceeding without consent?

Hints: Mrs. Nair's consent to the hysterectomy was invalid. She consented only to a hysteroscopic myomectomy. The consent form was specific to that procedure and did not mention hysterectomy, sterilisation or loss of fertility. The principles in Samira Kohli are directly applicable: consent to a diagnostic procedure does not imply consent to therapeutic intervention; consent to a conservative procedure does not imply consent to radical surgery. No emergency existed. The patient's vital signs were stable. The bleeding was controlled by packing and compression. There was no imminent threat to life. The surgeon had the option of closing the abdomen, obtaining proper consent and performing the hysterectomy at a later date. The emergency exception to informed consent is limited to situations where the patient is incapable of consenting and no authorised representative is immediately available, and where delay would endanger the patient's life or cause serious and irreversible deterioration. None of these conditions were present.

Q2. Evaluate the hospital's defence that the consent form was a general consent to surgery and implied consent to such additional procedures as were medically necessary. Is this defence legally sustainable? What are the limits of implied consent in surgical practice?

Hints: The defence that a general consent to surgery implies consent to such additional procedures as are medically necessary is legally unsustainable. The Supreme Court in Samira Kohli explicitly rejected this argument. Consent must be specific to the procedure. A patient who consents to a myomectomy does not consent to a hysterectomy, just as a patient who consents to a laparoscopy does not consent to a laparotomy. Implied consent is recognised only in limited circumstances: it may arise from the conduct of the parties, as when a patient voluntarily submits to a procedure with full knowledge of its nature; it may also arise in emergencies where the patient is incapable of consenting and treatment is immediately necessary to preserve life or prevent serious deterioration. Implied consent cannot be inferred from a general consent form that does not specifically address the procedure in question. A hysterectomy is a major surgical intervention with profound and irreversible consequences. It requires specific, informed, written consent.

Q3. Discuss the adequacy of the preoperative counselling and the consent form. What specific information should have been disclosed to Mrs. Nair before the surgery? Draft a revised consent form for hysteroscopic myomectomy that adequately addresses the risk of hysterectomy and the patient's right to refuse consent.

Hints: The preoperative counselling and consent form were grossly inadequate. Mrs. Nair was not informed that hysterectomy was a possible outcome of surgery for multiple fibroids, that her fertility might be lost, or that she had the right to refuse consent to hysterectomy and accept the risk of incomplete treatment or the need for a second procedure. A revised consent form must include: a clear description of the proposed procedure in plain language; a clear statement that the patient is consenting specifically to hysteroscopic myomectomy and that this consent does not extend to any other procedure; clear disclosure of material risks including bleeding, infection, perforation, and the possibility that the procedure may be unsuccessful or incomplete; clear disclosure that hysterectomy may be required if conservative measures fail to control bleeding or if unexpected findings are encountered, and that hysterectomy will result in permanent loss of fertility; a clear statement that the patient has the right to refuse consent

to hysterectomy and that such refusal will not affect the quality of care provided for the consented procedure; a space for the patient to indicate specifically whether they consent to hysterectomy if it becomes necessary during the procedure; and a statement that the patient has had the opportunity to ask questions and that all questions have been answered to their satisfaction.

Q4. Assess the appropriateness of the compensation awarded in the settlement. Is the amount of fifteen lakh rupees for loss of fertility adequate? How should courts quantify compensation for the loss of reproductive capacity? What factors should be considered?

Hints: The compensation of fifteen lakh rupees for loss of fertility is reasonable and consistent with judicial precedents. Loss of fertility is a catastrophic injury for a young woman who has not completed her family. It is not merely the loss of a biological function; it is the loss of the opportunity to experience pregnancy and childbirth, to raise another child and to complete the family as planned. It is a permanent and irreversible injury that affects the patient's physical, psychological and social well-being. Courts have awarded compensation for loss of fertility in the range of ten to twenty-five lakh rupees depending on factors including: the age of the patient and her remaining reproductive lifespan; the number of existing children; the psychological impact of the loss; the manner in which the patient was informed of the loss; and the degree of fault. Mrs. Nair was thirty-two years old with one child and a reasonable expectation of bearing another child. The violation of consent was egregious as the doctor proceeded without consent in the absence of any emergency. The compensation of fifteen lakh rupees, together with the other heads of damage, fairly compensates Mrs. Nair for her loss and serves the objectives of tort law: compensation, deterrence and accountability.

Q5. As the newly appointed Quality Assurance Manager of Sree Chitra Health City, you have been directed to develop a comprehensive informed consent policy to prevent recurrence of such incidents. Your policy should address the essential elements of valid consent, the distinction between general and specific consent, the procedure for obtaining consent in emergencies, the documentation requirements, the role of nurses and residents in the consent process, and the training and audit mechanisms.

Hints: The policy must establish that valid consent requires capacity, voluntariness, information, specificity and documentation. Consent must be obtained for each specific procedure; a general consent to treatment is not sufficient for major surgical interventions, anaesthesia, blood transfusion or invasive diagnostic procedures. Consent to a diagnostic procedure does not imply consent to therapeutic intervention. Consent to a conservative procedure does not imply consent to radical surgery. Consent to a procedure with the possibility of conversion to a more extensive procedure must specifically address that possibility. The medical practitioner obtaining consent must disclose the diagnosis, the nature and purpose of the proposed intervention, the material risks, the benefits reasonably expected, the alternatives including the option of no treatment, the consequences of refusing or delaying the intervention, and the identity and qualifications of the medical practitioner who will perform the intervention. For hysterectomy and sterilisation procedures, consent shall be obtained on a separate, dedicated consent form that clearly states that the procedure will result in permanent loss of fertility and includes a specific statement that the patient consents to the loss of fertility. In a genuine emergency where the patient is incapable of giving consent and no authorised representative is immediately available, the medical practitioner may proceed with life-saving treatment without consent, but the emergency must be documented in the medical record including the nature of the emergency, the reasons why consent could not be obtained and the

treatment provided. All consent shall be documented in writing on the hospital's approved consent forms, signed by the patient or authorised representative and signed by the medical practitioner obtaining consent. A copy of the signed consent form shall be provided to the patient. The medical practitioner performing the procedure is ultimately responsible for obtaining informed consent. All medical practitioners shall complete mandatory training on informed consent annually, and the Quality Assurance Department shall conduct periodic audits of consent documentation.

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A patient's consent is not a mere formality. It is the legal and ethical foundation of the doctor-patient relationship. It transforms what would otherwise be an unlawful touching into lawful medical treatment. It affirms the patient's status as a person, not merely an object of care.

** Supreme Court of India, Samira Kohli v. Prabha Manchanda (2008)**

LESSON-10

SPECIAL MEDICO-LEGAL ISSUES IN HOSPITALS

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Explain the legal framework governing poisons, narcotic drugs, psychotropic substances and hazardous chemicals, and the obligations of healthcare facilities in handling toxic substances
2. Analyse the Transplantation of Human Organs and Tissues Act, 1994 including the definition of brain death, the distinction between near relatives and altruistic donors, and the role of authorisation committees
3. Evaluate the legal status of euthanasia in India, distinguishing between active and passive euthanasia, voluntary and non-voluntary euthanasia, and the procedure for advance directives
4. Assess the medico-legal obligations of medical professionals in diagnosis, prescription, administration of drugs, anaesthesia and surgery
5. Apply the principles of special medico-legal issues to real-world hospital administration scenarios through case-based analysis

STRUCTURE OF THE LESSON

10.1 INTRODUCTION: THE INTERSECTION OF MEDICINE AND CRIMINAL LAW

Most medical practice occurs in the civil domain. Negligence is compensable; breach of contract is remediable; professional misconduct is disciplinable. But certain areas of healthcare intersect directly with criminal law. The possession and prescription of narcotic drugs, the transplantation of human organs and the ending of human life are activities that are lawful only when conducted within strict statutory boundaries. Outside those boundaries, they are offences punishable with imprisonment. This intersection of medicine and criminal law imposes upon the hospital administrator a heightened duty of compliance. The administrator must ensure that the hospital's pharmacy is licensed, that narcotic drugs are stored in double-locked cabinets, that registers are maintained and periodically verified, that prescriptions are issued only by registered medical practitioners and only for legitimate therapeutic purposes. The administrator must ensure that organ transplants are authorised by the appropriate committee, that brain death is certified by the prescribed board and that no commercial transaction underpins what is represented as altruistic donation. This lesson examines four areas of special medico-legal significance. Toxicology law regulates the possession, storage, prescription and disposal of poisons, narcotic drugs, psychotropic substances and hazardous chemicals. Organ transplantation law regulates the removal and transplantation of human organs and tissues, balancing the need to increase organ donation against the imperative to prevent commercial exploitation. Euthanasia law defines the circumstances in which the withdrawal or withholding of life-sustaining treatment is lawful and the procedure for advance directives. The legal aspects of diagnosis, prescription, drug administration, anaesthesia and surgery define the standards of care applicable to the core clinical activities of the hospital. Each of these areas is governed by specific legislation, supplemented by detailed rules and regulations, and enforced by designated authorities. Each requires the hospital administrator to implement systems, maintain records and train staff. Each carries severe penalties for non-compliance, including imprisonment, cancellation of registration and vicarious liability for the acts of employees.

10.2 INTRODUCTORY CASE STUDY: THE TRANSPLANT THAT WASN'T ALTRUISTIC – STATE v. DR. AMIT KUMAR

Between 2014 and 2016, an elaborate organ trafficking network operated in and around the National Capital Region. The network recruited vulnerable individuals from Bangladesh, Nepal and impoverished regions of India, offering payments of three to five lakh rupees in exchange for their kidneys. The recipients were wealthy Indian and foreign nationals who paid between twenty-five and forty lakh rupees for the transplant. The network was organised by touts, facilitated by corrupt laboratory technicians who fabricated tissue matching reports, and enabled by doctors who performed transplants with forged authorisation committee approvals.

Dr. Amit Kumar, a nephrologist, was the principal medical accused. He performed over five hundred renal transplants at various hospitals in Delhi-NCR, including procedures on foreign nationals. The transplants were presented to the authorisation committees as altruistic donations by friends or distant relatives. The donor-recipient pairs were coached to fabricate their relationships and to recite false histories during committee interviews. The committees, understaffed and overburdened, approved the transplants. The racket was uncovered when a Bangladeshi donor, who had been trafficked to India and coerced into donating his kidney, escaped and lodged a complaint with the police. The Central Bureau of Investigation registered a case under the Transplantation of Human Organs and Tissues Act, 1994, the Indian Penal Code and the Passports Act.

The investigation revealed systemic failures across multiple institutions. Hospitals had not conducted independent verification of donor-recipient relationships. Authorisation committees had conducted cursory interviews and had not video-recorded the proceedings as required. State authorities had not conducted periodic inspections of transplant facilities. The National Organ and Tissue Transplant Organisation had not been notified of the transplants. Dr. A Kumar was convicted under Sections 18 and 19 of the THOTA, 1994 which prohibit the removal of human organs for purposes of transplantation without authority and the commercial dealing in human organs. He was sentenced to rigorous imprisonment for seven years and a fine of five lakh rupees. The conviction was upheld by the Delhi High Court and the Supreme Court. Several hospitals were de-registered by the appropriate authorities and their transplant programmes were suspended.

Relevance to the Lesson: This case is the defining illustration of the regulatory purpose of the Transplantation of Human Organs and Tissues Act, 1994. The Act was enacted to prevent commercial dealing in human organs while facilitating ethical transplantation. The case demonstrates that the statutory safeguards—the distinction between near relatives and altruistic donors, the requirement of authorisation committee approval, the verification of donor-recipient relationships and the prohibition of payment—are not bureaucratic formalities. They are the legal architecture that distinguishes lawful transplantation from organ trafficking. Their circumvention is not a technical violation; it is a serious criminal offence that exploits the vulnerable and corrupts the medical profession.

10.3 TOXICOLOGY: LEGAL PROVISIONS AND HOSPITAL OBLIGATIONS

The Legislative Framework

The regulation of poisons, narcotic drugs, psychotropic substances and hazardous chemicals in India is governed by a complex legislative framework comprising multiple statutes administered by different ministries. The Poisons Act, 1919 empowers state governments to regulate the possession for sale and the sale of specified poisons. State governments may make rules requiring the licensing of vendors, prescribing the quantities that may be sold and regulating the safe custody and labelling of poisons. The Act applies to substances specified in the schedule, including arsenic, strychnine and other toxic alkaloids.

The Drugs and Cosmetics Act, 1940 regulates the import, manufacture, distribution and sale of drugs and cosmetics. It classifies drugs into various schedules with corresponding regulatory requirements. Schedule H drugs, which include many antibiotics and psychotropic substances, cannot be sold except on the prescription of a registered medical practitioner and the prescription must be in writing and dated. Schedule X drugs, which include narcotic and psychotropic substances, are subject to even stricter regulation: the prescription must be in writing, in duplicate, and must be retained by the pharmacist for two years.

The Narcotic Drugs and Psychotropic Substances Act, 1985 is the principal legislation for combating drug trafficking and regulating the legitimate use of narcotic drugs and psychotropic substances for medical and scientific purposes. The Act prohibits the cultivation, production, manufacture, possession, sale, purchase, transport, warehousing, use, consumption, import, export and transhipment of narcotic drugs and psychotropic substances except for medical or scientific purposes and in accordance with the conditions of a licence issued under the Act.

The Environment (Protection) Act, 1986 and the rules framed thereunder, including the Manufacture, Storage and Import of Hazardous Chemical Rules, 1989 and the Bio-Medical Waste Management Rules, 2016, regulate the handling, storage and disposal of hazardous chemicals and bio-medical waste.

Obligations of Hospitals

Every hospital that operates a pharmacy must be licensed under the Drugs and Cosmetics Act, 1940. The licence is issued by the State Drugs Control Authority and is subject to conditions regarding the premises, equipment, personnel and storage facilities. The licence must be renewed periodically, and the licensing authority has the power to inspect the premises and to suspend or cancel the licence for contravention of the Act or the rules.

Narcotic drugs and psychotropic substances must be stored in a double-locked cabinet or a safe, with access restricted to authorised personnel. The hospital must maintain a register of narcotic drugs in Form NC-1, recording the receipt, issue and balance of each drug on a daily basis. The register must be available for inspection by the Narcotics Commissioner or any authorised officer.

Schedule H and Schedule X drugs must be stored separately from other drugs. The pharmacy must maintain a register of prescriptions for these drugs, and the prescriptions must be retained for the prescribed period. The pharmacist must verify that the prescription is issued by a registered medical practitioner, that it is in writing and dated, and that it contains all the required particulars.

Bio-medical waste, including discarded cytotoxic drugs, expired or surplus pharmaceuticals and contaminated items, must be segregated, stored, transported and disposed of in accordance with the Bio-Medical Waste Management Rules, 2016. The hospital must obtain authorisation from the State Pollution Control Board, maintain records of waste generation and disposal, and submit annual reports.

Medical Termination of Pregnancy

The Medical Termination of Pregnancy Act, 1971, as amended in 2021, regulates the circumstances in which pregnancy may be terminated. The Act permits termination of pregnancy by a registered medical practitioner where the length of the pregnancy does not exceed twenty weeks, or twenty-four weeks in specified categories of women, or where the termination is necessary to save the life of the pregnant woman. The Act requires that the termination be performed with the consent of the pregnant woman. No consent other than that of the pregnant woman is required. The opinion of one registered medical practitioner is required for termination up to twenty weeks; the opinion of two registered medical practitioners is required for termination between twenty and twenty-four weeks. The Act also requires that every termination of pregnancy be reported to the Chief Medical Officer of the district in the prescribed form. Failure to report is an offence punishable with fine.

PCPNDT Act, 1994

The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 prohibits the use of pre-natal diagnostic techniques for the purpose of sex selection and prohibits the communication of the sex of the foetus to the pregnant woman or her relatives.

The Act requires every genetic counselling centre, genetic laboratory and genetic clinic to be registered. It requires that no pre-natal diagnostic procedure be conducted unless the pregnant woman is over thirty-five years of age, has a history of genetic abnormalities or falls within other prescribed categories. It requires that the person conducting the ultrasonography maintain a register and display a notice that disclosure of the sex of the foetus is prohibited. Violation of the PCPNDT Act is punishable with imprisonment up to three years and fine up to ten thousand rupees for the first offence, and imprisonment up to five years and fine up to fifty thousand rupees for subsequent offences. The registration of the medical facility may be suspended or cancelled.

10.4 ORGAN TRANSPLANTATION: THE THOTA FRAMEWORK

The Transplantation of Human Organs and Tissues Act, 1994

The Transplantation of Human Organs and Tissues Act, 1994 is the principal legislation regulating the removal, storage and transplantation of human organs and tissues for therapeutic purposes. The Act was enacted to prevent commercial dealing in human organs, to regulate the removal of organs from living and deceased donors and to promote deceased organ donation. The Act defines human organ to include any part of a human body consisting of a structured arrangement of tissues which, if wholly removed, cannot be replicated by the body. This includes the kidney, liver, heart, lung, pancreas and intestine. The 2011 amendment extended the Act to human tissues, including skin, bone, cartilage, cornea, heart valves and blood vessels.

Living Donor Transplantation

The Act permits the removal of an organ from a living person for transplantation into another person under two circumstances. First, a near relative may donate an organ to a recipient. Near relative is defined as spouse, parents, children, siblings, grandparents and grandchildren. The donor must be over eighteen years of age and must give voluntary, informed consent. No authorisation committee approval is required for near-relative donation, but the hospital must satisfy itself that the donor is a near relative and that the consent is voluntary. Second, a person who is not a near relative may donate an organ to a recipient only with the approval of the Authorisation Committee constituted by the appropriate government. The donor must be over eighteen years of age and must give voluntary, informed consent. The donor must not receive any payment or other consideration for the donation. The Authorisation Committee must interview the donor and the recipient, verify their identities and addresses, satisfy itself that the donation is altruistic and not commercial, and record the proceedings on video.

Deceased Donor Transplantation

The Act recognises brain-stem death as a form of death. A person is dead when there is irreversible cessation of all functions of the brain-stem. Certification of brain-stem death must be made by a board of four medical experts: the medical superintendent or nominee of the hospital, the treating physician, a neurologist or neurosurgeon, and a surgeon or physician nominated by the medical administrator. The certification must be conducted twice, with an interval of six hours, and must be documented in Form 10. Organs may be removed from a deceased person for transplantation if the person had, during their lifetime, authorised the donation, or if no such authorisation is known, the near relative authorises the donation. The hospital must ensure that the death certificate is issued, that the cause of death is recorded and that no commercial dealing is involved.

Swap Transplantation and Paired Exchange

The Act permits swap transplantation where a near-relative donor is incompatible with the intended recipient but is compatible with another recipient, and the near-relative donor of that other recipient is compatible with the first recipient. Such paired exchange transplants require the approval of the Authorisation Committee.

Prohibition of Commercial Dealing

Section 19 of the Act prohibits the making or receiving of any payment for the supply of human organs. Any person who contravenes this provision is punishable with imprisonment for a term which may extend to ten years and with fine which may extend to one crore rupees. A registered medical practitioner who is convicted of an offence under this section may be suspended from practising medicine for a period of five years.

NOTTO, ROTTO and SOTTO

The Act establishes the National Organ and Tissue Transplant Organisation, Regional Organ and Tissue Transplant Organisations and State Organ and Tissue Transplant Organisations to coordinate organ procurement and allocation, to maintain registries of donors and recipients, and to promote deceased organ donation.

10.5 EUTHANASIA: THE RIGHT TO DIE WITH DIGNITY

Active and Passive Euthanasia

Euthanasia is the intentional ending of life to relieve pain and suffering. A distinction is drawn between active euthanasia, which involves the administration of a lethal substance to cause death, and passive euthanasia, which involves the withdrawal or withholding of life-sustaining treatment with the knowledge that this will result in death. Active euthanasia is illegal in India. The administration of a lethal injection or any other act intended to cause death is an offence under Section 302 or Section 304 of the Indian Penal Code, regardless of the motive or the consent of the patient. Passive euthanasia is legal in India under certain circumstances. The Supreme Court in Aruna Ramachandra Shanbaug v. Union of India recognised the legality of passive euthanasia for patients in a permanent vegetative state, subject to the approval of the High Court. The Court in Common Cause v. Union of India expanded this to recognise the validity of advance directives and to establish a comprehensive procedure for the withdrawal or withholding of life-sustaining treatment.

Advance Directives

An advance directive, also known as a living will, is a written document in which a person specifies the medical treatment they would or would not receive if they become terminally ill and incapable of making decisions. The Supreme Court in Common Cause held that the right to life under Article 21 includes the right to die with dignity and that the right to die with dignity includes the right to refuse life-sustaining treatment through an advance directive. An advance directive must be executed voluntarily, in writing and signed by the person making it and two attesting witnesses. It must specify the circumstances in which the directive is to operate and the treatment to be withheld or withdrawn. It must be registered with the jurisdictional health

department or handed over to the family physician. The directive may be revoked at any time by the person who made it.

When a person who has executed an advance directive becomes terminally ill and incapable of making decisions, the treating physician must verify the authenticity of the directive, confirm that the patient is in the condition specified in the directive and obtain the consent of the nominated representative or the family members. The physician must then constitute a primary medical board and a secondary medical board to confirm that the patient is terminally ill and that the conditions of the advance directive are satisfied. Only after these confirmations may life-sustaining treatment be withheld or withdrawn.

Persistent Vegetative State

For patients who have not executed an advance directive and are in a persistent vegetative state with no hope of recovery, the decision to withdraw life-sustaining treatment must be made by the near relatives in consultation with the medical board and must be approved by the High Court. The Supreme Court has prescribed a detailed procedure for such cases, including the constitution of medical boards, the involvement of the near relatives and the oversight of the court.

Palliative Care

The withdrawal or withholding of life-sustaining treatment is distinct from the administration of palliative care. The administration of opioids and other medications to relieve pain and suffering, even if such administration may have the secondary effect of hastening death, is lawful under the doctrine of double effect. The physician's intention is to relieve pain, not to cause death.

10.6 LEGAL ASPECTS OF DIAGNOSIS AND PRESCRIPTION

The Duty to Diagnose

The duty of care owed by a medical professional to a patient includes the duty to make a reasonably careful and competent diagnosis. This duty requires the doctor to take a thorough history, to conduct a proper physical examination, to order appropriate investigations and to correctly interpret the results of those investigations. A failure to diagnose, or a delayed diagnosis, may constitute negligence if the patient suffers injury as a result. The patient must prove that a reasonably competent practitioner would have made the diagnosis earlier and that the delay caused injury that would otherwise have been avoided. The standard of care in diagnosis is the same as in treatment: the doctor is judged by the practice of a responsible body of medical opinion. An error of judgment is not negligence. The doctor is not required to be infallible.

Pre-Conception and Pre-Natal Diagnostic Techniques

The PCPNDT Act, 1994 imposes specific obligations on medical professionals engaged in pre-natal diagnostic procedures. No pre-natal diagnostic procedure may be conducted unless the pregnant woman is over thirty-five years of age, has a history of genetic abnormalities or falls within other prescribed categories. The person conducting the procedure must explain the implications of the test and must obtain written consent. The sex of the foetus must not be

disclosed to the pregnant woman or her relatives. The Central Supervisory Board and State Supervisory Boards monitor compliance with the Act. Appropriate authorities at the district level conduct inspections, investigate complaints and initiate prosecution for violations.

The Prescription as a Legal Document

A prescription is a legal document. It is the written order from a registered medical practitioner to a pharmacist authorising the dispensing of a specified medication to a specified patient. The prescription must contain certain mandatory particulars. Every prescription must be in writing and must be dated. It must contain the name, address and registration number of the prescribing doctor. It must contain the name, age and gender of the patient. It must specify the name of the medication, the dose, the frequency, the route of administration and the duration of treatment. For narcotic drugs and psychotropic substances, the prescription must be in duplicate, and one copy must be retained by the pharmacist. The National Medical Commission Code of Medical Ethics Regulations, 2002 requires that every physician prescribe drugs with generic names wherever possible. The physician must ensure rational prescription and use of drugs. Prescribing irrational combinations, excessive quantities or unnecessary medications is unethical and may constitute professional misconduct.

Off-Label Prescribing

Off-label prescribing is the prescription of a medication for an indication, age group or dosage not approved by the Central Drugs Standard Control Organisation. Off-label prescribing is not illegal, but it carries additional risks and responsibilities. The physician must have a reasonable basis for believing that the off-label use is safe and effective, must inform the patient that the use is off-label and the reasons for the recommendation, and must monitor the patient closely for adverse effects.

10.7 LEGAL ASPECTS OF ADMINISTRATION OF DRUGS

The Five Rights

The administration of medications is a high-risk activity. Errors in medication administration are a leading cause of patient injury and malpractice claims. The standard of care requires the nurse or other healthcare professional administering the medication to verify the five rights: the right patient, the right drug, the right dose, the right route and the right time. The right patient must be verified by checking the patient's identity band and, where possible, asking the patient to state their name. The right drug must be verified by comparing the medication order with the medication label and, where necessary, checking against the patient's allergy status. The right dose must be verified by calculating the dose accurately and, for high-risk medications, having the calculation independently verified. The right route must be verified by confirming that the medication is intended for the route of administration ordered. The right time must be verified by checking the frequency of administration and the last dose administered.

High-Risk Medications

Certain medications are associated with a high risk of patient harm if administered in error. These include insulin, opioids, anticoagulants, chemotherapy agents and concentrated electrolytes. Hospitals must have specific policies and procedures for the prescribing,

dispensing and administration of high-risk medications. Insulin is a particular source of error. Units must be written in full; the abbreviation U must not be used. Insulin doses must be independently verified by two qualified healthcare professionals before administration. Opioids require special precautions. The prescription must specify the dose, frequency and route. The patient must be monitored for respiratory depression and oversedation. Naloxone must be readily available in areas where opioids are administered.

Medication Errors

A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm. Medication errors may occur at any stage of the medication use process: prescribing, dispensing, administration or monitoring. When a medication error occurs, the healthcare professional who discovers the error must immediately assess the patient for harm, notify the treating doctor and take corrective action. The error must be documented in the patient's medical record and reported through the hospital's incident reporting system. The hospital has a duty to be transparent with the patient and family about the error and its consequences.

Adverse Drug Reactions

An adverse drug reaction is a harmful or unintended response to a medication administered at normal doses. Adverse drug reactions are distinguished from medication errors; they may occur despite proper prescribing and administration. The hospital must have a system for the detection, documentation and reporting of adverse drug reactions to the Pharmacovigilance Programme of India.

10.8 LEGAL ASPECTS OF ANAESTHESIA AND SURGERY

Pre-Operative Assessment

The administration of anaesthesia is a high-risk medical act that requires careful pre-operative assessment. The anaesthesiologist must evaluate the patient's medical history, current medications, allergies and previous anaesthetic experiences. The patient must be risk-stratified using a standardised system such as the American Society of Anesthesiologists physical status classification. The pre-operative assessment must be documented in the patient's medical record. The anaesthesiologist must obtain informed consent for the anaesthetic procedure, explaining the type of anaesthesia, the risks and benefits, and the alternatives.

Intra-Operative Care

During surgery, the anaesthesiologist is responsible for monitoring the patient's vital signs, maintaining the airway, administering anaesthetic agents and other medications, and managing fluid balance. The anaesthesiologist must maintain a continuous record of the patient's physiological parameters and the medications administered. The standard of care in anaesthesia requires the use of monitoring equipment appropriate to the type of anaesthesia and the patient's condition. This includes pulse oximetry, capnography, electrocardiography and non-invasive blood pressure monitoring. For general anaesthesia, end-tidal carbon dioxide monitoring is mandatory.

Surgical Safety Checklist

The World Health Organization Surgical Safety Checklist is an evidence-based tool designed to reduce surgical complications and mortality. The checklist is completed at three critical junctures: before induction of anaesthesia, before skin incision and before the patient leaves the operating room. Each item on the checklist must be verbally confirmed by the surgical team and documented. The National Accreditation Board for Hospitals requires the use of the surgical safety checklist for accreditation. Non-use of the checklist, or incomplete or perfunctory use, may be evidence of negligence in the event of an adverse outcome.

Wrong-Site Surgery

Wrong-site surgery is a never event. It should never occur under any circumstances. The prevention of wrong-site surgery requires a systematic approach including preoperative site marking, a time-out procedure immediately before incision, and verification of the operative consent, the operating list and the imaging studies. Site marking must be performed by the operating surgeon, with the patient awake and participating. The mark must be unambiguous, using an indelible marker, and must be visible after skin preparation and draping. The mark must be at or near the incision site. The time-out must be conducted immediately before the start of the procedure, with all members of the surgical team pausing to confirm the correct patient, correct site and correct procedure. The time-out must be documented.

Retained Foreign Bodies

The retention of a surgical instrument, sponge or other foreign body in a patient after surgery is a never event. The prevention of retained foreign bodies requires a systematic approach including manual counting of sponges and instruments, the use of radio-frequency tagged sponges and instrument detection systems, and a standardised count reconciliation procedure. The count must be performed by two members of the surgical team, typically the circulating nurse and the scrub nurse. The count must be performed at the beginning of the procedure, before the closure of a cavity and at the conclusion of the procedure. Any discrepancy in the count must be reported to the surgeon immediately and must be resolved before wound closure.

10.9 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES

Consent Forms and Their Limitations

The consent form is a contractual document. It evidences the patient's agreement to undergo a specified procedure and confirms that the patient has been informed of the nature, risks and alternatives of the procedure. However, the consent form is not a waiver of liability. A patient cannot contractually waive their right to sue for negligence. Consent forms often contain clauses in which the patient acknowledges that they have been informed of the risks and that no guarantees have been made about the outcome. These clauses are evidentiary; they assist the doctor in defending against a claim that the patient was not adequately informed. They do not, however, exempt the doctor from liability for negligent performance of the procedure.

Contracts for Deceased Organ Donation

The Transplantation of Human Organs and Tissues Act, 1994 prohibits any payment for the supply of human organs. Any contract that provides for payment for organ donation is illegal

and void. The donor cannot enforce payment, and the recipient cannot recover payment already made.

Contracts for Medical Termination of Pregnancy

The Medical Termination of Pregnancy Act, 1971 requires that the termination be performed by a registered medical practitioner and, where the pregnancy exceeds twenty weeks, by two registered medical practitioners. A contract to perform a termination of pregnancy in violation of the Act is illegal and void. The patient cannot enforce the contract, and the doctor cannot recover fees for services rendered in contravention of the Act.

Advance Directives and Nominated Representatives

An advance directive is a contract between the person making the directive and the medical practitioners who will subsequently treat them. The directive is binding on the medical practitioners, subject to the verification and confirmation procedures prescribed by the Supreme Court. A medical practitioner who provides life-sustaining treatment in contravention of a valid advance directive may be liable for battery. The nominated representative appointed under the Mental Healthcare Act, 2017 has the authority to make treatment decisions on behalf of the person with mental illness when that person lacks capacity. The relationship between the nominated representative and the medical practitioner is contractual. The medical practitioner must comply with the decisions of the nominated representative, provided those decisions are consistent with the person's advance directive and with professional standards.

Confidentiality and Data Protection Contracts

Hospitals enter into contracts with third-party vendors for the storage and processing of patient data. These contracts must comply with the Digital Personal Data Protection Act, 2023. The hospital, as a fiduciary, must ensure that the vendor, as data processor, provides adequate safeguards for the protection of personal data. The contract must specify the purpose and duration of processing, the categories of data processed and the obligations of the data processor. The contract must also provide for audit rights and for the return or destruction of data upon termination of the contract.

10.10 STUDENT LEARNING ACTIVITIES

Activity 1: Narcotic Drugs Audit and Compliance

You are the Administrator of a three hundred bed multi-speciality hospital. The Narcotics Commissioner's office has issued a show-cause notice to the hospital alleging irregularities in the maintenance of narcotic drugs registers. An inspection revealed that the register for morphine injections was not maintained on a daily basis, that the stock balance did not match the physical count, and that prescriptions for Schedule X drugs were not being retained as required. Conduct a comprehensive audit of the hospital's compliance with the Narcotic Drugs and Psychotropic Substances Act, 1985 and the Drugs and Cosmetics Act, 1940. Your audit should cover the licensing status of the pharmacy, the storage facilities for narcotic drugs and psychotropic substances, the maintenance of registers, the verification of prescriptions, the training of pharmacy and nursing staff, and the disposal of expired or surplus narcotic drugs. Prepare a corrective action plan with specific timelines and responsible persons, and draft a response to the show-cause notice.

Activity 2: Organ Transplant Authorisation Committee Simulation

The State Government has constituted you as a member of the District Level Authorisation Committee under the Transplantation of Human Organs and Tissues Act, 1994. An application has been received for approval of a living donor kidney transplant. The donor is a twenty-eight year old man who claims to be a friend of the fifty-five year old recipient. The donor and recipient reside in different districts and have provided affidavits stating that they have known each other for five years. The tissue matching report indicates ninety per cent HLA matching. The social worker's report notes that the donor is unemployed and that the recipient is a wealthy businessman. Draft a detailed procedure for the Authorisation Committee to follow in evaluating this application. Your procedure should address the verification of identity and addresses, the assessment of the donor's understanding of the procedure and its risks, the assessment of the voluntariness of the consent, the inquiry into the relationship between the donor and recipient, the documentation of the proceedings and the criteria for approval or rejection. Prepare a set of questions to be asked to the donor and recipient during the interview, and draft a reasoned order either granting or refusing approval based on the facts provided.

Activity 3: Advance Directive and End-of-Life Care Policy

A seventy-two year old patient with terminal metastatic cancer has been admitted to your hospital. The patient has executed an advance directive under the Supreme Court's guidelines in Common Cause v. Union of India, stating that she does not wish to receive artificial nutrition and hydration, mechanical ventilation or cardiopulmonary resuscitation. Her son, who is her nominated representative, supports the advance directive. The treating physician is uncomfortable withholding artificial nutrition and hydration and has requested legal guidance. Draft a comprehensive hospital policy on advance directives and end-of-life care. Your policy should address the procedure for verification and registration of advance directives, the determination of the patient's capacity, the constitution and functions of the primary and secondary medical boards, the role of the nominated representative and family members, the documentation requirements and the procedure for resolving disagreements among stakeholders. Also draft a guidance note for medical staff on the distinction between withholding life-sustaining treatment and administering palliative care.

Activity 4: Surgical Safety Checklist Implementation

The National Accreditation Board for Hospitals has conducted a surveillance visit to your hospital and has issued a non-conformity regarding the implementation of the surgical safety checklist. The auditors observed that the time-out procedure was being conducted inconsistently, that site marking was not being performed for some procedures, and that the checklist was being completed retrospectively rather than at the designated time points. Design a comprehensive surgical safety programme for the hospital. Your programme should include a revised surgical safety checklist policy, a training module for surgeons, anaesthesiologists and nurses, a process for preoperative site marking, a standardised time-out script, a system for documentation and audit, and a non-punitive incident reporting mechanism for near misses. Develop a one-page visual aid for display in all operating rooms summarising the three phases of the checklist and the key actions required at each phase.

10.11 SUMMARY

The legal framework governing poisons, narcotic drugs and psychotropic substances is designed to prevent diversion of these substances for illicit purposes while ensuring their availability for legitimate medical use. Hospitals must be licensed under the Drugs and Cosmetics Act, 1940 and, where they handle narcotic drugs, under the Narcotic Drugs and Psychotropic Substances Act, 1985. Narcotic drugs must be stored in double-locked cabinets, registers must be maintained on a daily basis, and prescriptions must be in writing, in duplicate and retained for the prescribed period. Bio-medical waste must be managed in accordance with the Bio-Medical Waste Management Rules, 2016.

The Transplantation of Human Organs and Tissues Act, 1994 regulates the removal and transplantation of human organs and tissues. Living donor transplantation is permitted for near relatives without authorisation committee approval, and for altruistic donors with approval. Near relatives include spouse, parents, children, siblings, grandparents and grandchildren. Brain-stem death is recognised as a form of death and must be certified by a board of four medical experts. Commercial dealing in human organs is prohibited and punishable with imprisonment up to ten years and fine up to one crore rupees.

Euthanasia is the intentional ending of life to relieve pain and suffering. Active euthanasia, the administration of a lethal substance, is illegal in India. Passive euthanasia, the withdrawal or withholding of life-sustaining treatment, is legal under certain circumstances. The Supreme Court has recognised the validity of advance directives, which are written documents in which a person specifies the medical treatment they would or would not receive if they become terminally ill and incapable of making decisions. Advance directives must be executed voluntarily, in writing and with two attesting witnesses. They are binding on medical practitioners, subject to verification and confirmation by medical boards.

The legal aspects of diagnosis and prescription require the medical professional to exercise reasonable care and skill in making a diagnosis and in prescribing medications. Prescriptions are legal documents and must contain the mandatory particulars. The PCPNDT Act, 1994 prohibits the use of pre-natal diagnostic techniques for sex selection and prohibits the communication of the sex of the foetus.

The administration of drugs requires strict adherence to the five rights: right patient, right drug, right dose, right route and right time. High-risk medications, including insulin, opioids and anticoagulants, require additional precautions. Medication errors must be documented and reported, and the patient must be informed.

Anaesthesia and surgery are high-risk medical acts that require careful pre-operative assessment, intra-operative monitoring and post-operative care. The surgical safety checklist is an evidence-based tool that reduces surgical complications and mortality. Wrong-site surgery and retained foreign bodies are never events that should never occur and, when they do occur, are prima facie evidence of negligence.

Healthcare-specific contractual issues include the limitations of consent forms, the illegality of contracts for payment for organ donation, the binding nature of advance directives, and the obligations of data fiduciaries under the Digital Personal Data Protection Act, 2023.

10.12 KEY WORDS WITH EXPLANATIONS

Narcotic Drugs and Psychotropic Substances include opium, morphine, codeine, heroin and other derivatives of the opium poppy as narcotic drugs, and amphetamines, barbiturates, benzodiazepines and other substances with central nervous system effects as psychotropic substances. They are regulated under the NDPS Act, 1985.

Schedule H and Schedule X Drugs are prescription-only medications under the Drugs and Cosmetics Rules. Schedule H drugs cannot be sold except on the prescription of a registered medical practitioner. Schedule X drugs are narcotic and psychotropic substances subject to stricter regulation, including prescription in duplicate and retention by the pharmacist for two years.

THOTA is the Transplantation of Human Organs and Tissues Act, 1994, the principal legislation regulating organ and tissue transplantation in India. It prohibits commercial dealing, regulates living and deceased donation, and establishes authorisation committees and brain death certification procedures.

Brain-Stem Death is the irreversible cessation of all functions of the brain-stem, recognised as a form of death under the THOTA, 1994. Certification must be made by a board of four medical experts, with two certifications conducted six hours apart.

Near Relative is defined under the THOTA, 1994 as spouse, parents, children, siblings, grandparents and grandchildren. Near relatives may donate organs without authorisation committee approval.

Authorisation Committee is a committee constituted by the appropriate government under the THOTA, 1994 to approve living donor transplants where the donor is not a near relative. It must interview the donor and recipient, verify identities, assess voluntariness and record proceedings on video.

Euthanasia is the intentional ending of life to relieve pain and suffering. Active euthanasia is illegal in India; passive euthanasia is legal under certain circumstances. It is distinguished from physician-assisted suicide, which is also illegal.

Advance Directive is a written document in which a person specifies the medical treatment they would or would not receive if they become terminally ill and incapable of making decisions. It is recognised by the Supreme Court in Common Cause v. Union of India and is binding on medical practitioners subject to verification and confirmation procedures.

PCPNDT Act is the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994. It prohibits the use of pre-natal diagnostic techniques for sex selection and prohibits the communication of the sex of the foetus to the pregnant woman or her relatives.

Surgical Safety Checklist is an evidence-based tool developed by the World Health Organization to reduce surgical complications and mortality. It is completed at three critical

junctures: before induction of anaesthesia, before skin incision and before the patient leaves the operating room.

Never Event is a serious, preventable patient safety incident that should never occur if appropriate safeguards are implemented. Examples include wrong-site surgery, retained foreign body and wrong-route administration of medication.

Five Rights are the five verifications required before medication administration: right patient, right drug, right dose, right route and right time. They constitute the standard of care for medication administration.

10.13 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What are the storage and record-keeping requirements for narcotic drugs under the Narcotic Drugs and Psychotropic Substances Act, 1985?

Ans. Narcotic drugs must be stored in a double-locked cabinet or safe, with access restricted to authorised personnel. The hospital must maintain a register of narcotic drugs in Form NC-1, recording the receipt, issue and balance of each drug on a daily basis. The register must be available for inspection by the Narcotics Commissioner or any authorised officer. Prescriptions for narcotic drugs must be in duplicate, and one copy must be retained by the pharmacist for a period of two years.

Q2. Who constitutes the board for certification of brain-stem death under the Transplantation of Human Organs and Tissues Act, 1994?

Ans. The certification of brain-stem death must be made by a board of four medical experts: the medical superintendent or nominee of the hospital in which the person has died; the treating physician; a neurologist or neurosurgeon; and a surgeon or physician nominated by the medical administrator from the panel of experts approved by the appropriate authority. The certification must be conducted twice, with an interval of six hours.

Q3. What is the distinction between active euthanasia and passive euthanasia, and what is the legal status of each in India?

Ans. Active euthanasia is the intentional administration of a lethal substance to cause death. Passive euthanasia is the withdrawal or withholding of life-sustaining treatment with the knowledge that this will result in death. Active euthanasia is illegal in India and constitutes an offence under Section 302 or Section 304 of the Indian Penal Code. Passive euthanasia is legal in India under certain circumstances: for patients who have executed a valid advance directive, or for patients in a persistent vegetative state with the approval of the High Court.

Q4. What are the mandatory particulars that must be included in a valid prescription?

Ans. A valid prescription must be in writing and dated. It must contain the name, address and registration number of the prescribing doctor. It must contain the name, age and gender of the patient. It must specify the name of the medication, the dose, the frequency, the route of

administration and the duration of treatment. For narcotic drugs and psychotropic substances, the prescription must be in duplicate.

Q5. What is the legal status of off-label prescribing in India?

Ans. Off-label prescribing, the prescription of a medication for an indication, age group or dosage not approved by the Central Drugs Standard Control Organisation, is not illegal in India. However, it carries additional responsibilities. The physician must have a reasonable basis for believing that the off-label use is safe and effective, must inform the patient that the use is off-label and the reasons for the recommendation, and must monitor the patient closely for adverse effects. Off-label prescribing that is negligent or fraudulent may constitute professional misconduct.

B. Essay Type Questions with Hints

Q1. Critically examine the regulatory framework for organ transplantation in India under the Transplantation of Human Organs and Tissues Act, 1994. How does the Act balance the need to increase organ donation against the imperative to prevent commercial exploitation?

Hints: Begin with the legislative history and purpose of the THOTA, 1994. Explain the distinction between near relatives and altruistic donors, and the different regulatory requirements for each. Discuss the role of the Authorisation Committee and the safeguards against commercial dealing: verification of identity, assessment of voluntariness, video recording of proceedings and prohibition of payment. Explain the recognition of brain-stem death and the certification procedure. Discuss the swap transplantation and paired exchange provisions. Analyse the effectiveness of the Act in achieving its objectives, referring to the organ trafficking case study. Identify gaps and challenges: inadequate infrastructure for deceased donor transplantation, variations in Authorisation Committee practices and the need for greater public awareness. Conclude with recommendations for reform.

Q2. Analyse the Supreme Court's jurisprudence on euthanasia and advance directives from Aruna Ramachandra Shanbaug to Common Cause v. Union of India. What is the procedure for executing and implementing an advance directive, and what safeguards are in place to prevent misuse?

Hints: Begin with the facts and holding in Aruna Shanbaug: recognition of passive euthanasia for patients in persistent vegetative state, requirement of High Court approval. Explain the evolution in Common Cause: recognition of advance directives as an incident of the right to die with dignity, detailed procedure for execution and implementation. Describe the requirements for a valid advance directive: voluntary execution, writing, two attesting witnesses, registration or custody, specification of circumstances and treatment. Explain the procedure for implementation: verification of directive, confirmation of terminal illness, primary and secondary medical boards, involvement of nominated representative and family. Discuss the safeguards against misuse: cooling-off period, multiple medical opinions, judicial oversight in cases without advance directives. Conclude with an assessment of whether the procedure is workable and the implementation challenges.

Q3. Discuss the legal obligations of hospitals and medical professionals under the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994. What are the prohibited practices, and what are the penalties for contravention?

Hints: Explain the constitutional context: the right to life of the female child, the need to address sex-selective abortion. Describe the scope of the Act: prohibition of sex selection before and after conception, regulation of pre-natal diagnostic techniques, prohibition of communication of foetal sex. Discuss the registration requirements for genetic counselling centres, genetic laboratories and genetic clinics. Explain the conditions for conducting pre-natal diagnostic procedures: age of pregnant woman, history of genetic abnormalities, written consent. Discuss the record-keeping requirements and the display of notices. Analyse the enforcement mechanism: Central Supervisory Board, State Supervisory Boards, appropriate authorities at district level. Explain the penalties: imprisonment up to three years and fine for first offence, imprisonment up to five years and fine for subsequent offences, suspension or cancellation of registration. Conclude with the role of hospital administrators in ensuring compliance.

Q4. Evaluate the legal and ethical issues surrounding never events in surgery, with particular reference to wrong-site surgery and retained foreign bodies. What systems and protocols should hospitals implement to prevent these events?

Hints: Define never events and explain why they are considered prima facie evidence of negligence. Describe the epidemiology and causes of wrong-site surgery: communication failures, inadequate site marking, lack of time-out procedure. Describe the epidemiology and causes of retained foreign bodies: count discrepancies, fatigue, complex procedures. Explain the WHO Surgical Safety Checklist and the evidence for its effectiveness. Discuss the specific protocols for site marking: surgeon to perform marking, patient awake and participating, unambiguous mark, visible after preparation. Discuss the specific protocols for instrument and sponge counts: two-person count, count at beginning, before cavity closure and at conclusion; reconciliation of discrepancies; use of technology. Discuss the legal consequences of never events: civil liability for negligence, professional misconduct proceedings, criminal prosecution in cases of gross negligence. Conclude with the hospital administrator's responsibility to implement systems, train staff and foster a culture of safety.

Q5. You are the Administrator of a two hundred fifty bed corporate hospital. The hospital has been served with a show-cause notice by the State Drugs Control Authority alleging that the pharmacy has been dispensing Schedule H drugs without verifying prescriptions, that the narcotic drugs register has not been maintained for the preceding three months, and that expired drugs have not been disposed of in accordance with the Bio-Medical Waste Management Rules. Draft a comprehensive response to the show-cause notice and a corrective action plan.

Hints: Structure your answer as a formal response to the regulatory authority. Acknowledge the receipt of the show-cause notice and express commitment to compliance. Address each allegation separately, with factual admissions or denials and explanations for any deficiencies. For Schedule H drugs: describe the corrective action taken, including training of pharmacy staff, implementation of prescription verification protocol and enhanced supervision. For narcotic drugs register: describe the immediate reconciliation of stock, the reconstitution of the register and the appointment of a designated narcotic drugs custodian. For expired drugs: describe the immediate segregation and storage of expired drugs, the engagement of a common bio-medical waste treatment facility and the procedure for regular disposal. Provide a detailed corrective action plan with timelines and responsible persons. Conclude with an undertaking of future compliance and a request for closure of the proceedings.

C. Analytical Multiple Choice Questions

1. Under the Transplantation of Human Organs and Tissues Act, 1994, which of the following is NOT considered a near relative for the purpose of living donor transplantation?
a) Spouse
b) Siblings
c) Grandparents
d) First cousin
Correct Answer: d) First cousin

2. Under the Narcotic Drugs and Psychotropic Substances Act, 1985, a prescription for a Schedule X drug must be:
a) In writing, dated and retained by the patient
b) In writing, in duplicate, and one copy retained by the pharmacist for two years
c) In writing, in triplicate, and one copy sent to the Narcotics Commissioner
d) Oral, with written confirmation within twenty-four hours
Correct Answer: b) In writing, in duplicate, and one copy retained by the pharmacist for two years

3. The Supreme Court in Common Cause v. Union of India recognised the validity of advance directives. Which of the following is NOT a requirement for a valid advance directive?
a) It must be executed voluntarily and in writing
b) It must be signed by the person making it and two attesting witnesses
c) It must be approved by a medical board before execution
d) It may be revoked at any time by the person who made it
Correct Answer: c) It must be approved by a medical board before execution

4. A patient undergoes surgery and a surgical sponge is inadvertently left in the abdomen, discovered three weeks later. Under the doctrine of res ipsa loquitur:
a) The patient must prove that the surgeon was negligent
b) The surgeon must prove that they were not negligent
c) The hospital must prove that the patient contributed to the error
d) The sponge manufacturer is strictly liable
Correct Answer: b) The surgeon must prove that they were not negligent

5. Under the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, the sex of the foetus:
a) May be disclosed to the pregnant woman if she requests
b) May be disclosed to the spouse with the woman's consent
c) May not be disclosed to the pregnant woman or her relatives
d) May be disclosed only after twenty-four weeks of pregnancy
Correct Answer: c) May not be disclosed to the pregnant woman or her relatives

6. A patient is administered an antibiotic to which they have a documented severe allergy. The allergy is clearly noted in the medical record. The nurse administering the medication fails to check the allergy status. The patient suffers anaphylaxis and dies. The nurse's actions constitute:
a) Simple negligence, civil liability only
b) Gross negligence, potential criminal liability under Section 304A IPC

c) No negligence, as the doctor prescribed the medication
d) Contributory negligence by the patient
Correct Answer: b) Gross negligence, potential criminal liability under Section 304A IPC

7. Under the Transplantation of Human Organs and Tissues Act, 1994, swap transplantation (paired exchange) requires:
a) No approval, as both donors are near relatives
b) Approval of the hospital's ethics committee
c) Approval of the Authorisation Committee
d) Approval of the State Health Department
Correct Answer: c) Approval of the Authorisation Committee

10.14 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Compatible Donor, The Incompatible Committee

Maharaja Agrasen Superspeciality Hospital is a three hundred fifty bed tertiary care hospital located in a metropolitan city, registered as a private limited company and accredited by NABH. The hospital has a well-established nephrology and renal transplant programme with two full-time nephrologists, a transplant surgeon and a dedicated transplant coordinator. The hospital is registered under the Transplantation of Human Organs and Tissues Act, 1994 and has performed approximately one hundred fifty renal transplants over the preceding five years.

Mr. Rajesh Sharma, a forty-eight year old businessman, has been on maintenance haemodialysis for three years due to end-stage renal disease secondary to diabetes. His wife, Mrs. Sunita Sharma, aged forty-five, volunteered to donate her kidney. Tissue typing revealed that Mrs. Sharma was incompatible due to blood group mismatch and positive cross-match. The transplant coordinator initiated a search for a compatible donor through the National Organ and Tissue Transplant Organisation's paired exchange network. A match was identified. Mr. Venkatesh Iyer, a thirty-two year old software engineer, was willing to donate a kidney to Mr. Sharma. Mrs. Sharma was compatible with Mr. Iyer's uncle, who was also in need of a transplant. The swap transplant was arranged.

The hospital submitted an application to the State Authorisation Committee for approval of the swap transplant. The application included identification documents of both donors and both recipients, affidavits from both donors stating that they were donating voluntarily without any payment or coercion, affidavits from both recipients stating that no payment was made or promised, tissue typing and cross-match reports confirming compatibility, and medical fitness reports for both donors.

The Authorisation Committee, composed of the Director of Health Services, a nephrologist from a government hospital, a legal expert and a social worker, scheduled a hearing conducted via video conference. Each donor and recipient was interviewed separately. During the interview, the Committee noted that Mr. Iyer was thirty-two years old, unmarried and lived with his elderly mother. He was the sole earning member of the family. He stated that he had known the recipient's family for two years through a common friend. When asked about his motivation for donation, he stated that he wanted to help a fellow human being. The Committee inquired whether Mr. Iyer had received any payment or promise of payment, or any offer of employment, business opportunity or other benefit. He denied this. The Committee noted that the HLA matching between Mr. Iyer and Mr. Sharma was ninety-five per cent, which is

unusually high for unrelated individuals. The Committee asked Mr. Iyer whether he had any genetic relationship with Mr. Sharma. He stated that he did not. The Committee interviewed Mrs. Sharma, who confirmed that she had met Mr. Iyer on two occasions through the transplant coordinator and denied any financial arrangement.

The Authorisation Committee issued an order declining to approve the swap transplant. The order stated that the Committee was not satisfied that the donation was altruistic and voluntary. The donor, Mr. Iyer, was young, unmarried and the sole earning member of his family. His motivation for donating a kidney to a stranger was not adequately explained. The high degree of HLA matching between unrelated individuals raised a suspicion of undisclosed genetic relationship or commercial dealing. In the absence of independent verification of the donor's financial circumstances and the relationship between the parties, the Committee was unable to certify that this was not a commercial transaction. The Committee recommended that the hospital conduct a more thorough social and financial investigation and reapply with additional documentation.

The hospital was dismayed by the Committee's order. The transplant coordinator had conducted a thorough psychosocial evaluation of Mr. Iyer, which included verification of his employment, income and family circumstances. The coordinator had interviewed his mother, who supported his decision. There was no evidence of any financial transaction. The high HLA matching was coincidental but not unprecedented. The hospital believed that the Committee had applied an excessively stringent standard and had effectively blocked a legitimate, altruistic transplant.

The hospital decided to reapply with additional documentation. It obtained a detailed affidavit from Mr. Iyer's employer confirming his employment, salary and that he had not received any unusual payments or benefits; a certificate from a chartered accountant confirming that no large deposits had been made in Mr. Iyer's bank accounts in the preceding six months; a psychological evaluation report from an independent psychiatrist confirming that Mr. Iyer had decision-making capacity and that his motivation was consistent with altruistic donation; and a letter from the National Organ and Tissue Transplant Organisation confirming that the high degree of HLA matching was within the expected range for the Indian population and did not indicate genetic relationship. The Committee reconsidered the application and granted approval. The transplant was successfully performed.

Questions for Analysis with Hints

Q1. Analyse the role and functions of the Authorisation Committee under the Transplantation of Human Organs and Tissues Act, 1994. What is the Committee's mandate, and what are the limits of its powers? Did the Committee in this case act within its jurisdiction?

Hints: The Authorisation Committee is constituted under Rule 7 of the Transplantation of Human Organs and Tissues Rules, 2014. Its mandate is to approve living donor organ transplantation where the donor is not a near relative. The Committee must satisfy itself that the donation is voluntary and altruistic, that no commercial dealing is involved, and that the donor has given informed consent after understanding the nature and risks of the procedure. The Committee's powers are investigative and evaluative, not inquisitorial. It may interview the donor and recipient, verify their identities and addresses, and inquire into their relationship and the circumstances of the proposed donation. Its jurisdiction is limited to determining

whether the statutory conditions for approval are satisfied. It is not empowered to impose additional conditions not found in the Act or Rules. It cannot refuse approval on the basis of suspicion or speculation. Its decision must be based on evidence and must be supported by reasons. In this case, the Committee acted within its jurisdiction in inquiring into the donor's motivation and financial circumstances, but its reliance on the donor's age, marital status and family responsibilities as grounds for suspicion was problematic. These factors are not evidence of commercial dealing and are equally consistent with genuine altruism. The Committee's refusal to approve the transplant without any affirmative evidence of commercial dealing was an excessive application of its powers.

Q2. Evaluate the Committee's concerns regarding the donor's age, marital status and financial circumstances. Are these factors relevant to the determination of whether a donation is altruistic and voluntary? What evidentiary standard should the Committee apply?

Hints: The donor's age, marital status and financial circumstances are relevant factors in the overall assessment of voluntariness and altruism, but they are not determinative. A young, unmarried, sole earning member of a family may be a perfectly altruistic donor. Conversely, a middle-aged, married, financially secure donor may be motivated by commercial considerations. The evidentiary standard that the Committee should apply is the balance of probabilities. The Committee must be satisfied, on the totality of the evidence, that it is more likely than not that the donation is voluntary and altruistic and that no commercial dealing is involved. The Committee should not require proof beyond reasonable doubt, nor should it require the hospital or the donor to prove a negative. The Committee should consider the consistency of the donor's account, the presence or absence of financial or other inducements, the relationship between the donor and recipient, the donor's understanding of the procedure and its risks, the donor's decision-making capacity, and the absence of coercion or undue influence. The absence of any affirmative evidence of commercial dealing, coupled with positive evidence of altruistic motivation, should ordinarily be sufficient to satisfy the Committee.

Q3. Discuss the evidentiary dilemma in proving the absence of commercial dealing. How can a hospital demonstrate that no payment has been made or promised? What safeguards can be implemented to prevent organ trafficking without imposing unreasonable burdens on legitimate altruistic donors?

Hints: The evidentiary dilemma in proving the absence of commercial dealing is inherent in the regulatory framework. The Act prohibits payment, but it does not require the donor to prove that no payment has been made. The burden is on the Committee to assess whether, on the totality of the evidence, it is satisfied that no commercial dealing is involved. Hospitals can assist the Committee by implementing robust safeguards and providing comprehensive documentation. These safeguards should include: a detailed psychosocial evaluation of the donor conducted by a qualified social worker or psychologist assessing motivation, understanding, decision-making capacity and freedom from coercion; verification of the donor's identity, address, employment and bank statements to identify any significant deposits or unusual financial transactions; a cooling-off period between the initial expression of interest and the donation; independent confirmation of the donor's account of their relationship with the recipient through interviews with family members or friends; and documentation of all communications between the hospital, the donor and the recipient. These safeguards do not eliminate the risk of commercial dealing, but they reduce it and provide the Committee with a substantial evidentiary basis for its decision.

Q4. Assess the hospital's response to the Committee's order. Was the decision to reapply with additional documentation appropriate? What alternative courses of action were available, and what are the advantages and disadvantages of each?

Hints: The hospital's decision to reapply with additional documentation was appropriate and pragmatic. The hospital had invested substantial resources in identifying the matched pair and preparing the donors and recipients. The recipients were deteriorating on dialysis. An appeal to the State Government or NOTTO would have been time-consuming and uncertain in outcome. Litigation challenging the Committee's order would have been adversarial and would have delayed the transplant further. The hospital's strategy was to address the Committee's concerns directly by providing the additional documentation that the Committee had implicitly requested. The employer's affidavit, the chartered accountant's certificate, the independent psychiatric evaluation and the letter from NOTTO addressing the HLA matching issue were responsive to the Committee's concerns. The alternative courses of action were less attractive. An appeal to the State Government would have been heard by the same officials who had appointed the Committee members; the likelihood of reversal was low. Litigation in the High Court would have been expensive, time-consuming and uncertain; the hospital would have had to establish that the Committee's decision was arbitrary and unreasonable, a high evidentiary burden. The decision to reapply was the most efficient and least adversarial option.

Q5. As the transplant coordinator of Maharaja Agrasen Superspeciality Hospital, you have been directed to develop a comprehensive standard operating procedure for swap transplantation applications. Your SOP should address the psychosocial evaluation of donors, the verification of donor-recipient relationship, the documentation required for Authorisation Committee approval, the preparation of donors and recipients for the Committee hearing, and the procedure for responding to Committee queries and orders.

Hints: The SOP must require that all potential living donors undergo a comprehensive psychosocial evaluation conducted by a qualified social worker or psychologist assessing motivation, understanding of the surgical procedure and risks, decision-making capacity, absence of coercion or undue influence, and expectations regarding the outcome. For swap transplantation, the hospital shall verify the relationship between each donor and their intended recipient through review of identification documents, interviews conducted separately and jointly, corroboration through interviews with family members, and review of any documentary evidence of the relationship including photographs or correspondence. The application to the Authorisation Committee shall include the completed application form, identification documents of all donors and recipients, affidavits of voluntary donation from all donors, affidavits of no payment from all recipients, tissue typing and cross-match reports, medical fitness reports for all donors, psychosocial evaluation reports, financial verification documents, and hospital undertaking regarding compliance with THOTA. The transplant coordinator shall prepare the donors and recipients for the Committee hearing by explaining the purpose and procedure of the hearing, reviewing the questions likely to be asked, rehearsing responses to ensure accuracy and consistency, and providing counselling to reduce anxiety. If the Committee raises queries or requests additional documentation, the hospital shall respond promptly and comprehensively, addressing each query specifically and providing all requested documentation. If the Committee refuses approval, the hospital shall consider reapplication with additional documentation, appeal to the State Government under Rule 7, appeal to NOTTO, or judicial review before the High Court, with the choice of remedy determined by

the nature of the Committee's concerns, the urgency of the transplant and the likelihood of success.

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The law cannot permit the exploitation of the poor and vulnerable by those who would profit from their distress. The Transplantation Act is a shield against such exploitation. But it must not become a barrier to the legitimate exercise of human compassion. To distinguish the altruistic donor from the exploited vendor is the difficult task of the Authorisation Committee.

** Supreme Court of India, Kuldeep Singh v. State of Tamil Nadu (2005)**

LESSON-11

FOUNDATIONS AND PROCESS OF COUNSELLING

LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Define counselling and distinguish it from related activities such as advice-giving, psychotherapy and information dissemination
2. Trace the historical evolution of the counselling profession from the vocational guidance movement to its contemporary status in healthcare
3. Compare and contrast the major theoretical approaches to counselling including psychodynamic, behavioural, cognitive-behavioural and humanistic approaches
4. Describe the sequential stages of the counselling process from relationship building through exploration, intervention and termination
5. Identify the core attitudes and micro-skills of effective counsellors including empathy, unconditional positive regard, congruence, active listening and reflection

STRUCTURE OF THE LESSON

11.1 INTRODUCTION: THE TALKING CURE IN HEALTHCARE

The hospital is a place of bodies. Its primary instruments are the scalpel, the syringe, the scanner. Its primary language is the language of pathology, physiology and pharmacology. Yet every experienced clinician knows that the patient who enters the hospital brings more than a diseased organ. They bring fear, uncertainty, hope and despair. They bring family members who are anxious, exhausted and sometimes angry. They bring questions that cannot be answered by a laboratory report: Why did this happen to me? What will become of my children? Is my life over? Counselling is the systematic application of the talking cure to these questions. It is a professional relationship in which a trained counsellor assists a client to explore their feelings, clarify their thoughts, understand their situation and make their own decisions. It is not advice-giving, though it may involve information. It is not psychotherapy, though it draws on many of the same theoretical foundations. It is a distinct discipline with its own history, its own body of knowledge and its own skills. For the hospital administrator, counselling is both a service provided to patients and a skill required of managers. Patient counselling improves adherence to treatment, reduces anxiety and enhances satisfaction. Staff counselling reduces burnout, resolves conflict and improves retention. The administrator who understands the foundations and process of counselling is better equipped to design effective counselling services, to supervise counsellors and to apply counselling skills in their own interactions with patients, families and staff. This lesson examines the foundations and process of counselling. It begins with the concept of counselling and its distinction from related activities. It traces the growth of counselling services from their origins in the vocational guidance movement to their current status as an essential component of comprehensive healthcare. It surveys the major theoretical approaches that inform counselling practice. It describes the sequential stages of the counselling process and the core attitudes and micro-skills that distinguish effective counsellors.

11.2 INTRODUCTORY CASE STUDY: THE SILENT PATIENT – WHEN EMPATHY REACHED THROUGH THE WALL

Mrs. Meera Krishnamurthy, a fifty-eight year old widow, was admitted to the oncology ward of a tertiary care hospital in Chennai with a diagnosis of Stage IV ovarian cancer. She had undergone debulking surgery and was receiving her third cycle of chemotherapy. She was cachectic, fatigued and in chronic pain. She had been a school teacher for thirty-four years and had retired the previous year. Her husband had died of a heart attack five years earlier. Her only son was employed in the United States and had not been able to travel due to visa delays. Mrs. Krishnamurthy was referred to the hospital's psycho-oncology service for assessment of depression. The referring oncologist noted that she was withdrawn, refused to eat, declined to participate in physiotherapy and had stopped communicating with the nursing staff. She lay in bed facing the wall, responding to questions with monosyllables or silence.

Ms. Priya Rajan, a counsellor with five years of experience in oncology settings, visited Mrs. Krishnamurthy in her room. She introduced herself, explained her role and asked Mrs. Krishnamurthy how she was feeling. Mrs. Krishnamurthy did not respond. She continued to face the wall. Ms. Rajan sat in silence for five minutes. She then said quietly: I am going to sit here with you for a while. You don't have to talk. I will just be here. She visited again the next day. She sat for ten minutes without speaking. On the third day, she brought a cup of tea and placed it on the bedside table. She said: I thought you might like some tea. I don't know if you like tea, but I always find it comforting. On the fourth day, Mrs. Krishnamurthy spoke. Her

voice was barely audible. She said: My husband used to bring me tea every morning. He would wake up before me and make it exactly the way I liked it. I haven't had tea since he died.

Over the following weeks, Ms. Rajan met with Mrs. Krishnamurthy three times a week. The sessions were initially brief, fifteen to twenty minutes. Mrs. Krishnamurthy spoke haltingly, often falling silent. Ms. Rajan did not press her. She reflected Mrs. Krishnamurthy's feelings: It sounds like you miss him very much. It sounds like you feel alone. She did not offer advice, reassurance or solutions. Gradually, Mrs. Krishnamurthy began to speak more freely. She spoke about her husband, their life together, his sudden death. She spoke about her son, her pride in his achievements, her loneliness without him. She spoke about her fear of death, her regret that she would not see her grandchildren, her anger that her life had been cut short just as she was about to enjoy her retirement. Ms. Rajan listened. She did not try to fix, to reframe or to cheer. She sat with Mrs. Krishnamurthy in her grief, her fear, her anger. She communicated, without words, that these feelings were acceptable, that Mrs. Krishnamurthy was not alone in them and that she was valued as a person regardless of her illness. Mrs. Krishnamurthy's mood improved. She began to eat, to participate in physiotherapy, to interact with the nursing staff. She started to write letters to her son, which Ms. Rajan helped her to send. She spoke to the oncologist about her treatment preferences and completed an advance directive. She died peacefully six weeks later, with Ms. Rajan present in the room.

Relevance to the Lesson: This case illustrates the essence of counselling. It is not about giving advice or providing solutions. It is about being present with another person in their suffering. It is about communicating acceptance and understanding without judgment. It is about creating a space in which the client can explore their own feelings and find their own way. The case also illustrates the core conditions of effective counselling identified by Carl Rogers: empathy, the ability to understand the client's internal frame of reference; unconditional positive regard, the acceptance of the client as a person of worth regardless of their behaviour or circumstances; and congruence, the genuineness and authenticity of the counsellor. Ms. Rajan did not need to be an expert in oncology or thanatology. She needed to be present, to listen and to care.

11.3 CONCEPT OF COUNSELLING: DEFINITION AND DISTINCTIONS

Defining Counselling

Counselling is a professional relationship between a trained counsellor and a client, in which the counsellor assists the client to explore their concerns, clarify their thoughts and feelings, understand their situation and make their own decisions. The British Association for Counselling and Psychotherapy defines counselling as the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources. Several elements of this definition warrant emphasis. Counselling is a relationship; it is not a technique applied to a passive recipient. It is professional, requiring training, supervision and adherence to ethical standards. It is client-centred; the counsellor does not impose solutions but facilitates the client's own exploration and decision-making. It is concerned with self-knowledge, emotional acceptance and growth, not merely with symptom relief.

Distinction from Advice-Giving

Counselling is often confused with advice-giving. An advisor diagnoses the problem, identifies the solution and instructs the client on what to do. A counsellor, in contrast, believes that the client is the expert on their own life and that the client's own solutions are more likely to be effective and sustainable than any solution imposed by an outsider. The distinction is fundamental to the counselling relationship. Advice-giving places the advisor in a position of superiority and the client in a position of dependency. Counselling places the counsellor and client in a collaborative partnership. Advice-giving assumes that the advisor knows what is best for the client. Counselling assumes that the client, with appropriate support, knows what is best for themselves.

Distinction from Psychotherapy

The distinction between counselling and psychotherapy is contested and increasingly blurred. Traditionally, psychotherapy was distinguished by its longer duration, its focus on deep-seated personality change and its work with more severe psychopathology. Counselling was distinguished by its shorter duration, its focus on situational problems and its work with less disturbed clients. In contemporary practice, the boundaries are less clear. Many counsellors work with clients who have severe and enduring mental health problems. Many psychotherapists work with clients on relatively circumscribed situational issues. The theoretical approaches and the core skills overlap substantially. In the Indian context, the Mental Healthcare Act, 2017 does not distinguish between counselling and psychotherapy for regulatory purposes, though professional associations maintain separate registers.

Distinction from Information Dissemination

Counselling is also distinct from information dissemination. A diabetes educator who explains the role of diet and exercise in blood glucose control is providing information, not counselling. However, the boundaries may blur when the educator also explores the patient's feelings about the diagnosis, their barriers to adherence and their motivation for change. Counselling may include the provision of information, but it is not defined by it.

Essential Characteristics of Counselling

Despite the diversity of settings and approaches, counselling is characterised by certain essential features. It is voluntary; the client chooses to engage in the counselling relationship and may withdraw at any time. It is confidential; the client's disclosures are protected, subject only to limited exceptions such as risk of serious harm to self or others. It is based on trust; the client must feel safe enough to explore vulnerable aspects of themselves. It is collaborative; the counsellor and client work together as partners. It is empowering; the goal is to enhance the client's capacity to manage their own life, not to create dependency on the counsellor.

11.4 GROWTH OF COUNSELLING SERVICES IN INDIA

The Pre-Professional Era

Counselling in its informal sense has existed in India for millennia. The guru-shishya parampara, the guidance of elders and the support of extended family provided emotional and practical assistance to individuals facing life challenges. Traditional healers, priests and

community leaders performed functions analogous to those of modern counsellors. However, counselling as a formal, professional discipline is a relatively recent development in India. The first university departments of psychology were established in the 1920s and 1930s, but their focus was primarily academic and experimental. Clinical psychology emerged as a distinct profession in the 1940s and 1950s, with the establishment of the first mental hospitals and the training of clinical psychologists.

The Vocational Guidance Movement

The formal origins of counselling in India can be traced to the vocational guidance movement of the 1940s and 1950s. The Directorate General of Employment and Training established vocational guidance units in major cities to assist young people in choosing careers. These units administered psychological tests, provided occupational information and offered individual guidance interviews. The approach was primarily directive and information-based, consistent with the trait-and-factor theory dominant in Western vocational psychology at the time.

The Expansion into Educational Settings

The 1960s and 1970s saw the expansion of counselling into educational settings. The University Grants Commission established counselling and guidance centres in several universities. The Central Board of Secondary Education introduced guidance and counselling as an integral component of the school curriculum. The National Council of Educational Research and Training developed training programmes for school counsellors. Despite these initiatives, the growth of school counselling was slow and uneven. Most schools lacked trained counsellors; those that had counsellors often assigned them administrative duties that left little time for direct student contact. Counselling was often conflated with discipline, and students were reluctant to seek help from counsellors perceived as aligned with authority.

The Mental Health Movement

The 1980s and 1990s witnessed the growth of the mental health movement in India. The National Mental Health Programme, launched in 1982, aimed to integrate mental health services into primary healthcare. Non-governmental organisations such as The Banyan, Sangath and the Schizophrenia Research Foundation pioneered community-based mental health care and demonstrated the feasibility and effectiveness of counselling delivered by non-specialist workers. The District Mental Health Programme, initiated in 1996, trained medical officers, nurses and social workers in the identification and management of common mental disorders. These professionals, while not designated as counsellors, performed many counselling functions: they listened empathetically, provided information, offered support and facilitated access to services.

The Contemporary Expansion

The past two decades have witnessed an unprecedented expansion of counselling services in India. The Mental Healthcare Act, 2017 created a legal mandate and policy framework for mental health services, including counselling. The Act recognised the right to access mental healthcare and required the government to provide affordable, accessible and quality mental health services. This has stimulated investment in mental health infrastructure and workforce development. The COVID-19 pandemic catalysed a dramatic increase in demand for mental health services. The pandemic-induced lockdowns, economic disruption and social isolation

precipitated a wave of anxiety, depression and distress. The healthcare system, ill-equipped to meet this demand, turned to tele-counselling and online mental health platforms. The pandemic also reduced the stigma associated with seeking help; mental health became a subject of public discourse rather than private shame. The corporate sector has emerged as a significant employer of counsellors. Employee Assistance Programmes, initially established by multinational corporations, have been adopted by Indian companies seeking to support employee well-being and productivity. These programmes provide confidential counselling to employees and their families on a range of personal and work-related issues. The National Education Policy, 2020 recognised the importance of counselling in educational settings. It recommended the establishment of school counselling services, the training of teachers in basic counselling skills and the integration of mental health education into the curriculum. The policy has stimulated state-level initiatives to recruit and deploy counsellors in government schools.

Current Challenges

Despite this growth, counselling services in India remain inadequate to meet the need. The National Mental Health Survey, 2016 estimated that the treatment gap for mental disorders exceeds eighty per cent. The shortage of trained counsellors is acute, particularly in rural areas. The quality of training is variable, and there is no single regulatory framework for the counselling profession. Counsellors work in a variety of settings—hospitals, schools, NGOs, corporate offices, private practice—with widely varying standards of training, supervision and ethical practice. The Mental Healthcare Act, 2017 addresses mental health professionals generally but does not specifically regulate counsellors. The Rehabilitation Council of India regulates counsellors working in rehabilitation settings. The National Medical Commission regulates clinical psychologists. But there is no equivalent regulatory body for the thousands of counsellors working in non-clinical settings. Professional associations such as the Indian Association of Clinical Psychologists and the Counselling Society of India have developed ethical codes and training standards, but these are not statutorily enforceable.

11.5 APPROACHES TO COUNSELLING: THEORETICAL FOUNDATIONS

The Psychodynamic Approach

The psychodynamic approach, originating in the work of Sigmund Freud and developed by subsequent theorists including Carl Jung, Alfred Adler and Melanie Klein, emphasises the influence of unconscious processes on behaviour and the importance of early childhood experiences in shaping adult personality. The psychodynamic counsellor seeks to help the client bring unconscious conflicts into conscious awareness, where they can be examined and resolved. The therapeutic relationship is itself a vehicle for this exploration; the client's patterns of relating to the counsellor are understood as repetitions of earlier relationship patterns, a phenomenon termed transference. The counsellor's emotional responses to the client, termed countertransference, provide additional information about the client's internal world. Psychodynamic counselling is typically longer-term than other approaches, though brief psychodynamic therapies have been developed for specific presentations. It is particularly suited to clients with long-standing, recurrent difficulties in relationships or with a desire for deep self-understanding. Its limitations include its intensive training requirements, its relative ineffectiveness for circumscribed behavioural problems and its limited empirical support compared to cognitive-behavioural approaches.

The Behavioural Approach

The behavioural approach, rooted in the work of Ivan Pavlov, John B. Watson and B.F. Skinner, focuses on observable behaviour and its environmental determinants. Behavioural counsellors view problematic behaviours as learned responses that can be unlearned or modified through the application of learning principles. Behavioural counselling does not concern itself with unconscious conflicts or deep-seated personality structures. It identifies specific, measurable target behaviours, analyses the antecedents and consequences that maintain them, and implements interventions designed to change them. Techniques include systematic desensitisation for phobias, exposure and response prevention for obsessive-compulsive disorder, and reinforcement schedules for habit change. Behavioural counselling is highly structured, time-limited and empirically supported. It is particularly effective for specific behavioural problems such as phobias, compulsions and habit disorders. Its limitations include its neglect of cognitive and emotional processes and its relative ineffectiveness for clients with complex, diffuse difficulties.

The Cognitive-Behavioural Approach

The cognitive-behavioural approach, developed by Aaron Beck and Albert Ellis, integrates behavioural techniques with a focus on cognitive processes. Cognitive-behavioural counsellors view psychological distress as resulting from maladaptive patterns of thinking, which in turn influence emotions and behaviour. Cognitive-behavioural counselling identifies the client's automatic thoughts—the rapid, evaluative thoughts that occur in response to triggering events—and the underlying core beliefs and schemas that generate them. The counsellor assists the client to examine the evidence for and against these thoughts, to generate alternative interpretations and to test these alternatives through behavioural experiments. Cognitive-behavioural therapy is the most extensively researched approach to counselling and is the treatment of choice for many common mental disorders, including depression and anxiety disorders. It is structured, time-limited and highly focused on specific problems. Its limitations include its relative neglect of developmental and relational factors and its requirement for a motivated, psychologically-minded client.

The Humanistic Approach

The humanistic approach, associated with Carl Rogers, Abraham Maslow and Rollo May, emphasises the inherent worth and dignity of the individual and the innate capacity for growth and self-actualisation. Humanistic counsellors view psychological distress as arising from conditions of worth—the internalised belief that one is valued only when one meets certain standards—which lead to incongruence between the real self and the ideal self. Rogers identified three core conditions that are both necessary and sufficient for therapeutic change: empathy, the ability to understand the client's internal frame of reference; unconditional positive regard, the acceptance of the client as a person of worth regardless of their behaviour; and congruence, the genuineness and authenticity of the counsellor. When these conditions are present, the client will move towards greater self-acceptance, self-understanding and self-direction. Person-centred counselling is non-directive; the counsellor does not interpret, advise or direct, but reflects the client's feelings and meanings. It is particularly suited to clients who are exploring questions of identity, meaning and values. Its limitations include its relative ineffectiveness for clients with severe mental illness and its lack of specific techniques for circumscribed problems.

The Solution-Focused Brief Therapy Approach

Solution-focused brief therapy, developed by Steve de Shazer and Insoo Kim Berg, represents a radical departure from traditional problem-focused approaches. It does not seek to analyse the problem or its causes; it seeks to construct solution. The solution-focused counsellor asks questions designed to elicit exceptions to the problem, times when the problem was less severe or absent; to identify the client's resources and strengths; and to construct a detailed description of how the client's life would be different when the problem is solved, a technique known as the miracle question. The counsellor and client collaborate to identify small, achievable steps towards this preferred future. Solution-focused brief therapy is highly efficient, often achieving significant change in as few as three to five sessions. It is particularly suited to clients who are focused on the present and future rather than the past and who are motivated to make changes. Its limitations include its relative ineffectiveness for clients with severe mental illness and its potential to minimise or bypass genuine emotional distress.

Integrative and Eclectic Approaches

Most contemporary counsellors do not adhere rigidly to a single theoretical approach. Integrative counsellors combine concepts and techniques from multiple approaches in a coherent and principled manner. Eclectic counsellors select techniques from different approaches based on their fit with the client's presenting problem and personal characteristics. The most influential integrative framework is the biopsychosocial model, which recognises that psychological distress arises from the interaction of biological, psychological and social factors. The biopsychosocial counsellor draws on cognitive-behavioural techniques to address maladaptive thinking, on humanistic approaches to foster self-acceptance and on systemic approaches to address family and social contexts.

11.6 THE COUNSELLING PROCESS: A SEQUENTIAL MODEL

Stage One: Relationship Building and Structuring

The first stage of counselling is concerned with establishing the therapeutic relationship and structuring the counselling work. This stage is foundational; the quality of the therapeutic alliance is one of the strongest predictors of outcome, regardless of the specific approach used. The counsellor begins by introducing themselves, explaining their role and describing the nature and purpose of counselling. This is the process of structuring. The counsellor clarifies practical arrangements: the frequency and duration of sessions, the fees if any, the procedures for cancelling or rescheduling appointments. The counsellor also explains the limits of confidentiality: that disclosures are protected, but that there are exceptions when there is a risk of serious harm to the client or others, or when disclosure is required by law. The counsellor also attends to the physical environment. The counselling room should be private, comfortable and free from distractions. The seating should be arranged to facilitate communication; sitting at a right angle, without a desk between counsellor and client, is often recommended. Simultaneously with structuring, the counsellor is building the therapeutic relationship through the communication of empathy, respect and genuineness. The counsellor listens attentively, communicates understanding and conveys acceptance. The client begins to feel safe enough to disclose their concerns.

Stage Two: Assessment and Goal Formation

The second stage involves the assessment of the client's concerns and the formulation of counselling goals. Assessment is not a one-time event but an ongoing process of hypothesis formation and testing. The counsellor invites the client to tell their story. This is not a forensic investigation; it is an invitation to share. The counsellor listens for the client's own understanding of their situation, their emotional responses, their coping efforts and the impact of the problem on their life. The counsellor also gathers relevant background information. This includes the client's personal and family history, their medical and mental health history, their current life circumstances and their previous experiences of counselling or therapy. The depth and breadth of assessment vary with the counselling approach and the nature of the client's concerns. Goal formation is a collaborative process. The counsellor assists the client to articulate what they hope to achieve through counselling. Goals should be specific, measurable, achievable, relevant and time-bound. They should be the client's goals, not the counsellor's goals for the client.

Stage Three: Exploration and Deepening

The third stage is the heart of the counselling process. The counsellor and client work together to explore the client's concerns in greater depth, to uncover underlying issues, to challenge maladaptive patterns and to generate new perspectives and possibilities. The counsellor continues to use the core skills of active listening, reflection and questioning. They attend not only to the content of the client's communication but also to the process—the feelings, the hesitations, the contradictions, the non-verbal cues. They reflect their understanding of the client's internal frame of reference, helping the client to feel heard and understood. In this stage, the counsellor may also introduce more active interventions. These may include challenging discrepancies between the client's words and actions, between their stated goals and their actual behaviour. They may include offering interpretations that link present patterns to past experiences. They may include teaching specific skills, such as relaxation techniques or assertiveness training.

Stage Four: Intervention and Action

The fourth stage translates insight into action. The counsellor and client collaborate to develop and implement strategies for change. The specific interventions depend on the counsellor's theoretical approach and the nature of the client's concerns. The cognitive-behavioural counsellor may work with the client to identify and challenge automatic thoughts, to test beliefs through behavioural experiments and to develop more adaptive thinking patterns. The solution-focused counsellor may work with the client to amplify exceptions, to identify resources and to take small steps towards the preferred future. The person-centred counsellor may continue to provide the core conditions, trusting in the client's innate capacity for growth. Action does not always mean behaviour change. For some clients, the action may be to accept themselves more fully, to grieve a loss or to make peace with a difficult past. The counsellor supports the client in whatever action is congruent with their goals and values.

Stage Five: Termination and Follow-Up

The final stage of counselling is termination. Termination is not an abrupt ending but a planned process. The counsellor and client review the work they have done, the progress made and the goals achieved. They identify what the client has learned about themselves and their coping

strategies. They anticipate future challenges and develop plans for maintaining gains. Termination may evoke strong feelings. The client may feel anxious about managing without the counsellor's support. They may feel grateful for the help they have received. They may feel angry about being abandoned. The counsellor acknowledges these feelings and helps the client to process them. Follow-up sessions, scheduled weeks or months after termination, may be arranged to review progress and provide additional support if needed. The door is left open for the client to return for future counselling if necessary.

11.7 ATTITUDES OF THE EFFECTIVE COUNSELLOR

Empathy

Empathy is the ability to understand the client's internal frame of reference and to communicate that understanding to the client. It is not sympathy, which is feeling for the client; it is feeling with the client, entering their subjective world without losing one's own identity. Empathy is both an attitude and a skill. As an attitude, it involves a genuine interest in the client's experience, a willingness to set aside one's own assumptions and judgments, and a respect for the client's unique perspective. As a skill, it involves the ability to perceive the client's feelings and meanings accurately and to reflect them in language that resonates with the client. Empathy is not agreement. The counsellor may understand the client's anger at a family member without agreeing that the anger is justified. Empathy is not approval. The counsellor may understand the client's desire to harm themselves without approving of that desire. Empathy is simply the accurate perception of the client's internal state. Research consistently demonstrates that empathy is one of the strongest predictors of positive counselling outcome. Clients who feel understood are more likely to remain in counselling, to disclose vulnerable material and to engage in the work of change.

Unconditional Positive Regard

Unconditional positive regard is the acceptance of the client as a person of inherent worth and dignity, regardless of their behaviour, feelings or characteristics. The counsellor does not evaluate the client as good or bad, worthy or unworthy. The counsellor accepts the client as they are, without conditions. Unconditional positive regard does not mean approving of all the client's behaviour. The counsellor may disagree with the client's actions, challenge their maladaptive patterns and set limits on unacceptable behaviour. The acceptance is of the person, not the behaviour. Clients who have internalised conditions of worth—who believe they are valued only when they meet certain standards—often find unconditional positive regard a profound and healing experience. They begin to accept themselves as they are, to relax their harsh self-criticism and to risk being authentic.

Congruence

Congruence, also termed genuineness or authenticity, is the consistency between the counsellor's internal experience and their external expression. The congruent counsellor does not hide behind a professional facade. They are real, transparent and human. Congruence does not mean self-disclosure without boundaries. The counsellor's focus remains on the client's needs, not on their own. Congruence means that when the counsellor is confused, they acknowledge their confusion; when they are moved, they show their emotion; when they make a mistake, they admit it. Congruence is essential to the therapeutic relationship. Clients are

acutely sensitive to incongruence, to the counsellor who says one thing but communicates another non-verbally. Incongruence erodes trust. Congruence deepens it.

Respect

Respect is the recognition of the client's autonomy and self-determination. The counsellor respects the client's right to make their own decisions, to choose their own goals and to live their own life according to their own values. The counsellor does not impose their own values, beliefs or solutions on the client. Respect is manifested in the counsellor's language, in their willingness to listen, in their non-judgmental attitude and in their collaboration with the client. It is communicated in small ways: addressing the client by their preferred name, honouring their time, respecting their physical boundaries.

Cultural Humility

Cultural humility is the recognition that the counsellor does not and cannot know everything about the client's cultural background. It is an attitude of openness, curiosity and respect for the client as the expert on their own culture. The culturally humble counsellor does not make assumptions based on the client's apparent ethnicity or religion. They ask: Tell me about your background. What is important to you? How does your culture understand this problem? They recognise that culture is complex, dynamic and individually experienced. Cultural humility also involves awareness of power dynamics. The counsellor recognises that the counselling relationship is inherently unequal and that this inequality may be compounded by differences in social status, education and economic resources. They work to minimise these power differentials and to empower the client.

11.8 SKILLS OF COUNSELLING: THE MICRO-SKILLS HIERARCHY

Attending Behaviour

Attending is the foundation of all counselling skills. It is the counsellor's demonstration, through verbal and non-verbal behaviour, that they are fully present and engaged with the client. Attending behaviour includes eye contact that is natural and culturally appropriate, not staring or avoiding. It includes a relaxed, open posture, facing the client, leaning slightly forward. It includes appropriate facial expressions that communicate interest and understanding. It includes verbal following, staying with the client's topic rather than introducing new topics or redirecting the conversation.

Active Listening

Active listening is more than hearing the client's words. It is the concentrated effort to understand the client's message in all its dimensions: the content, the feelings, the meanings, the context. The active listener does not plan their response while the client is speaking. They do not interrupt, finish the client's sentences or jump to conclusions. They listen for what is said and what is not said, for the themes that recur, for the emotions that are expressed and those that are suppressed.

Questioning

Questions are tools for gathering information, clarifying understanding and encouraging exploration. Effective counsellors use questions strategically, not habitually. Open-ended questions invite the client to elaborate and explore. They begin with what, how, could or would. How did you feel when that happened? What was that experience like for you? Open-ended questions cannot be answered with a single word; they require reflection and description. Closed-ended questions seek specific information. They begin with did, is, are or when. Did you take your medication? When did the pain start? Closed-ended questions are useful for gathering facts but, if overused, can make the client feel interrogated rather than understood.

Reflection of Feeling

Reflection of feeling is the skill of identifying the client's emotions and communicating that understanding back to the client. It is one of the most powerful tools for conveying empathy and deepening exploration. An effective reflection captures both the content and the intensity of the client's feeling. It sounds like you felt angry when he said that. Not just angry, but furious. It uses a feeling vocabulary that resonates with the client. It is offered tentatively, as an invitation for the client to correct or refine.

Paraphrasing and Summarising

Paraphrasing is the restatement of the client's message in the counsellor's own words. It communicates that the counsellor has heard and understood the client's communication. It also helps the client to clarify their own thinking. Summarising is the synthesis of several client statements into a coherent whole. It is used at transition points: at the beginning of a session to connect to previous work, during a session to consolidate progress, at the end of a session to review and plan. Summarising helps the client to see patterns and themes in their experience.

Challenging

Challenging, also termed confrontation, is the skill of pointing out discrepancies in the client's communication. The discrepancy may be between words and actions, between stated goals and actual behaviour, between verbal and non-verbal messages. Effective challenging is gentle, respectful and tentative. It is not an accusation; it is an observation. You say you want to quit smoking, but you haven't been able to go a full day without a cigarette. How do you understand that? The challenge is offered in the service of the client's goals, not as a criticism.

Immediacy

Immediacy is the skill of addressing the here-and-now relationship between counsellor and client. It is used when something is happening in the session that is affecting the therapeutic work. Immediacy may address the client's feelings about the counsellor: You seem hesitant to share that with me. I wonder what is making it difficult. It may address the counsellor's own experience: I notice that I am feeling protective of you as you describe that situation. It brings the relational process into awareness, where it can be explored and understood.

Information Giving and Psychoeducation

Information giving is the provision of factual information relevant to the client's concerns. It may include information about mental health conditions, treatment options, community resources or coping strategies. Psychoeducation is information giving with a therapeutic purpose. It is not simply the transmission of facts; it is the integration of information into the client's understanding of their situation and their capacity for change. The counsellor provides information, checks the client's understanding and explores its implications for the client's life.

11.9 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES

Confidentiality and Its Limits

Confidentiality is the cornerstone of the counselling relationship. Clients must feel safe to disclose sensitive, shameful or legally compromising information. The counsellor's ethical duty of confidentiality is reinforced by the professional codes of conduct and, in certain contexts, by statute. However, confidentiality is not absolute. The counsellor has a duty to breach confidentiality in certain circumstances. These include: when there is a serious and imminent risk of harm to the client or others; when disclosure is required by law, such as in cases of child abuse or notifiable diseases; and when ordered to disclose by a court of competent jurisdiction. The limits of confidentiality must be explained to the client at the outset of the counselling relationship. This is not a one-time event; it is an ongoing conversation. The counsellor should also document any decision to breach confidentiality, including the rationale for the decision and the steps taken to minimise the harm of disclosure.

Informed Consent in Counselling

Informed consent is as essential in counselling as in any other healthcare intervention. The client has the right to understand what counselling involves, what its risks and benefits are, what alternatives exist and what the counsellor's qualifications and approach are. Informed consent in counselling is a process, not a form. The counsellor discusses these matters with the client, answers their questions and ensures that they have sufficient information to make a voluntary decision. The consent may be documented in writing, but the conversation is the substance.

Contracts for Counselling Services

Counselling services are provided under contract. The contract may be explicit, with a written agreement specifying the fees, session frequency, cancellation policy and other terms. It may be implicit, inferred from the conduct of the parties. The contract should address the practical arrangements for counselling. It should specify the fee and the method of payment. It should specify the duration of sessions and the frequency of meetings. It should specify the procedure for cancelling or rescheduling appointments. It should specify the conditions under which the counsellor may terminate the relationship, such as non-payment or client behaviour that threatens the safety of the counsellor. The contract should also address the limits of the counsellor's responsibility. Counselling is not a guarantee of improvement. The counsellor does not promise to solve the client's problems or to make them happy. The contract should make clear that the client retains responsibility for their own life and decisions.

Record-Keeping in Counselling

Counsellors are required to maintain records of their work with clients. The record should document the client's identifying information, the dates and duration of sessions, the nature of the client's concerns, the interventions used and the progress made. The record should be factual, objective and professional. The record serves multiple purposes. It supports continuity of care if the client is seen by another counsellor. It provides a basis for supervision and quality assurance. It may be required for reimbursement by insurance companies. It may be subpoenaed in legal proceedings. The client has a right to access their counselling records, subject to certain exceptions. The counsellor should have a clear policy on access to records and should inform the client of this policy at the outset of counselling.

Counselling in Telemedicine

The COVID-19 pandemic accelerated the adoption of tele-counselling. Counsellors now routinely work with clients by telephone, video conference and text messaging. This shift raises new contractual and ethical issues. The counsellor must ensure that the tele-counselling platform is secure and compliant with data protection laws. The counsellor must verify the client's identity and location. The counsellor must consider the implications of providing services across state or national boundaries, where different laws may apply. The counsellor must have a plan for managing emergencies when the client is not physically present. The contract for tele-counselling should address these issues explicitly. It should specify the platform to be used, the procedures for verifying identity, the arrangements for emergency contact and the limitations of tele-counselling compared to face-to-face work.

11.10 STUDENT LEARNING ACTIVITIES

Activity 1: Reflective Journal on Empathy

You are a hospital administrator who has been asked to conduct a training session for nursing staff on communication with distressed patients and families. Before you can teach empathy, you must understand it from within. Spend one week maintaining a reflective journal on your own experiences of empathy. Each day, identify at least one interaction—with a patient, a family member, a colleague or even someone outside work—in which you experienced empathy, either as the giver or the receiver. Describe the interaction, the verbal and non-verbal communication, your internal experience and the outcome. What did empathy look like in that moment? What facilitated it? What barriers existed? At the end of the week, synthesise your observations into a one-page reflection on the nature of empathy in healthcare settings. How can hospital administrators and clinical staff cultivate empathy as both an attitude and a skill? What systemic factors in hospitals support or inhibit empathic communication?

Activity 2: Comparative Analysis of Counselling Approaches

You are the manager of a hospital-based psycho-oncology service. You are recruiting a counsellor to work with cancer patients and their families. Three candidates have been shortlisted. Candidate A is trained in psychodynamic counselling, Candidate B in cognitive-behavioural therapy and Candidate C in person-centred counselling. Prepare a comparative analysis of these three approaches as they would apply to the psycho-oncology setting. For each approach, address the following: the theoretical understanding of psychological distress in cancer patients; the goals of counselling; the typical interventions; the duration and structure

of treatment; the evidence base; and the strengths and limitations for this specific client population. Based on your analysis, recommend which candidate you would appoint and justify your recommendation. Also identify what training or supervision you would provide to the successful candidate to enhance their effectiveness in this specialised setting.

Activity 3: Counselling Process Simulation

You are a counsellor in the emergency department of a large teaching hospital. A forty-five year old man has been brought in by ambulance following a suicide attempt by overdose. He has been medically stabilised and is awaiting psychiatric assessment. The emergency physician has requested that you speak with him. Draft a detailed script of your first interaction with this patient. Your script should demonstrate: the structuring of the session, including introduction and explanation of confidentiality; the use of open-ended questions to invite the patient to share his experience; the reflection of feelings; the paraphrasing and summarising of content; and the collaborative formulation of immediate goals. Your script should be accompanied by a commentary explaining your choice of interventions at each point. What are you trying to achieve with each statement? What are you attending to in the patient's verbal and non-verbal communication? How are you balancing the need to gather information with the need to build relationship?

Activity 4: Informed Consent Document for Counselling Services

You are establishing a new employee assistance programme counselling service for the staff of a five hundred bed corporate hospital. You need to develop an informed consent document that will be provided to all employees who access the service. Draft a comprehensive informed consent document for the counselling service. Your document should address: the nature and purpose of counselling; the qualifications and approach of the counsellors; the confidentiality policy and its limits; the fees and payment arrangements; the session frequency and duration; the cancellation policy; the record-keeping policy and client access to records; the procedure for filing complaints; and the conditions for termination of counselling. Your document should be written in plain, accessible language, avoiding legal and technical jargon. It should be structured to facilitate understanding, with clear headings and short paragraphs. It should include a signature section where the client acknowledges that they have read and understood the information and voluntarily consent to participate in counselling.

11.11 SUMMARY

Counselling is a professional relationship in which a trained counsellor assists a client to explore their concerns, clarify their thoughts and feelings, understand their situation and make their own decisions. It is distinguished from advice-giving, which imposes solutions from outside; from psychotherapy, which traditionally focused on deeper personality change; and from information dissemination, which provides facts without exploration.

Counselling services in India have grown from the vocational guidance movement of the 1940s through the expansion of educational and mental health services to the contemporary proliferation of counselling in healthcare, corporate and community settings. The Mental Healthcare Act, 2017 and the National Education Policy, 2020 have created policy frameworks and stimulated investment. However, the profession remains inadequately regulated, and the treatment gap for mental disorders exceeds eighty per cent.

The major theoretical approaches to counselling include psychodynamic, behavioural, cognitive-behavioural, humanistic and solution-focused brief therapy. Each approach has its own conceptual framework, its own understanding of psychological distress and its own repertoire of interventions. Most contemporary counsellors adopt an integrative or eclectic stance, drawing on multiple approaches in a coherent and client-responsive manner.

The counselling process can be conceptualised as a sequence of stages: relationship building and structuring; assessment and goal formation; exploration and deepening; intervention and action; and termination and follow-up. These stages are not rigidly linear; the counsellor moves back and forth between them in response to the client's needs. However, the framework provides a useful map for both novice and experienced counsellors.

The effective counsellor embodies certain core attitudes: empathy, the ability to understand the client's internal frame of reference; unconditional positive regard, the acceptance of the client as a person of inherent worth; congruence, the genuineness and authenticity of the counsellor; respect, the recognition of the client's autonomy and self-determination; and cultural humility, the openness to the client as the expert on their own culture.

The effective counsellor also masters a hierarchy of micro-skills. Attending and active listening are the foundation. Questioning, reflection of feeling, paraphrasing and summarising are tools for exploration and understanding. Challenging and immediacy are advanced skills for deepening the work. Information giving and psychoeducation integrate the counsellor's knowledge with the client's experience.

Healthcare-specific contractual issues in counselling include the limits of confidentiality, the process of informed consent, the explicit or implicit contract for services, the obligations of record-keeping and the adaptations required for tele-counselling. The counsellor must navigate these issues with ethical sensitivity and legal awareness.

11.12 KEY WORDS WITH EXPLANATIONS

Counselling is a professional relationship in which a trained counsellor assists a client to explore their concerns, clarify their thoughts and feelings, understand their situation and make their own decisions. It is distinguished from advice-giving, psychotherapy and information dissemination.

Empathy is the ability to understand the client's internal frame of reference and to communicate that understanding to the client. The counsellor enters the client's subjective world without losing their own identity. Empathy is both an attitude and a skill.

Unconditional Positive Regard is the acceptance of the client as a person of inherent worth and dignity, regardless of their behaviour, feelings or characteristics. The counsellor does not evaluate the client as good or bad but accepts them without conditions.

Congruence is the consistency between the counsellor's internal experience and their external expression. The congruent counsellor is genuine, authentic and transparent. It is not to be confused with self-disclosure without boundaries.

Psychodynamic Approach is an approach to counselling originating in the work of Sigmund Freud that emphasises unconscious processes and early childhood experiences. It

seeks to bring unconscious conflicts into conscious awareness where they can be examined and resolved.

Cognitive-Behavioural Approach is an approach that integrates behavioural techniques with a focus on cognitive processes. It identifies maladaptive automatic thoughts and underlying core beliefs, assists the client to examine the evidence for and against these thoughts, and tests alternatives through behavioural experiments.

Person-Centred Approach is a humanistic approach developed by Carl Rogers that emphasises the inherent worth and dignity of the individual and the innate capacity for growth. The counsellor provides empathy, unconditional positive regard and congruence, trusting in the client's capacity for self-direction.

Solution-Focused Brief Therapy is an approach that focuses on constructing solutions rather than analysing problems. It uses questions to elicit exceptions, identify resources and construct a detailed description of the preferred future. It is typically brief, often achieving significant change in three to five sessions.

Attending Behaviour is the counsellor's demonstration, through verbal and non-verbal behaviour, that they are fully present and engaged with the client. It includes eye contact, posture, facial expression and verbal following.

Reflection of Feeling is the skill of identifying the client's emotions and communicating that understanding back to the client. It captures both the content and intensity of the feeling and is a powerful tool for conveying empathy and deepening exploration.

Challenging is the skill of pointing out discrepancies in the client's communication. The discrepancy may be between words and actions, between stated goals and actual behaviour, or between verbal and non-verbal messages. It is offered gently, respectfully and tentatively.

Immediacy is the skill of addressing the here-and-now relationship between counsellor and client. It is used when something is happening in the session that is affecting the therapeutic work. It brings the relational process into awareness where it can be explored.

Informed Consent in Counselling is the client's right to understand what counselling involves, its risks and benefits, alternatives and the counsellor's qualifications and approach. It is a process of ongoing conversation, not merely a form to be signed.

Limits of Confidentiality are the circumstances under which the counsellor is ethically and legally obligated to breach confidentiality. These include serious and imminent risk of harm to self or others, disclosure required by law and court order. They must be explained to the client at the outset of counselling.

11.13 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What is the distinction between counselling and advice-giving?

Ans. Counselling and advice-giving differ fundamentally in their assumptions about the client and the nature of the helping relationship. Advice-giving assumes that the advisor knows what is best for the client and that the client's role is to follow the advisor's instructions. Counselling assumes that the client is the expert on their own life and that the counsellor's role is to facilitate the client's own exploration and decision-making. Advice-giving creates dependency; counselling empowers.

Q2. What are the three core conditions of effective counselling identified by Carl Rogers?

Ans. The three core conditions are empathy, unconditional positive regard and congruence. Empathy is the ability to understand the client's internal frame of reference and to communicate that understanding. Unconditional positive regard is the acceptance of the client as a person of inherent worth, without conditions or judgments. Congruence is the genuineness and authenticity of the counsellor, the consistency between their internal experience and external expression.

Q3. What are the five stages of the counselling process described in this lesson?

Ans. The five stages are: relationship building and structuring; assessment and goal formation; exploration and deepening; intervention and action; and termination and follow-up. These stages are not rigidly linear; the counsellor moves back and forth between them in response to the client's needs. However, the framework provides a useful map for the counselling journey.

Q4. What is the miracle question in solution-focused brief therapy?

Ans. The miracle question is a technique used in solution-focused brief therapy to help the client construct a detailed description of their preferred future. The counsellor asks: Suppose tonight, while you are sleeping, a miracle happens and all your problems are solved. But because you are sleeping, you don't know that the miracle has happened. When you wake up tomorrow, what will be the first small sign that the miracle has occurred? What else will be different? The question shifts the focus from problem analysis to solution construction.

Q5. What are the limits of confidentiality in the counselling relationship?

Ans. Confidentiality is not absolute. The counsellor is ethically and legally obligated to breach confidentiality in certain circumstances: when there is a serious and imminent risk of harm to the client or others; when disclosure is required by law, such as in cases of child abuse, notifiable diseases or under the Prevention of Money Laundering Act; and when ordered to disclose by a court of competent jurisdiction. The limits of confidentiality must be explained to the client at the outset of counselling.

B. Essay Type Questions with Hints

Q1. Trace the growth of counselling services in India from the vocational guidance movement to the present day. What factors have contributed to the recent expansion of counselling, and what challenges remain for the professionalisation of counselling in India?

Hints: Begin with the vocational guidance movement of the 1940s and 1950s. Discuss the expansion into educational settings in the 1960s and 1970s, including the role of the UGC,

CBSE and NCERT. Analyse the contribution of the mental health movement, including the National Mental Health Programme, the District Mental Health Programme and non-governmental organisations. Discuss the impact of the Mental Healthcare Act, 2017 and the National Education Policy, 2020. Analyse the role of the COVID-19 pandemic in reducing stigma and accelerating tele-counselling. Discuss the challenges: inadequate workforce, variable training standards, absence of statutory regulation and the treatment gap. Conclude with recommendations for the professionalisation of counselling in India.

Q2. Compare and contrast the cognitive-behavioural approach and the person-centred approach to counselling. What are the key theoretical differences, and how do these differences manifest in the practice of counselling?

Hints: Structure your answer around key dimensions. Theoretical foundations: CBT is rooted in cognitive psychology and learning theory; person-centred is rooted in humanistic psychology. View of human nature: CBT views maladaptive behaviour as learned and modifiable; person-centred views the individual as having an innate capacity for growth. Role of the counsellor: CBT counsellor is active, directive and educative; person-centred counsellor is non-directive and facilitative. Nature of the therapeutic relationship: CBT views relationship as necessary but not sufficient; person-centred views relationship as both necessary and sufficient. Goals of counselling: CBT seeks symptom reduction and skill development; person-centred seeks self-acceptance and self-actualisation. Techniques: CBT uses cognitive restructuring, behavioural experiments, homework; person-centred uses reflection, empathic understanding, congruence. Evidence base: CBT is extensively researched and empirically supported; person-centred has less empirical support but strong process-outcome research. Conclude with the integrative trend in contemporary practice.

Q3. Describe the five stages of the counselling process. What are the counsellor's tasks at each stage, and what skills are particularly important?

Hints: Structure your answer around the five stages. For each stage, describe: the purpose of the stage; the counsellor's tasks; the specific skills required; the challenges commonly encountered; and how the stage transitions to the next. For relationship building and structuring: attending, active listening, explanation of confidentiality, physical environment. For assessment and goal formation: questioning, paraphrasing, summarising, formulation, SMART goals. For exploration and deepening: reflection of feeling, challenging, immediacy, working with resistance. For intervention and action: psychoeducation, skill training, behavioural experiments, action planning. For termination and follow-up: review of progress, consolidation of learning, anticipation of future challenges, management of termination feelings. Conclude with the recursive nature of the process and the importance of flexibility.

Q4. What are the core attitudes of the effective counsellor? Why are these attitudes considered more important than specific techniques in some approaches to counselling?

Hints: Identify and explain the five attitudes: empathy, unconditional positive regard, congruence, respect and cultural humility. For each attitude, define it, distinguish it from related concepts, provide examples of its manifestation in counselling and explain its therapeutic function. Discuss the person-centred claim that these attitudes are both necessary and sufficient for therapeutic change. Evaluate this claim in light of research evidence and the practice of other therapeutic approaches. Discuss the integration of attitudes and techniques:

attitudes provide the foundation, techniques are the tools. Conclude that attitudes are necessary but not sufficient; competent counsellors need both.

Q5. You are the manager of a hospital-based counselling service. A patient has filed a complaint alleging that a counsellor disclosed confidential information to the patient's spouse without consent. The counsellor states that the patient was suicidal and that the disclosure was necessary to protect the patient's safety. There is no documentation of the counsellor's assessment of risk or the decision to breach confidentiality. Draft a comprehensive policy on confidentiality and its limits for the counselling service, including procedures for risk assessment, documentation and disclosure.

Hints: Structure your answer as a formal policy document. Begin with a preamble affirming the importance of confidentiality. Define the scope of the policy. State the general principle that client information is confidential and will not be disclosed without consent. Specify the exceptions to confidentiality: risk of serious harm to self or others; disclosure required by law; court order. For each exception, provide detailed guidance: what constitutes serious and imminent risk; how to assess risk; the threshold for disclosure; the procedure for making a disclosure; the documentation required. Include a section on documentation: what must be documented, when and where. Include a section on communicating the limits of confidentiality to clients at the outset of counselling and periodically thereafter. Conclude with training requirements and review procedures.

C. Analytical Multiple Choice Questions

1. Which of the following statements best distinguishes counselling from advice-giving?
a) Counselling is longer-term than advice-giving
b) Counselling focuses on the client's feelings, while advice-giving focuses on the client's behaviour
c) Counselling facilitates the client's own decision-making, while advice-giving imposes the advisor's solution
d) Counselling requires professional training, while advice-giving does not
Correct Answer: c) Counselling facilitates the client's own decision-making, while advice-giving imposes the advisor's solution

2. Carl Rogers identified three core conditions as necessary and sufficient for therapeutic change. These are:
a) Empathy, unconditional positive regard and congruence
b) Transference, countertransference and resistance
c) Reinforcement, punishment and extinction
d) Interpretation, confrontation and immediacy
Correct Answer: a) Empathy, unconditional positive regard and congruence

3. A counsellor says to a client: You say you want to leave your partner, but every time you talk about it, you look down and your voice becomes very quiet. I wonder if there is a part of you that is ambivalent. This intervention is an example of:
a) Reflection of feeling
b) Paraphrasing
c) Challenging
d) Immediacy
Correct Answer: c) Challenging

4. The miracle question is a technique associated with which approach to counselling?
a) Psychodynamic counselling
b) Cognitive-behavioural therapy
c) Person-centred counselling
d) Solution-focused brief therapy
Correct Answer: d) Solution-focused brief therapy

5. Under which of the following circumstances is a counsellor ethically and legally obligated to breach confidentiality?
a) The client discloses that they committed a minor traffic offence five years ago
b) The client discloses that they are experiencing suicidal ideation with a specific plan and intent
c) The client's spouse requests information about the client's treatment
d) The client's employer requests information about the client's fitness for work
Correct Answer: b) The client discloses that they are experiencing suicidal ideation with a specific plan and intent

6. A client in counselling says: I just can't do anything right. I tried to cook dinner for my family and I burned the rice. I'm a complete failure. A cognitive-behavioural counsellor would be most likely to:
a) Reflect the client's feeling of inadequacy
b) Explore the client's childhood experiences of criticism
c) Ask the client to examine the evidence for the belief that they are a complete failure
d) Ask the miracle question
Correct Answer: c) Ask the client to examine the evidence for the belief that they are a complete failure

7. The term cultural humility refers to:
a) Knowledge of the cultural practices of all client populations
b) The recognition that the counsellor does not and cannot know everything about the client's culture
c) The adaptation of counselling techniques to match the client's cultural background
d) The use of interpreters and culturally adapted assessment tools
Correct Answer: b) The recognition that the counsellor does not and cannot know everything about the client's culture

11.14 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Counsellor, The Survivor and The Summons

Ganga Ram Memorial Hospital is a four hundred fifty bed tertiary care teaching hospital in Delhi with a well-established Department of Mental Health, including a counselling service staffed by five counsellors, two clinical psychologists and three psychiatric social workers. Ms. Anita Sharma is a senior counsellor with twelve years of experience, holding a Master's degree in Counselling Psychology from the Tata Institute of Social Sciences and registered with the Counselling Society of India. She has worked in the oncology service for eight years.
Mrs. Kavita Singh is a thirty-eight year old woman diagnosed with Stage III breast cancer. She underwent a mastectomy and was receiving adjuvant chemotherapy. She was referred to the counselling service by her oncologist, who noted that she was anxious, withdrawn and having

difficulty sleeping. Mrs. Singh was seen by Ms. Sharma for twelve sessions over a period of four months. The counselling addressed her fears about cancer recurrence, her distress about changes in her body image, her concerns about the impact of her illness on her young daughter and her grief over the death of her mother from breast cancer ten years earlier. Mrs. Singh made significant progress. Her anxiety decreased, her sleep improved and she resumed many of her normal activities.

During her eighth session, Mrs. Singh disclosed something she had never told anyone before. When she was sixteen years old, she had been sexually abused by her maternal uncle. The abuse had occurred repeatedly over a period of two years. She had never reported it to anyone; her mother was ill, her father was absent and she was afraid that disclosing the abuse would destroy her family. Her uncle had died five years ago. Mrs. Singh stated that she had never spoken of the abuse before because she was ashamed and feared being blamed. She said that the counselling had helped her to feel safe enough to disclose. She explicitly stated that she did not want anyone else to know, that she did not want to report the abuse to the police and that she did not want her family to be contacted. Ms. Sharma listened, reflected Mrs. Singh's feelings of shame and fear, affirmed her courage in disclosing and assured her that the abuse was not her fault. She reviewed the limits of confidentiality with Mrs. Singh and confirmed that, in the absence of current risk of harm to Mrs. Singh or others, she would maintain confidentiality. She documented the disclosure and her decision-making in Mrs. Singh's counselling record.

Six months later, Ms. Sharma received a summons from the Court of the Additional Sessions Judge, Delhi. The summons directed her to appear before the court and to bring all records pertaining to her counselling of Mrs. Kavita Singh. Mrs. Singh's uncle had died intestate, and a dispute had arisen among his heirs regarding the distribution of his estate. Mrs. Singh's aunt, the widow of the deceased uncle, had filed a petition claiming that her husband had no children and that she was entitled to the entire estate. Mrs. Singh's cousins, the children of another uncle, had filed a cross-petition alleging that the deceased uncle had sexually abused Mrs. Singh and that this conduct should disentitle his widow from inheriting his property. Mrs. Singh's counselling records had been subpoenaed as evidence of the alleged abuse.

Ms. Sharma faced an excruciating dilemma. Mrs. Singh had disclosed the abuse in the context of a confidential therapeutic relationship, with the explicit understanding that her disclosure would not be shared. Ms. Sharma had assured her of confidentiality, subject only to the standard exceptions, none of which applied. Breaching confidentiality now would betray Mrs. Singh's trust and potentially cause her profound psychological harm. However, the summons was issued by a court of competent jurisdiction. Failure to comply with the summons could result in contempt of court proceedings, with potential penalties including fine and imprisonment. Ms. Sharma consulted with the Head of the Department of Mental Health and the hospital's legal counsel.

After careful consideration, the hospital decided to file an application to set aside the summons. The application was supported by an affidavit from Ms. Sharma detailing the circumstances of the disclosure and the importance of confidentiality to the counselling relationship. The application also included an affidavit from Mrs. Singh, who had been contacted and had provided her written instructions that she did not consent to disclosure and that the disclosure would cause her severe distress. The court heard the application in chambers. The judge acknowledged the importance of confidentiality in therapeutic relationships and the potential harm to Mrs. Singh from disclosure. However, the judge also noted that the evidence was

relevant to the issues in the civil dispute and that the court had a duty to ensure a fair trial. The judge directed that the counselling records be produced to the court for in camera inspection, that only the portions directly relevant to the alleged abuse be disclosed to the parties, and that the records be sealed and not form part of the public record. The judge also directed that Mrs. Singh's identity be protected and that she not be required to testify unless she voluntarily agreed to do so. Ms. Sharma complied with the court's order. She produced the counselling records, redacted to remove all information not directly relevant to the abuse disclosure. The records were reviewed by the judge in chambers, and the relevant portions were disclosed to the parties under a confidentiality order. Mrs. Singh was not contacted by the parties and did not testify.

Questions for Analysis with Hints

Q1. Analyse the ethical and legal dimensions of confidentiality in the counselling relationship. What are the limits of confidentiality, and how should counsellors balance their duty of confidentiality to the client with their duty to comply with court orders?

Hints: Confidentiality is the cornerstone of the counselling relationship. Clients must feel safe to disclose sensitive, shameful or legally compromising information without fear that their disclosures will be shared without their consent. However, confidentiality is not absolute. Exceptions include serious and imminent risk of harm to self or others, disclosure required by law such as child abuse or notifiable diseases, and court order. When a counsellor receives a court order, they face a conflict between the duty of confidentiality to the client and the duty to comply with the court's order. The counsellor is not required to comply immediately and without question. Steps to protect confidentiality while complying with the court's legitimate need for evidence include: consulting with legal counsel and clinical supervisors; notifying the client and seeking their instructions; filing an application to set aside or modify the summons; requesting that the records be reviewed by the judge in chambers; seeking a confidentiality order limiting the use and dissemination of the records; and redacting the records to remove irrelevant or privileged information.

Q2. Evaluate Ms. Sharma's decision-making in response to the summons. What options were available to her, and what factors should she have considered in choosing among them? Did she act appropriately?

Hints: Ms. Sharma's decision-making was exemplary. First, she recognised the conflict immediately and did not act unilaterally. She consulted with her department head and the hospital's legal counsel, ensuring that her response was informed by both clinical and legal expertise. Second, she notified Mrs. Singh of the summons and sought her instructions. This respects the client's autonomy and allows the client to participate in decisions that profoundly affect their interests. Mrs. Singh's explicit refusal of consent provided strong grounds for the application to set aside the summons. Third, she supported the hospital's application to set aside the summons, articulating the importance of confidentiality in counselling and the specific harm that disclosure would cause to Mrs. Singh. Fourth, she complied with the court's modified order in a manner that minimised the intrusion into Mrs. Singh's confidentiality, producing only the relevant portions of the records and redacting unnecessary information. The only potential criticism is that Ms. Sharma did not discuss the possibility of court-ordered disclosure with Mrs. Singh at the outset of counselling. While she reviewed the standard limits of confidentiality, she may not have specifically addressed the possibility of disclosure in civil litigation. This is a lesson for future informed consent practices.

Q3. Discuss the adequacy of the court's order. Did it appropriately balance the competing interests of patient confidentiality and the court's need for relevant evidence? What additional safeguards could have been implemented?

Hints: The court's order was a thoughtful and proportionate response to a difficult conflict of interests. It recognised the importance of confidentiality in therapeutic relationships and the potential harm to Mrs. Singh from disclosure, while also recognising the court's duty to ensure a fair trial and the relevance of the evidence to the issues in dispute. The order balanced these competing interests through several safeguards: in camera inspection ensured that the records were reviewed by the judge alone, not by the parties or their counsel, before any decision was made about disclosure; disclosure of only the relevant portions minimised the intrusion into Mrs. Singh's privacy; the sealing of the records prevented them from becoming part of the public record; the confidentiality order restricted the use of the disclosed information to the litigation; and the protection of Mrs. Singh's identity and the direction that she not be required to testify shielded her from further intrusion. Additional safeguards could have included requiring that the records be reviewed by an independent expert rather than the judge, requiring that the parties demonstrate a compelling need for the evidence before any disclosure is ordered, and requiring that Mrs. Singh be provided with independent legal representation. However, the safeguards implemented were substantial and likely achieved an appropriate balance.

Q4. As the Head of the Department of Mental Health, you are responsible for developing a policy to guide counsellors in responding to court orders and subpoenas for client records. Draft a comprehensive policy addressing: the initial response to a summons; consultation with legal counsel and supervisors; notification of the client; applications to set aside or modify the summons; production of records; and documentation.

Hints: The policy must require that upon receipt of a court order or subpoena, the counsellor shall immediately confirm the date by which a response is required, make a copy of the order or subpoena for the client's file, and refrain from disclosing any information until the procedure outlined in the policy has been followed. The counsellor shall immediately consult with the Head of the Department and the hospital's legal counsel, who shall advise on the validity and scope of the order, the applicable law regarding privilege and confidentiality, and the options available. Unless prohibited by a court order, the counsellor shall notify the client in writing, including a copy of the order, an explanation of the counsellor's legal obligations, the client's right to consent to or refuse disclosure, and the actions the counsellor proposes to take. The counsellor shall seek the client's written instructions regarding disclosure. If the client refuses consent, the counsellor shall, in consultation with legal counsel, file an appropriate application with the court to quash or set aside the subpoena, modify the scope of the order, have the records reviewed by the judge in chambers, limit disclosure to only those portions directly relevant to the proceedings, or impose a confidentiality order restricting the use and dissemination of the records. If the court orders disclosure, the counsellor shall produce the records in a manner that minimises the intrusion into the client's privacy, redacting all information not directly relevant to the proceedings, producing the records directly to the court or under seal, and seeking a confidentiality order. The counsellor shall document all actions taken and the rationale for decisions.

**Q5. What are the implications of this case for informed consent in counselling? How should counsellors discuss the limits of confidentiality with clients, particularly regarding the potential

for disclosure in civil litigation? Draft a plain-language explanation of confidentiality and its limits suitable for inclusion in an informed consent document.**

Hints: This case underscores the importance of a robust informed consent process that addresses not only the standard limits of confidentiality but also the potential for disclosure in civil litigation. Most clients understand that counsellors are required to breach confidentiality in cases of serious risk of harm. Fewer understand that their counselling records may be subpoenaed in family disputes, personal injury litigation or other civil proceedings. A plain-language explanation of confidentiality and its limits should include: a statement of the general principle that what the client tells the counsellor is confidential and will not be shared with anyone without permission; a clear explanation of the exceptions to confidentiality, including risk of serious harm to self or others, suspected abuse or neglect of a child or vulnerable adult, legal reporting requirements for certain diseases, and court orders requiring production of records or testimony; an acknowledgment that while these exceptions are rare, they can occur, and that the counsellor will take all reasonable steps to protect the client's privacy while complying with legal obligations; and an invitation for the client to ask questions and to discuss any concerns about confidentiality before proceeding. This explanation should be provided verbally and in writing at the outset of counselling and revisited periodically, particularly if the client discloses information that may be subject to disclosure. The counsellor should document that the explanation was provided and that the client acknowledged understanding.

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The curious paradox is that when I accept myself as I am, then I change. This is the lesson of person-centred therapy: that the facilitative conditions of empathy, unconditional positive regard and congruence are not merely techniques to be applied, but attitudes to be lived.

Carl Rogers, On Becoming a Person (1961)

LESSON-12

COUNSELLING APPLICATIONS IN HOSPITAL SETTINGS

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LEARNING OBJECTIVES

After completing this lesson, you will be able to:

1. Apply a systematic framework for assessing and diagnosing client problems in hospital counselling contexts, integrating clinical information, psychosocial history and standardised assessment tools
2. Select appropriate counselling strategies and interventions based on client presentation, therapeutic goals and the specific constraints of healthcare settings
3. Explain the mechanisms of behaviour change through counselling, including the stages of change model and the application of motivational interviewing
4. Evaluate the role of counselling in hospital performance improvement across clinical outcomes, patient satisfaction, staff well-being and risk management
5. Design counselling-based interventions for specific hospital populations including patients with chronic illness, caregivers and healthcare staff experiencing burnout

STRUCTURE OF THE LESSON

12.1 INTRODUCTION: COUNSELLING AS A CLINICAL AND ADMINISTRATIVE TOOL

Counselling in hospitals serves two distinct but interrelated purposes. The first is clinical: counselling alleviates psychological distress, supports adaptation to illness, enhances treatment adherence and improves quality of life for patients and their families. The second is administrative: counselling improves communication, resolves conflict, reduces staff burnout and contributes to the organisational performance of the hospital itself. These two purposes are not separate. A patient who receives empathic counselling about their diabetes management is more likely to adhere to medication and dietary recommendations, reducing hospital readmissions and improving clinical outcomes. A nurse who receives supportive counselling after a traumatic patient death is less likely to experience burnout and more likely to provide compassionate care to subsequent patients. A hospital that integrates counselling into its quality improvement infrastructure is investing simultaneously in patient welfare and organisational effectiveness. This lesson examines the application of counselling in hospital settings. It begins with the assessment and diagnosis of client problems, a process that in hospital contexts requires integration of medical information, psychosocial history and standardised assessment tools. It then surveys the range of counselling strategies and interventions available to the hospital counsellor, with attention to the specific constraints and opportunities of healthcare environments. It examines the mechanisms of behaviour change, including the transtheoretical model and motivational interviewing, which are particularly relevant to counselling for treatment adherence and lifestyle modification. Finally, it explores the role of counselling in hospital performance improvement, demonstrating how counselling skills and interventions can contribute to clinical excellence, patient satisfaction, staff well-being and risk management.

12.2 INTRODUCTORY CASE STUDY: THE CARDIAC WARD AND THE COUNSELLOR-LED QUALITY IMPROVEMENT INITIATIVE

The Department of Cardiology at a five hundred bed tertiary care hospital in Mumbai was experiencing a persistent problem. Patients admitted with acute myocardial infarction were being discharged with comprehensive recommendations for secondary prevention: antiplatelet therapy, statins, beta-blockers, smoking cessation, dietary modification and regular follow-up. Yet within six months of discharge, nearly forty per cent of patients had discontinued one or more of their medications, and only thirty per cent had achieved target blood pressure and LDL cholesterol levels. Readmission rates for recurrent cardiac events were significantly higher than benchmarked standards. The department had attempted multiple interventions. Pharmacists provided medication counselling at discharge. Nurses made follow-up telephone calls. A patient education booklet was developed and distributed. None of these interventions produced sustained improvement in adherence or clinical outcomes.

The department sought the assistance of the hospital's mental health service. A senior counsellor, Ms. Meera Nair, was embedded in the cardiology team for a six-month pilot project. Her role was not to provide traditional psychotherapy but to develop and implement a counselling-based intervention to improve treatment adherence. Ms. Nair began with a thorough assessment. She conducted semi-structured interviews with twenty patients who had been readmitted for recurrent cardiac events. She also interviewed ten patients who had maintained good adherence and achieved target clinical outcomes. She observed discharge counselling sessions and reviewed patient education materials.

Her assessment revealed several critical findings. Patients understood the purpose of their medications intellectually but did not feel personally vulnerable to recurrent events. The asymptomatic nature of hypertension and hyperlipidaemia undermined the perceived need for daily medication. Many patients held fatalistic beliefs about heart disease: what will happen will happen. Side effects, particularly statin-related myalgia, were common but patients did not report them to physicians, assuming they were unavoidable or fearing that the medication would be discontinued. Family members, particularly spouses, played a crucial role in medication adherence but were rarely included in discharge counselling. The discharge process was rushed, and patients were too overwhelmed by the experience of the cardiac event to absorb complex information.

Based on this assessment, Ms. Nair designed a multi-component intervention integrated into existing clinical workflows. The intervention included a structured counselling session with each patient and their identified family caregiver prior to discharge. The session was conducted by a trained counsellor using principles of motivational interviewing. The counsellor did not lecture the patient about the importance of adherence but explored the patient's own understanding of their illness, their concerns about medications and their personal goals for recovery. The counsellor elicited the patient's own reasons for taking medications and helped the patient to connect daily medication taking with their valued life activities—being able to play with grandchildren, to return to work, to travel. The intervention also included a simple side-effect management protocol. Patients were instructed to report any muscle pain or other symptoms to a designated nurse telephone line. The nurse triaged the symptoms, provided reassurance and arranged for medication review by the cardiologist if indicated. Patients were told that most side effects could be managed by adjusting the dose or switching to an alternative medication and that they should not discontinue medication without consulting the team. The intervention included a family component. The caregiver was trained to provide practical support for medication taking and to recognise early warning signs of recurrent cardiac events. The counsellor addressed the caregiver's own anxiety and provided strategies for managing their stress.

The intervention was evaluated using a pre-post design with historical controls. Six months after implementation, medication adherence measured by pharmacy refill rates increased from sixty per cent to eighty-two per cent. Blood pressure control improved from forty-five per cent to sixty-eight per cent. LDL cholesterol control improved from thirty per cent to fifty-five per cent. Cardiac readmission rates decreased by thirty-five per cent. Equally important, patient satisfaction scores for the cardiology service improved significantly. Patients reported feeling more involved in their care, more confident in managing their condition and more supported by the hospital after discharge. The cardiologists reported that the counsellor's assessments had deepened their understanding of their patients' barriers to adherence and that they had modified their own communication practices as a result.

Relevance to the Lesson: This case illustrates every major theme of this lesson. It demonstrates the importance of thorough assessment before designing interventions; the counsellor's interviews revealed barriers that were not apparent from clinical records or routine interactions. It illustrates the selection of appropriate counselling strategies; motivational interviewing was specifically suited to the problem of ambivalence about medication taking. It demonstrates the application of behaviour change principles; the intervention targeted multiple determinants of behaviour including perceived susceptibility, outcome expectations and social support. And it demonstrates the contribution of counselling to hospital performance

improvement; the intervention improved clinical outcomes, patient satisfaction and resource utilisation.

12.3 ASSESSING AND DIAGNOSING CLIENT PROBLEMS IN HOSPITAL SETTINGS

The Purpose of Assessment in Hospital Counselling

Assessment in hospital counselling serves multiple purposes. It identifies the nature and severity of the client's psychological distress. It elucidates the client's understanding of their illness and treatment. It identifies barriers to adherence and self-management. It uncovers the client's personal goals, values and resources. It informs the selection of appropriate interventions. It establishes a baseline against which progress can be measured. Assessment in hospital settings is distinguished from assessment in other counselling contexts by several features. The client is often not self-referred; they may be referred by a physician or nurse who has identified psychological distress or adherence problems. The client is physically ill and may be experiencing pain, fatigue or cognitive impairment that affects their ability to participate in assessment. The time available for assessment is often limited by the exigencies of medical care. The assessment must be integrated with the client's medical treatment and communicated to the treating team, subject to the client's consent.

Domains of Assessment

A comprehensive assessment in hospital counselling addresses multiple domains. The medical domain includes the client's diagnosis, prognosis, symptoms, treatment regimen and response to treatment. The counsellor must understand the medical facts of the client's condition to provide accurate psychoeducation and to distinguish psychological distress from organic symptoms. This information is obtained from the medical record and from consultation with the treating team.

The psychological domain includes the client's emotional state, cognitive appraisals, coping strategies and psychiatric history. The counsellor assesses for anxiety, depression, post-traumatic stress and adjustment disorders, which are common in medically ill populations. The counsellor also assesses the client's understanding of their illness, their beliefs about its cause and controllability, and their expectations for the future.

The behavioural domain includes the client's health-related behaviours: medication adherence, diet, physical activity, tobacco and alcohol use, and sleep. The counsellor assesses patterns of behaviour, antecedents and consequences, and the client's readiness to change.

The social domain includes the client's family relationships, social support, occupational functioning and financial circumstances. Illness affects and is affected by the client's social context. The counsellor assesses the availability and quality of support, the impact of illness on family roles and responsibilities, and any practical barriers to adherence such as cost of medications or transportation to appointments.

The cultural domain includes the client's cultural background, religious and spiritual beliefs, and explanatory models of illness. Culture shapes how clients understand and respond to illness, how they communicate with healthcare providers and what treatments they find

acceptable. The counsellor approaches cultural assessment with humility, recognising that the client is the expert on their own culture.

Assessment Methods

The clinical interview is the primary assessment method in hospital counselling. The counsellor conducts a semi-structured interview that covers the domains described above while remaining responsive to the client's immediate concerns and distress. The interview is not a forensic interrogation; it is a therapeutic conversation in which the counsellor communicates empathy and builds relationship while gathering information.

Standardised assessment instruments supplement the clinical interview. These instruments provide objective, quantifiable measures of psychological symptoms, quality of life, treatment adherence and other relevant constructs. They facilitate screening, diagnosis and monitoring of progress. Commonly used instruments in hospital settings include the Hospital Anxiety and Depression Scale, the Patient Health Questionnaire-9 for depression, the Generalised Anxiety Disorder-7 and the Morisky Medication Adherence Scale.

Behavioural observation is an important assessment method, particularly for clients who are unable to communicate verbally due to illness or treatment. The counsellor observes the client's appearance, behaviour, affect and interaction with family members and healthcare providers. These observations are integrated with information from other sources to form a comprehensive formulation.

Collateral information from family members and healthcare providers is essential in hospital settings. Family members can provide information about the client's pre-morbid functioning, adherence patterns and social context. Physicians and nurses can provide information about the client's medical status, response to treatment and behaviour during medical encounters. Collateral information must be obtained with the client's consent and used judiciously, recognising that family members and providers have their own perspectives and biases.

Formulation and Diagnosis

The assessment culminates in a formulation that integrates information from multiple domains into a coherent understanding of the client's problems and their determinants. The formulation addresses four questions. What is the nature of the client's problems? What factors have predisposed the client to develop these problems? What factors have precipitated the problems at this time? What factors are maintaining the problems? The formulation may include a psychiatric diagnosis using the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders. Common diagnoses in hospital settings include adjustment disorders, depressive disorders, anxiety disorders and neurocognitive disorders. However, many clients receiving hospital counselling do not meet criteria for a psychiatric diagnosis; their distress is a normal response to serious illness, not a mental disorder. The formulation should normalise this distress while identifying when professional intervention is indicated. The formulation is communicated to the treating team, with the client's consent, to inform the overall treatment plan. It is also shared with the client, in accessible language, to enhance their understanding of their situation and to engage them as a collaborator in the counselling process.

12.4 SELECTING COUNSELLING STRATEGIES AND INTERVENTIONS

Principles of Intervention Selection

The selection of counselling strategies and interventions in hospital settings is guided by several principles. The intervention must be appropriate to the client's presenting problems, goals and preferences. It must be feasible within the constraints of the hospital environment, including time limits, the client's physical condition and the availability of resources. It must be acceptable to the client and to the referring healthcare providers. It must be evidence-based, supported by research demonstrating its effectiveness for similar populations and problems. The counsellor's theoretical orientation informs but does not dictate intervention selection. An integrative approach, drawing on multiple therapeutic traditions in a coherent and client-responsive manner, is particularly well-suited to the complexity and diversity of hospital populations.

Psychoeducation

Psychoeducation is the provision of information about illness, treatment and coping to clients and their families. It is one of the most frequently used interventions in hospital counselling and is often sufficient as a standalone intervention for clients with mild to moderate distress who are seeking information and reassurance. Effective psychoeducation is tailored to the client's existing knowledge, beliefs and concerns. It is provided in plain language, avoiding medical jargon. It is interactive, inviting the client to ask questions and to relate the information to their own experience. It is hopeful, emphasising what can be done rather than focusing exclusively on limitations and losses. Psychoeducation may be provided individually or in groups. It may be delivered verbally, in writing or through multimedia. It may address a single topic, such as the mechanism of action of antidepressant medication, or a comprehensive curriculum, such as a diabetes self-management education programme.

Cognitive-Behavioural Interventions

Cognitive-behavioural interventions are widely used in hospital counselling for clients experiencing depression, anxiety and difficulty adjusting to illness. These interventions are based on the premise that psychological distress is mediated by maladaptive patterns of thinking and behaviour. Cognitive restructuring assists clients to identify, examine and modify automatic thoughts and underlying beliefs that contribute to distress. A client with heart disease who thinks I will never be able to exercise again after experiencing breathlessness may be helped to examine the evidence for and against this prediction, to generate alternative interpretations and to test these alternatives through graded activity. Behavioural activation addresses depression by increasing engagement in valued activities. Hospitalised clients are often inactive due to illness, treatment and the institutional environment. Behavioural activation helps clients to identify activities that are meaningful and achievable, to schedule these activities and to monitor their mood in relation to activity. Problem-solving therapy is a structured intervention that assists clients to cope with practical problems arising from illness. The client is taught a systematic method: define the problem, generate alternative solutions, evaluate the alternatives, select and implement a solution, and evaluate the outcome. Problem-solving therapy is particularly effective for clients with multiple, concrete problems such as managing symptoms, accessing services and communicating with healthcare providers.

Supportive Counselling

Supportive counselling is the provision of empathy, validation and encouragement to clients experiencing distress. It is not a distinct technique but a therapeutic stance that underlies all effective counselling. Supportive counselling is particularly important in hospital settings, where clients are confronting existential threats, physical suffering and profound uncertainty. Supportive counselling does not seek to change the client's personality or to resolve deep-seated conflicts. It seeks to help the client to bear their distress, to maintain their self-esteem and to mobilise their existing coping resources. It is appropriate for clients who are in crisis, who have limited psychological mindedness or who are not motivated for more intensive, insight-oriented work.

Family and Caregiver Interventions

Illness affects not only the patient but also their family members and caregivers. Family interventions in hospital settings address the needs of both the patient and the family as a system. Family counselling may focus on communication, helping family members to express their concerns and to understand each other's perspectives. It may focus on role restructuring, helping the family to adapt to changes in the patient's functional capacity. It may focus on caregiver support, addressing the stress, burden and grief experienced by family members who provide care. Family interventions require attention to issues of confidentiality and consent. The patient must consent to the involvement of family members and to the sharing of information about their medical condition and treatment.

Crisis Intervention

Crisis intervention is a time-limited, focused intervention for clients experiencing acute psychological distress that overwhelms their usual coping mechanisms. Crises in hospital settings may be precipitated by the diagnosis of a life-threatening illness, sudden deterioration, traumatic injury or the death of a loved one. Crisis intervention follows a structured sequence. The counsellor establishes rapport and assesses the nature and severity of the crisis. The counsellor helps the client to articulate the precipitating event and their emotional response. The counsellor assists the client to mobilise their existing coping resources and social supports. The counsellor develops a plan for immediate safety and follow-up care. Crisis intervention is not psychotherapy; its goal is not personality change but restoration of the client's pre-crisis level of functioning. It is typically brief, one to three sessions, and focused on the here and now.

End-of-Life Counselling

End-of-life counselling supports patients and families facing death. It addresses multiple tasks: managing pain and other symptoms, making decisions about life-sustaining treatment, completing advance directives, saying goodbye to loved ones, finding meaning in life and in death, and preparing for the dying process. End-of-life counselling requires the counsellor to confront their own feelings about death and to remain present with the dying person without withdrawing emotionally or imposing their own beliefs. The counsellor does not impose hope or deny despair but accompanies the patient wherever they are: in hope, in fear, in acceptance, in anger. The counsellor also supports the patient's family, before and after death. Bereavement counselling helps family members to process their grief and to adapt to life without the deceased.

12.5 CHANGING BEHAVIOUR THROUGH COUNSELLING

The Stages of Change Model

The transtheoretical model of behaviour change, developed by Prochaska and DiClemente, describes change as a process that unfolds through a series of stages. The model is particularly relevant to hospital counselling, where clients are often ambivalent about changing behaviours that contribute to their illness. In the precontemplation stage, the client has no intention of changing the target behaviour within the foreseeable future. They may be unaware of the problem, or they may have made previous unsuccessful attempts to change and given up. The counsellor's task is not to push for change but to raise awareness and to help the client to consider the possibility of change. In the contemplation stage, the client is aware of the problem and is seriously considering change but has not yet made a commitment to act. They are weighing the pros and cons of changing and of maintaining the status quo. The counsellor's task is to help the client to resolve their ambivalence, to tip the decisional balance in favour of change. In the preparation stage, the client intends to take action within the next month and may have made some preliminary steps. The counsellor's task is to help the client to develop a realistic, detailed action plan and to anticipate and overcome barriers. In the action stage, the client is actively modifying their behaviour and environment. This stage requires the greatest commitment of time and energy. The counsellor's task is to support the client's efforts, to reinforce progress and to help the client to maintain motivation. In the maintenance stage, the client works to consolidate their gains and to prevent relapse. The counsellor's task is to help the client to develop strategies for coping with high-risk situations and to view lapses as learning opportunities rather than failures. Termination is the stage at which the client has fully integrated the new behaviour into their life and experiences no temptation to return to the old pattern. Many clients do not reach termination; they remain in maintenance, requiring ongoing vigilance.

Motivational Interviewing

Motivational interviewing is a collaborative, goal-oriented style of communication designed to strengthen a person's own motivation and commitment to change. It was developed by William Miller and Stephen Rollnick for the treatment of substance use disorders and has since been applied to a wide range of health behaviours. Motivational interviewing is founded on four principles. Express empathy involves understanding the client's perspective without judging, criticising or blaming. Develop discrepancy involves helping the client to recognise the gap between their current behaviour and their broader goals and values. Roll with resistance involves avoiding argumentation and responding to the client's resistance not with confrontation but with reflection and redirection. Support self-efficacy involves affirming the client's belief that they are capable of change. The counsellor using motivational interviewing does not tell the client why they should change or how they should change. They elicit the client's own reasons for change, explore the client's own ideas about how to change and support the client's own efforts. The counsellor's stance is one of partnership, not expertise.

Behavioural Techniques

Behavioural techniques are derived from learning theory and are used to modify specific, observable behaviours. They are often combined with cognitive interventions in cognitive-behavioural therapy. Stimulus control involves modifying the environment to reduce cues for undesired behaviour and increase cues for desired behaviour. A patient trying to quit smoking

might be advised to remove ashtrays and lighters from their home and to avoid situations where they typically smoked. Reinforcement involves the use of rewards to increase the frequency of desired behaviour. Reinforcement may be external, such as praise from the counsellor or tangible rewards, or internal, such as the satisfaction of achieving a goal. Reinforcement must be contingent on the behaviour, immediate and meaningful to the client. Goal setting involves breaking down long-term goals into specific, measurable, achievable, relevant and time-bound sub-goals. The counsellor helps the client to define what they want to achieve, to identify the steps required and to monitor their progress. Self-monitoring involves the client systematically observing and recording their own behaviour. A patient with diabetes might be asked to record their blood glucose levels, dietary intake and physical activity. Self-monitoring increases awareness of the behaviour and its determinants and provides feedback on progress.

Relapse Prevention

Relapse prevention is a cognitive-behavioural approach to maintaining behaviour change over time. It is based on the recognition that lapses are common and do not signify failure; the goal is to prevent a lapse from escalating into a full relapse. Relapse prevention involves identifying high-risk situations that threaten the maintenance of change, developing coping strategies for these situations, and challenging cognitive distortions that follow a lapse, such as the abstinence violation effect: I've blown it, so I might as well give up completely.

12.6 COUNSELLING FOR HOSPITAL PERFORMANCE IMPROVEMENT

Counselling and Clinical Outcomes

Counselling contributes to improved clinical outcomes through multiple mechanisms. It reduces psychological distress, which is itself a clinically significant outcome and also interferes with recovery from physical illness. It improves treatment adherence by addressing patient beliefs, concerns and barriers. It enhances self-management skills, enabling patients to manage chronic conditions more effectively. It facilitates communication between patients and healthcare providers, reducing misunderstandings and improving shared decision-making. The evidence base for counselling in medical settings is robust. Meta-analyses demonstrate that psychological interventions improve outcomes across a range of conditions, including cardiovascular disease, cancer, diabetes and chronic pain. The effect sizes are modest but clinically meaningful and cost-effective.

Counselling and Patient Experience

Patient experience is a core domain of healthcare quality and is increasingly linked to reimbursement through value-based purchasing programmes. Counselling directly improves patient experience by addressing the emotional and informational needs that are often neglected in busy clinical encounters. Patients who receive counselling report greater satisfaction with their care, greater confidence in their healthcare providers and greater involvement in decision-making. They are more likely to recommend the hospital to others and less likely to file complaints or litigation.

Counselling and Staff Well-Being

Healthcare professionals are at high risk for burnout, compassion fatigue and moral distress. The demands of clinical work, the emotional intensity of patient care and the bureaucratic

burdens of modern healthcare combine to erode professional well-being and to drive talented clinicians from the profession. Counselling services for staff address this crisis. Employee assistance programmes provide confidential counselling for personal and work-related problems. Peer support programmes train clinicians to provide emotional support to colleagues following adverse events or patient deaths. Balint groups and other reflective practice forums provide structured opportunities for clinicians to explore the emotional dimensions of their work. The benefits of staff counselling extend beyond individual well-being. Burnout is associated with reduced productivity, increased errors and lower patient satisfaction. Organisations that invest in staff well-being reap returns in quality, safety and retention.

Counselling and Risk Management

Counselling contributes to risk management by reducing the likelihood of adverse events and mitigating the consequences when adverse events occur. Improved communication between patients and healthcare providers reduces the risk of misunderstandings, non-adherence and preventable complications. Patients who feel heard and respected are less likely to file complaints or litigation when outcomes are unfavourable. When adverse events do occur, disclosure and apology programmes, which draw on counselling principles, reduce the likelihood of litigation and the severity of claims. These programmes train clinicians to communicate openly and empathetically with patients and families following adverse events, to explain what happened, to accept responsibility, to apologise and to offer compensation where appropriate.

Implementing Counselling Services for Performance Improvement

Implementing counselling services for performance improvement requires attention to multiple levels of the organisation. At the strategic level, hospital leadership must articulate a vision for patient- and family-centred care and must allocate resources to support counselling services. Counselling should be positioned not as an optional add-on but as an integral component of high-quality care. At the operational level, counselling services must be integrated into clinical workflows. Referral pathways should be clear and accessible. Counsellors should be embedded in clinical teams where possible. Communication between counsellors and referring clinicians should be timely and bidirectional. At the clinical level, counsellors must be trained in the specific needs of medical populations and in the skills of interprofessional collaboration. They must be able to translate psychological concepts into language that is meaningful to patients and clinicians. They must be comfortable working in fast-paced, technologically intensive environments where their primary tool remains the therapeutic relationship. At the evaluation level, counselling services must be held accountable for their contribution to organisational performance. This requires the collection and analysis of data on processes and outcomes. Process measures include the volume and characteristics of clients served, the timeliness of access and patient satisfaction with counselling services. Outcome measures include changes in psychological distress, treatment adherence, clinical outcomes, patient experience scores and staff turnover.

12.7 HEALTHCARE-SPECIFIC CONTRACTUAL ISSUES IN COUNSELLING

The Scope of Counselling Practice in Hospitals

The scope of counselling practice in hospitals is defined by a complex interplay of professional regulation, institutional policy and contractual agreements. Counsellors in hospitals must be

clear about what services they are authorised and competent to provide and what services fall outside their scope. Counsellors do not diagnose or treat medical conditions. They do not prescribe medications. They do not perform procedures. Their role is to address the psychological, social and behavioural dimensions of illness and healthcare. The boundaries of this role must be clearly communicated to patients, families and referring clinicians.

Referral and Consultation Agreements

Counsellors in hospitals typically receive referrals from physicians, nurses and other healthcare professionals. The referral should specify the reason for referral, the information that has already been provided to the patient and any specific questions to be addressed. The counsellor should provide feedback to the referring clinician, with the patient's consent, summarising the assessment findings, the interventions provided and the recommendations for ongoing care. These referral and consultation relationships should be formalised in written agreements that specify the responsibilities of each party, the procedures for communication and the mechanisms for resolving disagreements. The agreements should also address the allocation of costs and the handling of disputes.

Confidentiality and Information Sharing

Confidentiality in hospital counselling is governed by the same ethical principles and legal exceptions that apply in other counselling contexts. However, hospital settings create additional complexities. The counsellor is part of a multidisciplinary team, and effective patient care requires the sharing of relevant information among team members. The patient must understand and consent to this information sharing. The counsellor should explain to the patient, at the outset of the relationship, the limits of confidentiality within the team setting. The patient should be informed that relevant information will be shared with other members of the healthcare team who are involved in their care and that this sharing is essential to coordinated, effective treatment. When information is shared, it should be limited to what is necessary for the recipient's role in the patient's care. The counsellor should not disclose information that is irrelevant to the patient's medical treatment or that would unnecessarily invade the patient's privacy.

Documentation and Record-Keeping

Counsellors in hospitals are required to maintain records of their work with patients. These records are part of the patient's medical record and are subject to the same legal and regulatory requirements as other clinical documentation. The counselling record should document the date and duration of each session, the patient's presenting concerns and status, the interventions provided, the patient's response and the plan for ongoing care. The record should be factual, objective and professional. It should not include the counsellor's unprocessed emotional responses or speculative formulations. The patient has a right to access their counselling records, subject to limited exceptions. The counsellor should be familiar with the hospital's policy on patient access to records and should inform patients of their rights.

Liability and Indemnity

Counsellors in hospitals are typically employees of the hospital and are covered by the hospital's vicarious liability for the acts of its employees. The hospital is responsible for the negligent acts of counsellors committed within the scope of their employment. Counsellors

should maintain their own professional indemnity insurance as a safeguard against claims that may fall outside the scope of the hospital's coverage. They should also ensure that their practice is consistent with the standards of their profession and with the policies of the hospital.

Tele-counselling and Digital Health

The COVID-19 pandemic accelerated the adoption of tele-counselling in hospital settings. Counsellors now routinely provide services by telephone and video conference. This shift raises new contractual issues. The hospital must ensure that the tele-counselling platform is secure and compliant with data protection laws. The counsellor must verify the patient's identity and location. The counsellor must have a plan for managing emergencies when the patient is not physically present. The patient must be informed of the limitations of tele-counselling compared to face-to-face work and must consent to this mode of service delivery. These issues should be addressed in a tele-counselling policy and in the informed consent documents provided to patients.

12.8 STUDENT LEARNING ACTIVITIES

Activity 1: Assessment and Formulation Exercise

You are a counsellor in the diabetes clinic of a large teaching hospital. You receive a referral from an endocrinologist regarding Mr. Rajesh Kumar, a fifty-two year old businessman with type 2 diabetes. Mr. Kumar's HbA1c has been persistently elevated at 9.5 per cent despite multiple medication adjustments. The endocrinologist notes that Mr. Kumar reports taking his medications regularly but his pharmacy refill records show gaps. He has missed his last two appointments. Develop a comprehensive assessment framework for Mr. Kumar. Identify the domains you would assess and the specific questions you would ask in each domain. Describe how you would integrate information from the medical record, the clinical interview and collateral sources. Based on the limited information available, develop a preliminary formulation of Mr. Kumar's problems and their determinants. Identify the interventions you would consider and the factors that would influence your selection of interventions.

Activity 2: Motivational Interviewing Role Play

You are a counsellor working in a pre-operative assessment clinic. A fifty-eight year old patient scheduled for elective coronary artery bypass grafting continues to smoke one pack of cigarettes per day. The cardiac surgeon has told the patient that smoking significantly increases the risk of post-operative complications and graft failure and has strongly advised him to quit. The patient states that he understands the risks but has tried to quit many times and failed. He is ambivalent about making another attempt before surgery. Write a detailed script of a motivational interviewing session with this patient. Your script should demonstrate: the use of open-ended questions to elicit the patient's perspective; reflective listening to communicate understanding; the development of discrepancy between the patient's current behaviour and his broader goals and values; rolling with resistance rather than confronting it; and supporting the patient's self-efficacy. Include a commentary explaining your choice of interventions at each point.

Activity 3: Designing a Staff Counselling Programme

You are the administrator of a four hundred bed tertiary care hospital. The chief medical officer has requested that you develop a proposal for a staff counselling programme to address high rates of burnout and turnover among nurses and resident doctors. Your proposal must be evidence-based, feasible within the hospital's budget and acceptable to the intended users. Develop a comprehensive proposal for a staff counselling programme. Your proposal should include: a needs assessment plan; the objectives and scope of the programme; the service delivery model (individual counselling, group support, peer support or a combination); the staffing requirements and qualifications; the referral pathways; the confidentiality policy; the evaluation framework; and the budget. Justify your recommendations with reference to the literature on healthcare professional burnout and staff support interventions.

Activity 4: Quality Improvement Project Design

You are a counsellor embedded in the oncology service of a teaching hospital. The head of the service has asked you to develop a counselling-based intervention to improve advance care planning and completion of advance directives among patients with advanced cancer. Currently, fewer than twenty per cent of eligible patients have documented advance care planning discussions or completed advance directives. Design a quality improvement project to address this gap. Your project design should include: a baseline assessment of current practices and barriers; a description of the intervention, including its theoretical basis, content, format and dose; a plan for implementing the intervention, including training of staff and integration into clinical workflows; a plan for evaluating the intervention, including process and outcome measures, data collection methods and analysis; and a plan for sustaining and spreading the intervention if it is effective.

12.9 SUMMARY

Counselling in hospital settings serves both clinical and administrative purposes. It alleviates psychological distress, supports adaptation to illness, enhances treatment adherence and improves quality of life for patients and their families. It also improves communication, resolves conflict, reduces staff burnout and contributes to organisational performance.

Assessment in hospital counselling is a comprehensive process that addresses multiple domains: medical, psychological, behavioural, social and cultural. The clinical interview is the primary assessment method, supplemented by standardised instruments, behavioural observation and collateral information. The assessment culminates in a formulation that integrates information from multiple sources into a coherent understanding of the client's problems and their determinants.

The selection of counselling strategies and interventions is guided by the client's presenting problems, goals and preferences; the constraints of the hospital environment; and the evidence base. Common interventions in hospital settings include psychoeducation, cognitive-behavioural interventions, supportive counselling, family interventions, crisis intervention and end-of-life counselling.

Behaviour change through counselling is facilitated by understanding the process of change and by using techniques that are matched to the client's stage of readiness. The transtheoretical model describes change as a process that unfolds through precontemplation, contemplation, preparation, action, maintenance and termination. Motivational interviewing is a collaborative, goal-oriented style of communication that is particularly effective for clients who are

ambivalent about change. Behavioural techniques, including stimulus control, reinforcement, goal setting and self-monitoring, are used to modify specific behaviours. Relapse prevention helps clients to maintain change over time.

Counselling contributes to hospital performance improvement through multiple mechanisms. It improves clinical outcomes by reducing psychological distress, improving treatment adherence and enhancing self-management. It improves patient experience by addressing emotional and informational needs. It improves staff well-being by providing support for healthcare professionals at risk for burnout. It contributes to risk management by reducing the likelihood of adverse events and by mitigating the consequences when adverse events occur.

Healthcare-specific contractual issues in counselling include defining the scope of practice, formalising referral and consultation relationships, managing confidentiality and information sharing within multidisciplinary teams, maintaining appropriate documentation, and addressing the liability and indemnity of counsellors. The expansion of tele-counselling has created new contractual and ethical challenges that must be addressed through policy and informed consent.

12.10 KEY WORDS WITH EXPLANATIONS

Assessment is the systematic process of gathering information about a client's problems, their determinants and their resources. In hospital counselling, assessment integrates medical information, psychosocial history, standardised instruments and collateral information.

Formulation is a coherent understanding of the client's problems and their determinants that integrates information from multiple domains. It addresses the nature, predisposing factors, precipitating factors and maintaining factors of the client's difficulties.

Psychoeducation is the provision of information about illness, treatment and coping to clients and their families. It is a frequently used intervention in hospital counselling that may be sufficient as a standalone intervention for clients with mild to moderate distress.

Cognitive Restructuring is a cognitive-behavioural intervention that assists clients to identify, examine and modify automatic thoughts and underlying beliefs that contribute to psychological distress.

Behavioural Activation is a cognitive-behavioural intervention for depression that focuses on increasing engagement in valued activities. It is particularly relevant for hospitalised clients who are inactive due to illness, treatment and the institutional environment.

Motivational Interviewing is a collaborative, goal-oriented style of communication designed to strengthen a person's own motivation and commitment to change. It is founded on four principles: express empathy, develop discrepancy, roll with resistance and support self-efficacy.

Transtheoretical Model is a model of behaviour change developed by Prochaska and DiClemente that describes change as a process unfolding through stages: precontemplation, contemplation, preparation, action, maintenance and termination.

Relapse Prevention is a cognitive-behavioural approach to maintaining behaviour change over time. It involves identifying high-risk situations, developing coping strategies and challenging cognitive distortions that follow a lapse.

Crisis Intervention is a time-limited, focused intervention for clients experiencing acute psychological distress that overwhelms their usual coping mechanisms. Goals are restoration of pre-crisis functioning and mobilisation of resources.

End-of-Life Counselling is counselling that supports patients and families facing death. It addresses symptom management, treatment decisions, advance directives, legacy creation and the emotional and spiritual dimensions of dying.

Burnout is a psychological syndrome characterised by emotional exhaustion, depersonalisation and reduced personal accomplishment. It is common among healthcare professionals and associated with reduced quality of care, increased errors and high turnover.

Employee Assistance Programme is a workplace-based programme that provides confidential counselling and support services to employees and their families. It addresses personal and work-related problems, including mental health concerns, substance use, financial stress and family difficulties.

12.11 SELF ASSESSMENT QUESTIONS

A. Short Answer Questions

Q1. What are the five domains of assessment in hospital counselling described in this lesson?

Ans. The five domains are: medical domain, including the client's diagnosis, prognosis, symptoms, treatment regimen and response to treatment; psychological domain, including emotional state, cognitive appraisals, coping strategies and psychiatric history; behavioural domain, including health-related behaviours, patterns of adherence and readiness to change; social domain, including family relationships, social support, occupational functioning and financial circumstances; and cultural domain, including cultural background, religious and spiritual beliefs, and explanatory models of illness.

Q2. What are the four questions addressed by a comprehensive formulation in hospital counselling?

Ans. A comprehensive formulation addresses four questions: What is the nature of the client's problems? What factors have predisposed the client to develop these problems? What factors have precipitated the problems at this time? What factors are maintaining the problems? The formulation integrates information from multiple domains to provide a coherent understanding of the client's difficulties and to guide the selection of interventions.

Q3. What are the five stages of change in the transtheoretical model?

Ans. The five stages are: precontemplation, in which the client has no intention of changing the target behaviour within the foreseeable future; contemplation, in which the client is aware of the problem and is seriously considering change but has not yet committed to action;

preparation, in which the client intends to take action within the next month and may have made some preliminary steps; action, in which the client is actively modifying their behaviour and environment; and maintenance, in which the client works to consolidate their gains and to prevent relapse. Some versions of the model include a sixth stage, termination, in which the client experiences no temptation to return to the old behaviour.

Q4. What are the four principles of motivational interviewing?

Ans. The four principles are: express empathy, which involves understanding the client's perspective without judging, criticising or blaming; develop discrepancy, which involves helping the client to recognise the gap between their current behaviour and their broader goals and values; roll with resistance, which involves avoiding argumentation and responding to the client's resistance with reflection and redirection rather than confrontation; and support self-efficacy, which involves affirming the client's belief that they are capable of change.

Q5. What is burnout and how does counselling contribute to its prevention and management?

Ans. Burnout is a psychological syndrome characterised by emotional exhaustion, depersonalisation and reduced personal accomplishment. It is common among healthcare professionals due to the demands of clinical work, the emotional intensity of patient care and the bureaucratic burdens of modern healthcare. Counselling contributes to burnout prevention and management through employee assistance programmes that provide confidential counselling for personal and work-related problems; peer support programmes that train clinicians to provide emotional support to colleagues; and reflective practice forums that provide structured opportunities to explore the emotional dimensions of clinical work.

B. Essay Type Questions with Hints

Q1. Describe the process of assessment and formulation in hospital counselling. How does assessment in hospital settings differ from assessment in other counselling contexts, and what special considerations apply?

Hints: Structure your answer around the purpose, domains, methods and products of assessment. Explain the importance of assessment in guiding intervention selection and establishing baseline measures. Describe the five domains of assessment and the specific information sought in each domain. Discuss the methods of assessment: clinical interview, standardised instruments, behavioural observation and collateral information. Explain the concept of formulation and the four questions it addresses. Discuss the special considerations in hospital settings: the client is often not self-referred, is physically ill, has limited time and energy, and is embedded in a complex medical system. Discuss the importance of integrating assessment with the client's medical care and communicating findings to the treating team. Conclude with an example of a comprehensive formulation.

Q2. Compare and contrast motivational interviewing with traditional advice-giving approaches to health behaviour change. Why is motivational interviewing particularly effective for clients who are ambivalent about change?

Hints: Begin by defining motivational interviewing and its four principles. Contrast the collaborative, evocative stance of motivational interviewing with the directive, prescriptive

stance of traditional advice-giving. Explain the concept of ambivalence and why it is a normal, not pathological, stage of the change process. Discuss why advice-giving often fails with ambivalent clients: it elicits resistance, it ignores the client's own reasons for change, it does not address the decisional balance. Explain how motivational interviewing addresses ambivalence: by expressing empathy, the counsellor creates a safe environment for the client to explore both sides of their ambivalence; by developing discrepancy, the counsellor helps the client to connect behaviour change with their own values; by rolling with resistance, the counsellor avoids the confrontation that leads to defensiveness; by supporting self-efficacy, the counsellor empowers the client to take ownership of change. Conclude with a summary of the evidence base for motivational interviewing across multiple health behaviours.

Q3. Design a counselling-based intervention to improve medication adherence in patients with chronic illness. Your answer should include: a theoretical framework; a description of the intervention components; a plan for implementation; and a plan for evaluation.

Hints: Structure your answer as a project proposal. Begin with a brief review of the problem of non-adherence and its consequences. Identify the theoretical framework: the transtheoretical model, motivational interviewing, social cognitive theory or an integrative framework. Describe the intervention components: assessment of barriers to adherence; psychoeducation about the medication and the condition; motivational interviewing to address ambivalence; cognitive-behavioural strategies such as self-monitoring, goal setting and problem-solving; family involvement; side-effect management; and relapse prevention. Describe the implementation plan: training of counsellors; integration into clinical workflows; referral pathways; and materials. Describe the evaluation plan: process measures (number and characteristics of patients served, fidelity of intervention delivery) and outcome measures (adherence measured by pharmacy refill rates or electronic monitoring; clinical outcomes such as blood pressure, HbA1c or LDL cholesterol; patient-reported outcomes; and cost-effectiveness). Conclude with a discussion of sustainability and scalability.

Q4. Discuss the role of counselling in hospital performance improvement. How can counselling services demonstrate their value to hospital administrators and justify continued investment?

Hints: Structure your answer around the four domains of performance improvement: clinical outcomes, patient experience, staff well-being and risk management. For each domain, explain the mechanisms by which counselling contributes to performance, summarise the evidence base and provide specific examples. Discuss the challenge of demonstrating value in a resource-constrained environment. Explain the importance of measurement: counselling services must collect and analyse data on processes and outcomes. Describe the types of measures that are meaningful to hospital administrators: clinical outcome measures, patient experience scores, staff turnover rates, litigation rates and return on investment calculations. Discuss the importance of aligning counselling service goals with organisational priorities and communicating outcomes in language that resonates with administrators. Conclude with a framework for developing a business case for counselling services.

**Q5. You are the manager of a hospital counselling service. A patient has filed a complaint alleging that a counsellor disclosed confidential information to the patient's spouse without consent. The counsellor states that the patient was acutely suicidal and that the disclosure was necessary to protect the patient's safety. There is no documentation of the counsellor's assessment of risk or the decision to breach confidentiality. Draft a comprehensive policy on

confidentiality and its limits for the counselling service, including procedures for risk assessment, documentation and disclosure.**

Hints: Structure your answer as a formal policy document. Begin with a preamble affirming the importance of confidentiality. Define the scope of the policy. State the general principle that client information is confidential and will not be disclosed without consent. Specify the exceptions to confidentiality: risk of serious harm to self or others; disclosure required by law; court order. For each exception, provide detailed guidance: what constitutes serious and imminent risk; how to assess risk using standardised instruments and clinical judgment; the threshold for disclosure; the procedure for making a disclosure, including who to contact and what information to disclose; the documentation required, including the rationale for disclosure and the steps taken to minimise harm. Include a section on communicating the limits of confidentiality to clients at the outset of counselling and periodically thereafter. Include a section on training and audit. Conclude with a statement of accountability and review procedures.

C. Analytical Multiple Choice Questions

1. A client with type 2 diabetes states: I know I should check my blood sugar more often, but I just don't see the point. I feel fine. What difference does a number make? According to the transtheoretical model, this client is in which stage of change?
a) Precontemplation
b) Contemplation
c) Preparation
d) Action
Correct Answer: a) Precontemplation

2. A counsellor says to a client: You've mentioned several times that you want to quit smoking for your children, but you also say that cigarettes help you manage stress at work. I wonder how you balance those two important priorities. This intervention is an example of:
a) Expressing empathy
b) Developing discrepancy
c) Rolling with resistance
d) Supporting self-efficacy
Correct Answer: b) Developing discrepancy

3. A client with heart failure is readmitted with fluid overload. The client states: I know I'm supposed to weigh myself every day and call if I gain two pounds, but I just forget. I get busy and it slips my mind. Which of the following interventions is most directly indicated?
a) Cognitive restructuring to challenge the belief that forgetting is acceptable
b) Stimulus control to place the weighing scale in a visible location
c) Relapse prevention to address the abstinence violation effect
d) End-of-life counselling to address the client's denial
Correct Answer: b) Stimulus control to place the weighing scale in a visible location

4. A patient with metastatic cancer tells the counsellor: I'm not afraid of dying. I believe in God and I know I'm going to a better place. But I'm terrified of the process of dying. I don't want to be in pain. I don't want to be alone. I don't want to be a burden on my children. This patient is most likely experiencing:
a) Major depressive disorder

b) Generalised anxiety disorder
c) Normal existential distress in the context of terminal illness
d) Delusional disorder
Correct Answer: c) Normal existential distress in the context of terminal illness

5. A hospital implements a counselling-based intervention to improve medication adherence in patients with coronary artery disease. Six months later, medication adherence has increased from 60 per cent to 80 per cent, and cardiac readmission rates have decreased by 25 per cent. These outcomes are examples of:
a) Process measures
b) Outcome measures
c) Structure measures
d) Balancing measures
Correct Answer: b) Outcome measures

6. A counsellor receives a referral for a 75-year-old patient who is refusing to eat and has stopped taking his medications. The patient's son states that his father is depressed and needs counselling. Upon meeting the patient, the counsellor observes that the patient is withdrawn and speaks in monosyllables. The patient's medical record indicates that he was started on a new antihypertensive medication three days ago. The counsellor's first action should be:
a) Begin cognitive-behavioural therapy for depression
b) Refer the patient to a psychiatrist for medication evaluation
c) Consult with the treating physician about the possibility of medication side effects
d) Educate the son about the importance of supporting his father's autonomy
Correct Answer: c) Consult with the treating physician about the possibility of medication side effects

7. A hospital counsellor is providing tele-counselling to a patient who is at home recovering from cardiac surgery. During the session, the patient states that he is experiencing chest pain and shortness of breath. The counsellor should:
a) Continue the counselling session and address the patient's anxiety about his symptoms
b) Teach the patient a relaxation technique to manage his symptoms
c) Terminate the session immediately and instruct the patient to call emergency services
d) Schedule an earlier follow-up appointment with the patient's cardiologist
Correct Answer: c) Terminate the session immediately and instruct the patient to call emergency services

12.12 CONDENSED CASE STUDY FOR SELF-ASSESSMENT

The Burnout Epidemic on Ward 7

Ward 7 is a thirty-bed medical oncology unit at a five hundred bed tertiary care teaching hospital in Bengaluru. The unit treats patients with advanced solid tumours, many of whom are enrolled in Phase I and II clinical trials. The unit has forty-five nursing staff, twelve junior residents, six senior residents and four consultant oncologists. The patient-to-nurse ratio averages five to one, and the unit operates at ninety-five per cent occupancy.

Over the preceding eighteen months, the unit has experienced a steady deterioration in staff morale and functioning. Sickness absence among nursing staff has increased by forty per cent. Four experienced oncology nurses have resigned, citing stress and exhaustion. Two junior

residents have requested transfers to other departments. There have been three formal complaints from patients' families about staff rudeness and inattention. A serious medication error occurred when an exhausted nurse administered a tenfold overdose of vincristine; the error was detected before administration, but the incident was reported to the hospital's risk management committee.

The unit's medical director, Dr. Priya Nair, requested an urgent consultation from the hospital's Department of Mental Health. She described the staff as demoralised, irritable and unsupportive of each other. She noted that morale was lowest among the most experienced and committed nurses, who felt that they were constantly failing their patients and their colleagues.

Ms. Shalini Iyer, a senior counsellor with expertise in occupational mental health, was assigned to the project. She conducted a comprehensive needs assessment over four weeks. She reviewed unit-level data on staffing, occupancy, patient acuity, adverse events and staff turnover. She conducted individual interviews with twelve nurses, four residents and two consultants. She facilitated three focus groups with nursing staff. She observed handover meetings, medication rounds and family conferences.

Her assessment revealed multiple contributing factors. The unit's workload had increased substantially due to the expansion of the clinical trials programme. Patients on trials required more frequent assessments, more complex monitoring and more extensive documentation. Staff had not received additional training or protected time for these activities. The emotional demands of caring for young patients with advanced cancer, many of whom were dying, were profound and unacknowledged. Nurses described forming close relationships with patients and families over months or years and experiencing repeated grief as patients died. There was no formal or informal mechanism for processing this grief; staff were expected to maintain professional composure and move on to the next patient. The unit's culture was characterised by perfectionism and self-criticism. Staff held themselves to impossibly high standards and experienced any deviation from these standards as personal failure. Errors, even minor ones, were met with shame and concealment rather than open discussion and learning. Leadership on the unit was experienced as unsupportive. The nurse manager was perceived as distant and unavailable. The consultant oncologists were perceived as demanding and critical. There were no regular staff meetings or forums for staff to voice concerns. The physical environment was stressful. The unit was cramped and poorly ventilated. There was no dedicated staff break room; staff ate meals at the nurses' station, interrupted by frequent demands from patients and families.

Ms. Iyer developed a multi-component intervention informed by the literature on healthcare worker burnout and by the specific findings of her assessment. She established a weekly reflective practice group for nursing staff. The group was facilitated by Ms. Iyer and provided a confidential, supportive space for nurses to discuss their emotional responses to their work. The group was not a supervision group; its purpose was not to solve problems or to critique practice but to bear witness to the emotional experience of oncology nursing. She implemented a peer support programme. Interested nurses and residents were trained in basic supportive counselling skills and in the principles of psychological first aid. Peer supporters were available to colleagues following critical incidents, including patient deaths, adverse events and conflict with patients or families. The peer support programme was confidential and separate from the unit's management structure. She advocated for several organisational changes. The nurse manager was provided with leadership coaching. A dedicated staff break room was created. The handover process was restructured to reduce duplication and to include a brief check-in on

staff well-being. The clinical trials team provided additional training and protected time for nurses involved in trial coordination. She conducted a series of workshops for the consultant oncologists on supportive communication with staff. The workshops addressed the impact of physician behaviour on staff morale, the importance of expressing appreciation and strategies for delivering constructive feedback without undermining staff confidence.

Six months after implementation, Ms. Iyer re-administered the needs assessment measures. Sickness absence had decreased by thirty-five per cent. No further nursing staff had resigned. The medication error rate had decreased by fifty per cent. Staff scores on the Maslach Burnout Inventory had improved significantly across all three domains: emotional exhaustion, depersonalisation and personal accomplishment. Qualitative feedback from staff was overwhelmingly positive. Nurses described the reflective practice group as lifesaving. Residents reported that the peer support programme had helped them to cope with the emotional demands of oncology training. The unit's medical director reported that the culture of the unit had transformed; staff were more supportive of each other, more willing to acknowledge difficulties and more engaged in quality improvement.

Questions for Analysis with Hints

Q1. Analyse the factors contributing to burnout on Ward 7 using the job demands-resources model. What were the key demands and resources, and how did their imbalance produce burnout?

Hints: The job demands-resources model proposes that burnout results from an imbalance between job demands and job resources. On Ward 7, job demands were exceptionally high. Quantitative demands included high patient-to-nurse ratios, high occupancy rates and the increased documentation and monitoring requirements of the clinical trials programme. Emotional demands included repeated exposure to patient suffering and death, the grief of losing patients with whom staff had formed close relationships, and the moral distress of caring for patients with incurable illness. Cognitive demands included the complexity of managing patients on investigational protocols and the constant vigilance required to prevent medication errors. Job resources were severely depleted. Social support from colleagues was undermined by the unit's perfectionistic culture and the norm of concealing distress. Supervisor support from the nurse manager and consultant oncologists was perceived as inadequate. Autonomy and control over work were limited by the rigid demands of the clinical trials programme and the unpredictable nature of acute oncology. Feedback on performance was primarily negative and critical; staff rarely received positive feedback or expressions of appreciation. Opportunities for professional development were limited; the additional responsibilities of the clinical trials programme were experienced as demands, not resources. The imbalance between high demands and low resources produced emotional exhaustion, depersonalisation as a coping response, and reduced personal accomplishment from the gap between high internal standards and perceived failure.

Q2. Evaluate the intervention components developed by Ms. Iyer. Which components addressed individual-level factors, which addressed interpersonal factors, and which addressed organisational factors? Why is it important to intervene at multiple levels?

Hints: Individual-level components included peer support training that equipped individual nurses and residents with skills in supportive communication and psychological first aid, and workshops for consultant oncologists that addressed individual physician behaviour and

communication practices. These components enhanced individual resources and coping capabilities. Interpersonal-level components included the reflective practice group that created a structured opportunity for nurses to share their emotional experiences and receive support from colleagues, and the peer support programme that formalised and enhanced natural helping relationships. These components strengthened social support, one of the most powerful buffers against burnout. Organisational-level components included the creation of a dedicated staff break room addressing the physical environment, restructuring of the handover process addressing workflow and communication, leadership coaching for the nurse manager addressing supervisory practice, and advocacy for additional training and protected time for clinical trials nurses addressing workload and role clarity. These components reduced job demands and enhanced job resources at the systemic level. Intervening at multiple levels is essential because burnout is multi-determined; individual, interpersonal and organisational factors all contribute. Individual-level interventions without organisational change can be experienced as blaming the victim. Organisational-level interventions without individual and interpersonal support may be resisted or may not address the emotional needs that individual staff members experience.

Q3. Discuss the role of the reflective practice group in this intervention. What therapeutic factors were operating in the group? How did the group address the specific needs of oncology nurses?

Hints: The reflective practice group addressed the specific needs of oncology nurses through multiple therapeutic factors. Universality is the recognition that one's experiences are not unique; nurses discovered that their colleagues shared the same feelings of grief, guilt and exhaustion, normalising their distress. Catharsis is the expression of strong emotions that have been suppressed; the group provided a safe, confidential space for nurses to weep, express anger and acknowledge despair, which was therapeutic in itself and strengthened bonds among group members. Self-understanding is the development of insight into one's own patterns of thinking, feeling and behaving; nurses came to understand how the unit's perfectionistic culture had shaped their own self-critical tendencies and that their feelings of failure were not accurate reflections of their competence but products of impossible standards. Existential factors are the confrontation with fundamental issues of life, death and meaning; the group provided a space for nurses to explore their own beliefs about life and death, to find meaning in their work and to grapple with the spiritual dimensions of caring for the dying. Group cohesiveness is the sense of belonging and mutual support that develops among group members; as the group progressed, nurses reported feeling more connected to their colleagues, more willing to ask for help and more committed to supporting each other, transforming the unit's interpersonal climate.

Q4. As the counsellor, you are asked to develop a business case for sustaining and spreading this intervention to other departments. What data would you present to hospital administrators? How would you frame the intervention's value in terms of return on investment?

Hints: A business case for sustaining and spreading the staff counselling intervention would present data on return on investment framed in terms meaningful to hospital administrators. The cost side would include counsellor time, peer supporter training, staff release time for group participation and the cost of physical improvements such as the staff break room. The benefit side would quantify the financial impact of outcomes. Reduced staff turnover is a major source of cost savings; the cost of recruiting, hiring and training a replacement oncology nurse is estimated at three to five lakh rupees, and the intervention prevented four resignations in six months, generating estimated savings of twelve to twenty lakh rupees annually. Reduced

sickness absence generates savings through reduced reliance on overtime and agency staff; sickness absence decreased by thirty-five per cent, with estimated annual saving of eight lakh rupees. Reduced medication errors generates savings through avoidance of patient harm, extended hospitalisation, litigation and regulatory penalties; the serious medication error that preceded the intervention could have resulted in patient death and a malpractice claim of several crores, and the fifty per cent reduction in error rates represents substantial risk reduction. Improved staff retention also generates indirect benefits including experienced staff being more productive, providing higher quality care and mentoring junior colleagues. Improved patient experience reflected in satisfaction scores is increasingly linked to reimbursement through value-based purchasing programmes. A comprehensive business case would present these estimates with appropriate sensitivity analyses and compare the projected return on investment with alternative uses of hospital resources, also articulating non-financial benefits including improved patient safety, enhanced organisational reputation and alignment with the hospital's mission and values.

Q5. What are the implications of this case for the role of counselling in hospital performance improvement? How should hospital counselling services position themselves to address organisational as well as individual needs?

Hints: This case demonstrates that counselling services can and should address organisational as well as individual needs. The traditional model of hospital counselling, focused exclusively on individual patients referred for psychological distress, is too narrow. Counsellors have skills and knowledge directly applicable to organisational and systemic problems that affect patient care and staff well-being. For counselling services to position themselves as contributors to performance improvement, several shifts are required. First, counselling services must develop competence in organisational assessment and intervention, requiring knowledge of theories and methods from organisational psychology, occupational health and quality improvement, and the ability to analyse problems at multiple levels of the system and to design interventions addressing individual, interpersonal and organisational factors. Second, counselling services must build relationships with key stakeholders beyond traditional referral sources including nursing leadership, physician leadership, human resources, risk management and quality improvement, and must be able to communicate their value in language that resonates with these stakeholders. Third, counselling services must generate and use data; they must be able to measure the problems they are addressing, the processes they are implementing and the outcomes they are achieving, and to demonstrate their contribution to organisational priorities. Fourth, counselling services must be willing to work at the boundary between clinical care and organisational management, navigating complex issues of confidentiality, professional identity and role clarity while maintaining professional values and ethical standards. The Ward 7 intervention demonstrates that these shifts are possible and can produce substantial benefits for patients, staff and the organisation.

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The counsellor's task in the hospital is not merely to relieve distress but to restore agency. The patient who has been overwhelmed by illness, the family that has been immobilised by uncertainty, the staff that has been depleted by the demands of care—all need not only support but empowerment. The goal of counselling is not to create dependency but to restore the capacity for self-direction.

— From the archives of the Department of Mental Health, Tata Memorial Hospital

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