www.ijarp.com ISSN 2456-9992 Page: 01-22

International Journal Advanced Research Publications

Review Article

Volume: 01
Issue: 03

PROTECTION OF PATIENTS’ RIGHTS IN INDIA: A CRITICAL ANALYSIS OF CONSTITUTIONAL SAFEGUARDS UNDER ARTICLE 14 AND RELATED REGULATORY FRAMEWORKS

Vidyarthi Vijayaraj*

IV^th^, Year, B.A – LL.B. (HONS), Chettinad School of Law, Chettinad Hospital and Research Institute, Chettinad Academy of Research and Education, Kelambakkam-603103, Tamil Nadu, India.

Article Received: 02 November 2025, Article Revised: 22 November 2025, Published on: 12 December 2025

***Corresponding Author: Vidyarthi Vijayaraj**

IVth, Year, B.A – LL.B. (HONS), Chettinad School of Law, Chettinad Hospital and Research Institute, Chettinad Academy of Research and Education, Kelambakkam-603103, Tamil Nadu, India. DOI https://doi-doi.org/101555/ijarp.2442

ABSTRACT

The rights of patients are an emerging issue in healthcare law in India because of the constitutional guarantee (Article 14 of the Constitution of India) of the equality of all Indians before the law and protection from arbitrary action. The article reviews the complex legal, constitutional and regulatory mechanisms from which patients' rights emerge in India. It explains how constitutional provisions, legislation, court rulings and regulatory guidelines interact to create a framework for dignity, equality and non-discrimination in healthcare. The issues of informed consent, confidentiality of medical records, access to healthcare and protection from unethical behaviour are examined in detail. The article also discusses landmark court cases that expanded patients' rights through the broader constitutional principles of equality and the right to life under Article 21 of the Constitution of India. Furthermore, the article investigates the functions of regulatory bodies, such as the Medical Council of India (now NMC), consumer protection laws, and the Patients' Rights Charter endorsed by the Ministry of Health and Family Welfare. While organizations exist, however, the full enactment is not simple because of the level of awareness of laws, inconsistent implementation, and the lack of accountability. This article uses a doctrinal and analytical method to emphasize the value of institutions and ethical accountability, in addition to patient empowerment, in reducing the gulf between healthcare reality and woke constitutional aspirations. This article concludes by urging for the rights-based healthcare deriving from constitutional mandates that protects patients equitably.

KEYWORDS: patient rights, constitutional safeguards, healthcare equity, legal frameworks, judicial interpretation, regulatory standards.

1. INTRODUCTION

The awareness, scope and enforceability of patient rights is now an increasingly important area of focus in Indian health law today and as the country attempts to achieve an equitable healthcare system. Article 14 of the Constitution of India recognizes the right to equality before the law and equal protection of the law, which provides the foundational constitutional protection against arbitrary and discriminatory behaviour, for instance when delivering healthcare. Interactions in healthcare are often evidence of power imbalances and require the same level of legal protection against discrimination and arbitrariness as an ethical obligation and constitutional affirmation.

In India, the law concerning patients' rights does not appear in a single law, but through constitutional provisions, case law, statutory law, and executive charters. Article 14 and, its close constitutional companion Article 21 (right to life and personal liberty), have been expressly referenced by the Supreme Court in cases of systemic failings and acts of individuals that have exacerbated the patient experience of dignity, non-discrimination, and access to treatment. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) 4 SCC 37; AIR 1996 SC 2426), the Supreme Court held that the State's inaction to provide timely medical interventions was inconsistent with Article 21 and Article 14 of the Constitution and ordered the establishment of protocols for care in emergencies eras apart from holding the State liable regardless of available resources. Likewise, in *Pt. Parmanand Katara v. Union of India* (1989 AIR 2039), the Court imposed a clear obligation on all practitioners of medicine (both public and private) to deliver timely medical care in emergencies and stressed that there could never be a justification for delays in medical treatment for any reason given that the medical profession offers a constitutional protection.

Judicial activism has secured the principle of informed consent firmly in Indian jurisprudence. In *Samira Kohli v. Dr. Prabha Manchanda* (2008) (1 SCC 703), the Supreme Court demonstrated that valid medical consent requires not just voluntary but thorough disclosure. This feedback loop further reinforces the standards of dignity and self-determination. In following jurisprudence, the outlook is enforced that autonomy is embedded in both Article 21 and Article 14 as non-arbitrary and binding far-reaching health decisions.

These emergent constitutional standards now intersect and interact within and through statutory and regulatory schemes. Following *Indian Medical Association v. V.P. Shantha* [(1996) 6 SCC 651], the Consumer Protection Act, 2019, included healthcare services within its jurisdiction, allowing a patient who is aggrieved to seek redress for negligence and deficiency in services rendered. *The National Medical Commission Act, 2019 and the Code of Medical Ethics* (2002) establish professional standards and the provision for the redress of grievance. The Charter of Patient Rights (2018), issued by the Ministry of Health & Family Welfare, brings together various aspects of patient's rights in an understandable list of requirements, which include, among others, informed consent, confidentiality, and non-discrimination, which lack the power of a law.

In spite of significant advancements stemming from the courts and statutes, enforcement may still be lags behind, as patients are not aware of their rights, the oversight over regulatory bodies remains scattered, and many key protections from patient harm are not legally binding in their current form. In this paper, we critically examine the constitutional, statutory, and regulatory framework that governs patient rights in India and discuss a series of significant court cases and legislative changes spanning from the early 1990s to the present time before considering, in conclusion, whether constitutional protections in fact sufficiently protect patients from inequity and arbitrariness.

2. Statement of problem

Although India's laws, and the Constitution, particularly Section 14, set out principles aimed at achieving equality and protecting patients from discrimination, many people still find themselves vulnerable in situations they should be able to access medical care without fear of discrimination. Patients, particularly from low-income, rural, and marginalized groups continue to report experiences of discrimination and denying them fundamental rights to access needed medical care, to not receive outrageously inflated cost estimates from private hospitals, and not be discriminated against based on their religion, caste, or language. For example, surveys reveal that around one third of Muslim respondents and many from

Scheduled Castes and Scheduled Tribes reported experiences of discrimination in hospitals. Many patients also indicate that they are not aware of their rights, or they do not feel empowered to enforce those rights. Many reported out of fear of retaliation or simply because they doubt there would be an impact if a complaint was pursued. Even when a hospital makes an effort to provide a Charter of Patients' Rights, the patients generally find these rights are not adhered to in practice or, are simply intended to satisfy quality accreditation processes ensuring the hospital is in compliance with general standards. No matter how well intentioned, documented cases reveal stories of being denied or delayed access to healthcare ultimately causing tragedy and loss of life, or being subjected to unnecessary surgical operations and inflated fees, in part because of lack of regulation. Although, governing regulatory and consumer protection authorities exist, enforcement is sporadic and not practiced very effectively. Also, most patients face significant barriers to securing regulatory protections.

3. Research Objectives

A. To identify systemic gaps and challenges in enforcement of patient rights within Indian healthcare related to equality and non- discrimination.

B. To evaluate the effectiveness of regulatory frameworks and judicial interventions and activism in protecting patient autonomy, confidentiality, and access to healthcare

C. To explore the role and effect of judicial interventions and judicial activism in advancing and protecting healthcare rights for marginalized and vulnerable groups.

D. To analyze ethical and legal issues arising out of digital healthcare technology and its impact on patients' rights.

E. To make recommendations to strengthen legal and institutional frameworks that are patient-centered and equitable.

4. Research Questions

A. How effective is Article 14 in safeguarding patients’ rights to equality and non-discrimination within the Indian healthcare system?

B. Which constitutional and regulatory policies work together to safeguard patient autonomy, informed consent and confidentiality within India?

C. In what ways has judicial activism influenced the protective measures for healthcare rights of marginalized and vulnerable groups in India?

D. In what ways will emerging digital health technologies impact patient rights, particularly with respect to privacy of data and consent?
E. What reforms or policy developments would need to be in place for a more enforceable and patient-centered rights framework in India?

5. Research Methodology

The present study involves a **doctrinal and qualitative** study of the constitutional provisions, judicial decisions, and statutory framework as it relates to patients' rights in India. By employing the doctrinal method, significant care is given to legal documents and texts to explore and interpret constitutional provisions, statutes, judicial decisions, and literature pertaining to the relevant issues. The study methodology will also involve scrutiny of relevant legal literature, scholarly articles, and non-binding commentaries regarding patients' rights to explore the perspective and legal framework of patients' rights, in India.

6. Review of Literature

The topic of protecting patients' rights in India is receiving increasing academic attention, as global health systems progress to more systematically respect individual dignity, autonomy, and equality. Researchers in legal, bioethical, medical, and policy settings have begun exploring the framework from different interconnected facets, as to the strengths and persistent gaps in patients' rights in India.

6.1 Legal Framework

India's legal landscape is characterized by constitutional guarantees, a piecemeal series of statutes, and non-binding guidelines for protections relating to patient rights. Scholars often cite Article 14 of the Constitution as a basis for the right to equality and non-discrimination in healthcare settings. Article 21 has also been broadly interpreted to include the right to health, based on judicial precedent where cases such as *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) expanded health care rights within Article 21. Nonetheless, as expressed by Mukherjee (2023), there is no discrete Patients' Rights Act; protections are only partially addressed in the Consumer Protection Act, the National Medical Commission Act, the Code of Medical Ethics, and the non-binding Charter of Patient Rights, resulting in fragmented enforcement.

6.2 Judicial Developments

A considerable slice of the literature has examined judicial activism on behalf of patients' rights. Academic evaluations of relevant judicial decisions regarding cases in *Pt. Parmanand Katara v. Union of India*, and *Samira Kohli v. Dr. Prabha Manchanda* exemplify new doctrinal development on emergency health care and informed consent. There is a general trend in the literature supporting the judiciary as a path for advancing protections for patients, coupled with ongoing limitations that persist in the absence of legislative follow through.

6.3 Ethical and Institutional Challenges

Ethical reviews have analyzed the tension between patient autonomy and medical paternalism in health care settings, and the historical reliance on physician authority in Indian health care has been noted. Organizational studies have documented the insufficient implementation of informed consent, issues with confidentiality, and a lack of regard for patients who are culturally or economically marginalized. As Nair (2022) cautions, constitutional protections notwithstanding, the distance between ethical frameworks and everyday clinical practice remains significant.

6.4 Digital Health and Patient Rights

A new body of research investigates patient rights in the context of digital health. Articles covering telehealth, electronic record management, and AI-based diagnosis highlight heightened risks to data privacy and the additional challenge of obtaining informed consent when interacting in a virtual environment.

6.5 Comparative and International Perspectives

Comparative studies consistently found that India’s regime on patient rights lacks the normative clarity, enforceability, and grievance redressing systems found in the UK’s NHS Constitution, the EU’s GDPR, and the USA's Patient Bill of rights. Comparative studies suggest that India's patient rights might be streamlined to better meet global standards with the implementation of statutory frameworks and constituency levels of protections.

6.6 Gaps in Literature

Individual legal, ethical, regulatory, or comparative topics are addressed in the literature but interdisciplinary studies synthesizing constitutional law, ethical theory, and the patient experience are limited .The literature is lacking continuous or impact evaluation studies of implemented reforms, as well as systematic studies of comparative impact in different social and healthcare contexts.

7. Conceptual Framework of Patient Rights

7.1 Defining Patient Rights and Their Development

Patient rights refer to the legal, ethical, and institutional claims that protect the dignity, autonomy, and welfare of people seeking medical care. They arise from the story of human rights more broadly. Though not limited to, patient rights include the right to informed consent, confidentiality, non-discrimination, access to medical records, emergency care, and the right to be protected from neglect or malpractice. The Universal Declaration of Human Rights (UDHR) 1948 and other international documents recognized health as a right and initiated a global push towards patient-centered models of care.

In India, patient rights have emerged in parallel with health care reform in constitutional law, medical ethics, legislative rights, and entrepreneurial judicial activism. The previous models of care were traditionally paternalistic, emphasizing the doctor as the principal decision maker. Over the past several decades, decision making has made a shift towards participatory models that emphasize patient autonomy using shared decision making - informed by judgments from the Supreme Court along with changes to our normative thinking. This is evident in an important case like, Samira Kohli v. Dr. Prabha Manchanda (2008) which established the right to informed consent which further accentuated an obligation to respect an individual’s implicit autonomy in making medical decisions,

7.2 International Standards and Comparative Perspectives

Around the world, patient rights are recognized and articulated through binding and non-binding legal instruments. Evidence of an international agreement on minimum standards for the treatment of patients can be found in regulations and policies such as the World Health Organization (WHO), UNESCO's Universal Declaration on Bioethics and Human Rights (2006), and national patient charters. UNESCO sets forth principles of dignity, autonomy, justice, and equitable access to health care, and indicates that all interventions require informed and voluntary consent from the patient.

Countries with developed, well-resourced and regulated jurisdictions--such as the USA and the UK--provide binding and greater specifications of patient rights than many developing contexts can provide, for example, through statutory Bills of Rights, NHS charters, and regulatory frameworks. Such frameworks provide rights of access to care, rights to be involved in the decision-making treatment process, and rights to redress. They reflect values for transparency, access to information, and accountability for grievance, facets of governance that are considered guiding principles for change and improvement especially provided by civil society and the grassroots level in low- and middle-income countries (LMIC) (e.g., India). Cross-national comparisons indicate that while the content of patient rights is nearly universal, the institutional mechanisms of protection and enforcement, and public acceptance and recognition of such rights, vary tremendously.

World Health Organization (WHO)

The 1946 World Health Organization (WHO) Constitution defines health as a universal human right that all people are entitled to the highest attainable standard of health whether physical or mental - without distinction of any kind. It places an obligation on governments to take appropriate public health and social measures to achieve this right. While the WHO Constitution does not specifically reference the concept of "patients' rights", the concept of health as a universal human right is consistent with concepts of equality, dignity, access, and non-discrimination in health care. The assertion of health as a human right has informed several international declarations, conventions and charters on the rights of patients. These rights include informed consent, confidentiality, quality of care, and non-discrimination. The WHO emphasizes that patients should be treated with dignity and respect; and that health systems are accountable to provide equitable care for all patients regardless of their social or economic status. The WHO Constitution supports a rights-based approach to healthcare on a global scale.

UNESCO Universal Declaration on Bioethics and Human Rights (2006):

The UNESCO's Universal Declaration on Bioethics and Human Rights (2006) introduces the platform to initiate alignment between bioethics on one hand and universal principles of human rights in the world on the other. It professes the need to respect human dignity, human rights and fundamental freedoms, on which all healthcare and biomedical research must be based, "for all human beings". Significant articles of the Declaration stress that human interest and welfare must prevail over the interests of science or society. Key principles mention a duty to respect autonomy, informed consent, privacy, confidentiality, and non-discrimination; and special protective measures for vulnerable persons. The Declaration also notes the duty of the state to promote ethical medical practices that respect patient rights in its pursuit of equality, justice, and access to healthcare. As a global mechanism, the Declaration establishes a crucial framework to encourage countries to legitimize their own domestic laws and policies in accordance with these bioethical standards, thereby fortifying patient rights as protection for human rights. The Declaration is an important means to promote the patient-centred approach and accountability to ethical standards in health systems across the world.

7.3 Patient Rights in the Indian Context

In India, patient rights are based in the Constitution (Articles 14 and 21), the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, the Consumer Protection Act 2019, and a variety of judicial decisions. The Charter of Patients' Rights (2018) developed by the Ministry of Health and Family Welfare attempts to integrate the various rights, such as the rights to information, confidentiality, a second opinion, and to not be discriminated against when accessing health care, by using guidance from international documents and professional ethical codes as well as India's institutional obligations.

Judicial activism has been a hallmark of emerging patient rights jurisprudence. The Supreme Court has recognized in various rulings the right to health as an aspect of Article 21 right to live and Article 14 right to equality. Landmark cases such as *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) and *Pt. Parmanand Katara v. Union of India* (1989), required access to emergency medical services and the state be responsible for providing access to essential medical services in non-emergency medical situations. More recently, the right to privacy, which was upheld in *K.S. Puttaswamy v. Union of India* (2017), has been recognized with regards to medical confidentiality and uses of patients' health data.

In spite of these developments, India does not have a single law that addresses patient rights. The existing framework is multifaceted and consists of constitutional interpretation, sporadic provisions, and guidelines, while there remain challenges around public knowledge and awareness of available remedies, and the ability of patients in applying them in practice. Nevertheless, the advent of patient rights in India is analogous to an emerging global and national recognition for patient-centered standards in the provision and delivery of health care.

8. Constitutional protection under Article 14 & related provisions

8.1: The right to equality and non-discrimination in healthcare (Article 14)

Article 14 imposes the rights of "equality before the law" and "equal protection of the laws" in the Indian Constitution, establishing the foundation for the constitutional protection against arbitrary state action and discrimination based on religion, caste, sex, or economic status. In healthcare, this means that no person shall be denied a basic level of medical care, informed acceptance of relevant hospitals, or protection from exploitation, solely on the basis of illegal categorization or prejudice. Courts have recognized that equality in healthcare does not strictly mean formal equality, and requires an active recognition of social and economic barriers to healthcare, especially for disadvantaged or marginalized populations. Article 14 allows "reasonable classification" in the interest of public health (e.g. prioritizing care for certain groups in the event of epidemics), provided is not arbitrary and relates to a valid policy aim.

8.2 Interrelationship with Article 21 (Right to Life and Health) and Article 19 (Freedom of Choice)

Article 21 provides that "No person shall be deprived of his life or personal liberty, save in accordance with a procedure established by law"; this is the constitutional basis for the right to healthcare in India. The Supreme Court has broadened Article 21 to encapsulate health and medical care as components of the right to life and human dignity. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (AIR 1996 SC 2426), the Court held that the State's non-requisition in the provision of timely medical treatment of care and treatment, had denied the citizen their Article 21 rights and imposed an obligation on public authorities to provide reasonable medical infrastructure, medically accessible services, and emergency care to every person regardless of cost and/or logistical challenges. Article 21 also allows for patient autonomy including the right to refuse or withdraw benefit of medical treatment consistent with informed consent principles.

While Article 19 primarily protects the freedom of speech, profession, and movement, it also implicates healthcare. For example, patients have the right to free choices regarding their own healthcare, including the right to refuse unwanted medical procedures, that is partly based on the "freedom of choice" in Article 19(1)(a) and (g). The Supreme Court of India has recognized that a competent adult has the right to make decisions on medical treatment, including decisions that might be considered irrational, as long as such decisions informed and voluntary.

9. Judicial Activism and Landmark Case Law

9.1 Notable Supreme Court and High Court Rulings:

The Indian judiciary has been a key factor in the field of patient rights by expanding its realm of influence by utilizing the albeit unprecedented use of judicial activism towards guarantees in the Constitution related to patient rights beyond statutory schemes. Landmark Supreme Court judgements have clarified the limits of rights to health care in terms of dignity, equality, and access.

- ***Paschim Banga Khet Mazdoor Samity v. State of West Bengal*** (AIR 1996 SC 2426): The Supreme Court's ruling in this case defined that indefinite denial of emergency medical assistance violates Articles 14 and 21 of the Constitution, thus the State is obligated to provide adequate and timely health care, devoid of discrimination.
- ***Pt. Parmanand Katara v. Union of India*** (1989 AIR 2039): This case imposed a binding duty on all medical institutions and involved health practitioners (either private or public) to obtain emergency assistance devoid of procedural obligations, or identifying the emergency patient.
- ***Samira Kohli v. Dr. Prabha Manchanda*** (2008 1 SCC 703): The court clarified the legal permissible standard of informed consent as it pertains to patient autonomy and full disclosure of all options in advance of undertaking treatment.
- ***Indian Medical Association v. V.P. Shantha*** (1996 AIR 550): Broadened the scope of the Consumer Protection Act to include medical services, thus giving patients the right to pursue remedies for negligence and deficiency in services.
- ***CESC Ltd. v. Subash Chandra Bose*** (1992 AIR 573): Recognized the right to health as an intrinsic part of Article 21, citing international human rights standards.
- High court, aka superior court judgments only supplement the Supreme Court's path in operationalizing rights in healthcare contexts, while addressing pressing issues with respect to local rights surrounding access to medical records, breaches of privacy, or access to care with no bias against patients.

9.2 Review of Judicially-Imposed Liability and Protections for Patient Rights

The judiciary has provided several protections to access constitutional rights in health care:

- **Right to Emergency Care:** The courts have unequivocally rejected the refusal to provide emergency treatment as a breach of fu`ndamental rights.
- **Informed consent:** Courts, e.g., in Samira Kohli, have established the governing law for entirely disclosing and voluntarily providing consent in regard to medical treatment, i.e., ensuring patients are participating in their treatment decisions and are not merely a means of treating their illness.
- **Non-Discrimination:** Articles 14 and 21 have been read to prohibit arbitrary discrimination on grounds of caste, sex, economic status, or sickness.
- **Accountability and Access to Remedies:** Expanding medical services to public under the Consumer Protection Act, 1986 broadened access to legal remedies for medical malpractice or negligence.

These judicial directives have secured not only individual patients, but have also catalyzed changes in hospitals, medical education, and public health laws.

9.3 Role of Judiciary in Strengthening Patient Rights Jurisprudence

Role of Judiciary in Bolstering Patient Rights Jurisprudence The judiciary's proactive stance in health rights jurisprudence, not only reflects a broader commitment to social justice and constitutional morality, but also has taken the initiative for legislative and executive failures where there are omissions and gaps, as it has, developed precedential case law which has bolstered and framed rights-based health care for vulnerable and marginalized people.

Judicial intervention has democratized health care by embracing patients as rights-bearers, entitled to dignity, respect, and to not be discriminated against, as guaranteed by the Constitution. The courts have broadly interpreted Articles 14 and 21 to include health entitlements, while underscoring the indivisibility of civil and social rights. This jurisprudence has served as an impetus for regulatory clarifications, policy development, and increased public education about patients' rights.

Importantly, courts have supported a systemic view of patient rights not only as a remedy for individuals but also as a means of addressing institutional accountability, professional standards in medical practice, and equitable allocation of medical resources. The judiciary's interpretative leadership remains an important player in the development of a healthcare system which reflect legal norms and constitutional ideals.

10. Regulatory Frameworks Governing Patient Rights in India

10.1: National Human Rights Commission (NHRC) Guidelines

The National Human Rights Commission (NHRC) of India, whose purpose is to protect and promote human rights, has also developed a number of guidelines and advisories directly related to the protection of patients' rights within the healthcare context. The uttering of statements that medical institutions, both public and private, have a duty to respect and safeguard the dignity and equality of patients owed to them in healthcare contexts; to provide emergency care to any individual regardless of race, gender, creed, or ethnicity; and to respect patient confidentiality - the NHRC is concerned about addressing complaints in relation to denial of medical treatment, medical negligence, and disclosure of medical information, breach of medical confidentiality with respect to human rights violations.

Their guidelines emphasized the need for educating healthcare providers about human rights, improving patient awareness of their rights, put accountability mechanisms in place. While NHRC guidelines are not legally binding in the same manner as provincial medical acts or hospital policies, they are still moral and persuasive, and have played a role in raising the standards of patient care practices.

10.2 National Medical Commission and Indian Medical Council Regulations

The National Medical Commission (NMC), which superseded the Medical Council of India (MCI) in 2020, governs medical education, ethical conduct, and standards for medical professionals nationwide. The NMC's Code of Medical Ethics, Regulations, 2002, originally developed while MCI was in operation and now retained post-transition, provides clear expressions of the ethical obligations owed to patients, including respect for autonomy, informed consent, confidentiality, and non-discrimination in the provision of treatment. The NMC has also developed protocols for grievance redressal, disciplinary action in response to a doctor's practice of malpractice or unethical conduct, and continuing medical education to sensitize doctors to rights-based healthcare. The NMC operates as a quasi-judicial body to regulate, thereby enforcing professional discipline and providing an essential regulatory protection for patients/members of the public in the delivery of services.

10.3 The Charter of Patient Rights (2018)

The Ministry of Health and Family Welfare established the Charter of Patient Rights in 2018, which tries to bring together multiple rights into a single composite document that serves as a guide to health care providers and gives strength to patients. The Charter lists important rights related to patients, including, but not limited to, the right to informed consent, the right to confidentiality regarding medical information, the right to a second opinion, the right to not be discriminated against for reasons of disability, caste, gender or socio-economic status, as well as the right to complaint mechanisms. It promotes transparency in billing and provides the right to respectful treatment without consideration of the individual's background. Although not statutory law at this time, the Charter provides descriptive and normative value and a close alignment to constitutional principles and international standards of human rights and has had a normative influence on the direction of policy making and institutional practice in health care. The Charter has been integrated into a draft format by many regulation and human rights bodies that are attempting to reform health care reform with respect to a patient-centered focus.

10.4 Other Related Legislation

In addition to this legislation are other legal instruments which indirectly affirm patients' rights:

- **Consumer Protection Act, 2019**: This piece of legislation recognises the provision of healthcare as a service and allows patients to seek remedies for medical negligence, service deficiency and unfair trade practices through consumer courts/ forums. The Indian Medical Association v. V.P. Shantha decision by the Supreme Court in 1996 expanded consumer legal protection to include medical establishments.
- **Right to Information (RTI) Act, 2005**: The RTI Act allows patients and their families to obtain information from public authorities on hospital policies, treatment modalities, and costs, thus promoting transparency and accountability in public healthcare institutions.

11. Ethical Dimensions of Patient Rights

11.1 Medical Ethics and Responsibilities of the Profession

The philosophical underpinning for respect for patient rights in health care is medical ethics. The four-leaf clover: autonomy, beneficence, non-maleficence, and justice, is at the heart of medical ethics and assists health care professionals in providing ethically responsible treatment while acting in a patient's dignity and welfare. Professional responsibilities as set out under the National Medical Commission’s Code of Medical Ethics (2002) require physicians to: a) ensure informed consent has been obtained; b) upholding confidentiality; c) treat patients in an impartial manner without allowing personal biases to interfere with clinical decision-making; and d) avoid exploitation or malpractice practices. The physician’s responsibilities extend beyond technical competence to also include trust and respect established through open and honest communication and accountability. This ethical basis adds weight to the demands of the constitution when patient rights are incorporated in the ethics of professional conduct.

11.2 The Tension Between Patient Autonomy and Medical Paternalism

Throughout the ethical course of healthcare, there exists both a moral and practical tension between a patient's autonomy, or their right to make informed choices, and existing medical paternalism, or when healthcare providers make decisions because they believe it is relevant to the patient's best interests and medically warranted at the time (sometimes interfering with patient preferences). Historically (and especially in rural and traditional Indian healthcare settings), health care has gravitated toward some form of paternalism, and doctors are seen as the authoritative figure. Modern law and ethics are putting greater emphasis on autonomy and the courts are increasingly justifying patients’ rights to refuse or accept treatment in the context of informed consent (*Samira Kohli*). However, conflicts between autonomy and paternalism still create practical problems that challenge patient autonomy, especially around issues of patient medical literacy or when the consequences of a decision are time bound for informed consent to be honoured in practice. The resolution of the tension between contradictions in ethical reasoning requires thoughtful and nuanced ethical methodologies, patient education strategies, and shared decision-making models.

11.3 Emerging Challenges in the Digital Era

Finally, the advent of our digital world has, and is already beginning to introduce new ethical dilemmas for the rights of a patient. While the driveline of telemedicine has allowed care to expand in terms of access, it also invites scrutiny regarding care quality, data privacy – securing and securing information, and private virtual informed consent issues. Artificial intelligence (AI) technologies for diagnostic or therapeutic suggestions, or administrative decisions, could also further entrench algorithmic biases and could worsen discrimination that is less favorable compared with Article 14. The aggregation, storage, and transfer of protected health information require sound data security and protection measures; in India, however, there currently is no dedicated privacy framework for healthcare data. The Supreme Court of India reaffirmed in *K.S. Puttaswamy v. Union of India* (2017) that the constitutional guarantee of the right to privacy applies in the digital sphere, which raises the need for proactive regulation and governance of technology in order to prevent misuse and protect patient dignity. These challenges necessitate people working together across perspectives (e.g. ethics, clinical, technology, policy) to be able to develop a digital health ecosystem that is equitable, transparent, and patient-centred.

12. Comparative Perspectives

12.1 Lessons from Other Countries

Around the world, patient rights have developed through a combination of legislative mandates, court rulings, and administrative APIs that recognize and protect patient autonomy, transparency, and redress. In the United States, patient rights are based on federal laws, such as the Health Insurance Portability and Accountability Act (HIPAA), which strengthens data protection, and the Patient Self-Determination Act, which supports informed consent as well as advance directives. There is also a long-standing right to bring a tort action for medical negligence or malpractice, as well as robust protections for consumer rights through statutory protections.

The National Health Service constitutes a formal means by which rights of patients are established within the United Kingdom. It guarantees, in an unambiguous commitment, rights to information and involvement in the decision-making process, as well as timely access to health care regardless of the status of the patients. The NHS also establishes a framework which includes protections for the complaints process, protections from discrimination, and assures a governance model which keeps patients at the centre, establishing a balance between patient autonomy and the responsibilities of the state.

The European Union establishes patient rights in its member states that will essentially be entrenched in directives and regulations, principally in the Cross-Border Healthcare directive. This aspect provides rights to access healthcare services as a patient or EU resident without the fear of discrimination when receiving healthcare services across state borders in the European Union. The EU also recognizes data protections rights as strict and defined in the General Data Protection Regulation (GDPR), or requirements specific to the privacy of healthcare settings, but it is essentially unmistakably the international gold standard.

Bringing these jurisdictions together highlights a number of advantages of codifying patient rights into enforceable legal documents, establishing governance structures for the enforcement of these rights and embedding these patient and patient-centered ethical considerations within health care oversight. This trust also has illustrated how principles and norms of international human rights can be incorporated into domestic law systems in a manner that demonstrates a commitment to equality and justice for patient rights and human dignity.

12.2 Potential for Harmonizing Indian Law with Global Best Practice

As we have seen in the preceding sections, the legal dimensions around health care in India are expansive, but it is dispersed across several statutes, guidelines and judicial decisions. To harmonize Indian legislation with global best practices represents a significant sense of legitimate consolidation of protections in ways that can improve patient outcomes.

For example, a statutory Patient Bill of Rights, pulled from NHS or the US, would allow for clearer entitlements and obligations of health institutions which would reduce ambiguity and improve enforceability. Furthermore, strengthening data privacy legislation, aligned with the principles of GDPR, would strengthen current constitutional guarantees of confidentiality in privacy protections, as well as work to address challenges presented by digital health. We know that advanced jurisdictions also include mechanisms for timely grievance redressal, patient education and also accountability of healthcare providers and organizations. These practices would begin to address the issues of enforcement, accountability and legitimacy of enforcement within a context similar to India. Ideally, strengthening health truly is a multilateral function, and built upon exchanging knowledge and collaboration, this would help encourage or induce Indian regulatory bodies to bring standards and ethics into better alignment with global norms. Although existing socioeconomic and infrastructural ecosystem contexts demand a substantive challenge to rethink the approaches, harmonization shall attempt to explore the strengths of Indian constitutional guarantees and judicial activism to best inform a more coherent, accessible and patient-oriented best practice rights framework. Proximity toward best practices standards would facilitate the learning about a better quality of care; it would also acknowledge India's foundational commitments to dignity, equality, and justice in health.

13. Critical Issues and Challenges in Enforcement

13.1 Informed Consent and Autonomy

Informed consent is the foundation of patient autonomy and ethical medical practice, which requires healthcare providers to disclose all necessary information regarding diagnosis, treatment options, associated risks, and alternatives before obtaining patient agreement. In India, even with judicial clarifications, as noted in *Samira Kohli v. Dr. Prabha Manchanda* (2008), regarding valid and voluntary consent, there are still widespread challenges in practice. Some of these challenges include inadequate communication, paternalistic mindset of physicians, low health literacy, and Caste and other socio-cultural barriers to patient autonomy. Many patients, especially those from marginalized communities, remain unaware of their rights to the full disclosure of information, or to refuse treatment. There can therefore be a disconnect between constitutional ideals and lived realities, which undermines patients' dignity and self-determination in the process.

13.2 Confidentiality and Data Protection in Healthcare

Confidentiality of medical records and personal health information is a key element to building patient trust and safeguarding privacy. The digitization of health records and the use of telemedicine, while certainly beneficial, have also created increased appetite for health care providers and systems to worry about unauthorized access to patient data, breaches to confidentiality, and secondary use of patient data, without patient knowledge or consent.

Even if the Indian Medical Council's Code of Medical Ethics imposes stringent obligations of confidentiality on medical professionals, there still remains no comprehensive sectoral data protection law similar to the European Union's GDPR. Although the recognition of privacy as a fundamental right by the Supreme Court in *K.S. Puttaswamy v. Union of India* (2017) provides a powerful constitutional foundation to data protection claims, the actual practice of patient privacy is largely nominal. Patients routinely find it difficult to assert their right to confidentiality in practice because of gaps in legislation and lack of broad awareness about these rights.

13.3 Access to Affordable and Quality Healthcare

Access continues to be one of the biggest impediments to realizing patient rights based on the equality-required in Article 14. The distribution of public healthcare infrastructure is uneven, and people in rural and underserved populations have an acute shortage of trained health professionals, hospital beds, and basic medicines. The trend toward privatization of healthcare creates more choices for some, at the same time reproducing disparities in health access and affordability of good quality care for millions. As a function of out-of-pocket expenses for healthcare or a significant portion of their income spent on healthcare, many people are already, or at significant risk for, being medically impoverished. Schemes like the Ayushman Bharat, which expands insurance coverage, create access points, but do not address the larger systemic and inequity issues at work in healthcare access. At its core, equal access to affordable and quality healthcare remains a challenge, in large part, because of our constitutional requirements.

13.4 Discrimination and Inequality in Healthcare Delivery

Discriminatory practices, both overt and covert, permeate the provision of healthcare services, compromising patients’ constitutional rights not to be discriminated against and to treatment equality. Existing research shows that patients from lower caste, tribal, women's group, disability group, and people living with HIV/AIDS face a consistently repeated pattern of denial of treatment, longer waiting times, and/or disrespectful behaviors by providers. There are also numerous systemic biases, including stigma against gender diversity, mental health, or sexually transmitted disease (STD) that contribute to the marginalization of patients with these discriminations. Article 14 does provide for equal protection in situations of arbitrary exclusion, but is often difficult to enforce due to limited monitoring capacity and patients' limited awareness of their rights. Addressing inequalities will rely heavily on the work of plurality programs in development, cultural sensitivity training for staff, institution policies against discrimination in health systems.

14. Findings and Suggestion

14.1 Gaps in the Existing Legal Framework

Despite the rights specified in Articles 14 and 21 and several regulatory instruments in place, there are serious limitations to India's legal framework for protecting patient rights. The main limitation is the lack of a single, comprehensive Act that enumerates and endorses patient rights, so the constitutional framework of the protections is comprised of disparate legislations, policy recommendations, and subjective judicial robustness and interpretations. On some level, patient rights are stated in such language in various documents, such as in the Charter of Patient Rights (2018), however these documents do not have any statutory effect and do not result in significant, systematic change. In addition, having different entities governing Patient Rights protections (e.g., the National Medical Commission, Consumer Forums, Human Rights Commissions) creates ambiguity about who governs which right and dilutes accountability.

14.2. Policy and Implementation Gaps

From a policy perspective, India faces considerable challenges in actualizing "legal entitlements" to result. Even where entitlements exist and enforcement exists, lack of patient awareness and health literacy is impediment to the empowerment of individuals, leaving many marginalized persons incapable of claiming their rights. The enforcement structures of entitlements are often weak. Enforcement bodies are typically not resourced to even be able to adequately investigate complaints, sanction or monitor. The public health "safety net' is fragmented and unequal, putting particularly rural and marginalized communities at a great disadvantage, undermining the constitutional aspiration of equality. Finally, privatization and opaque hospital billing practices creates barriers to care and affordability. Digital health innovations promise greater access but raise ethical and data protection issues yet to be resolved, in addition to regulatory insufficiencies.

14.3 The Need for Stronger Patient-Centred Frameworks

Crucial to closing these gaps is a shift toward genuinely patient-centered approaches to healthcare that emphasize dignity, respect, transparency, participation, and equity. The area of law should also be reformed by enshrining patient rights in law (and clearly stating enforcement provisions) as is exemplary practice in some jurisdictions. Patient rights will be better protected by better health literacy programs and civil society engagement teaching patients how to advocate on their behalf when their rights have been violated. The regulatory authority will also need to be allocated considerable additional resources, a clearer authority or mandate, and a cooperative mandate across agencies in order to hold providers accountable and to respond to complaints in a timely way. All providers will receive ethics education, emphasizing with little or no room for ambiguity, a commitment to respect and informed consent in their practice. Finally, we must establish strong data protection legislation to protect patient confidentiality in an increasingly digital world that is aligned with the constitutionally protected right to privacy. We need a multi-sectoral, holistic approach to our needs that includes legal reform, new policies, ethical considerations and standards, and the empowerment of patients. This type of approach would address the gap between the rights reported on paper and the rights realized in practice, while continuing to advance a constitutional vision of equitable and dignified health-care treatment for all.

15. CONCLUSION

Within the context of India, the protection of patients' rights calls on constitutional obligations, regulatory mechanisms, and the engagement of the judiciary. The constitutional basis for the patient rights protections is grounded in patients' rights of equality and non-discrimination within Article 14, and a right to life and health via Article 21. Courts have had a role in the transformation of patients' rights through some of the landmark cases that have progressed through our legal system, and while we have antiquated statutes and shortcomings in the legal system, the protections of rights may be limited. Regulation activity recommended in a Charter of Patients' Rights (2018), and additional codes of ethics and rules promulgated by the National Medical Commission promote a good normative framework for patient rights, it lacks the authority of law that would enforce conformity to them.

The healthcare system in India needs to move from fragmented protections to a unified and patient-centered system of law that gives patients’ rights to autonomy, informed consent, confidentiality, and equitable access to care and treatment. In advocating for patient rights, there must be consideration for harmonizing laws with international best practices, increased institutional accountability and also a wider opportunity for patients through education and grievance mechanisms. Rights for patients is a key part of realizing constitutional assurances for dignity, equality and justice in health and healthcare, through which there must be coordinated work by courts, regulators.

REFERENCES

Primary Sources

1. The Constitution of India, Article 21.
2. The Constitution of India, Article 14.
3. *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) 4 SCC 37 ; AIR 1996 SC 2426.
4. *Pt. Parmanand Katara v. Union of India* (1989 AIR 2039).
5. *Samira Kohli v. Dr. Prabha Manchanda* (2008) (1 SCC 703).
6. *Indian Medical Association v. V.P. Shantha* (1996 AIR 550, 1995 SCC (6) 651).
7. *K.S. Puttaswamy v. Union of India* (2017).
8. *Charter of Patients’ Rights (Draft),* 2018.
9. *National Medical Commission Act, 2019, and Code of Medical Ethics Regulations*, 2002.

Secondary Sources

1. Olejarczyk. J.P. & Young. M., Patient Rights and Ethics, StatPearls [Internet] 15, 20 (2025 Jan; updated May 6, 2024).
2. *Bioethics for the World: UNESCO's Universal Declaration,* 2006 EMBO Rep. 400, 405.
3. *Patient Rights Implementation in Indian Health Facilities*, Maastricht Univ. 22, 27 (2024).
4. *The Right to Healthcare for LGBTQIA Indians*, Columbia Univ. 5, 9 (2023).