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The Viability of Implementing Alternative Dispute Resolution Mechanisms to Address Medical Negligence Cases in India

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This paper reflects on how the patient-health practitioner relationship in India is different from other countries, owing to several socio-economic and cultural factors. Though there are mechanisms for adjudicating medical negligence claims, traditional litigation, even after the introduction of the Consumer Protection Act, 2019, remains inadequate to decide such matters. The objective of this paper is to examine the feasibility and implications of implementing Alternative Dispute Resolution mechanisms to medical negligence cases involving civil liability in India. In doing so, the paper acknowledges that cases of criminal negligence, especially those causing death or grievous hurt, are non-arbitrable and fall outside the paper's scope. Using various pieces of literature and case law analysis, this paper first discusses how the Consumer Protection Act, 2019, deals with medical negligence and its limitations. It then examines the viability of employing ADR mechanisms, especially arbitration, in such cases. It finally calls for a directory pre-treatment arbitration clause in intake forms as a viable and economical alternative to traditional litigation and discusses its implications, and also briefly explores the potential of incorporation of a 'no-fault liability' system into ADR mechanisms.

Keywords: *medical negligence, consumer protection, criminal negligence, alternative dispute resolution, arbitration.*

INTRODUCTION

Imagine you feel breathless every time you climb the stairs and decide to have a comprehensive Cardiac Health Screening scheduled with a private hospital, with a series of

tests like an ECG, an echocardiogram and even a stress test. But citing various reasons, like the unavailability of medical personnel in charge and high volume of patients, the hospital cancels appointments repeatedly, and when asked for a refund, they refuse to do so.

If you were to file a claim for deficiency of services under the Consumer Protection Act, 2019, it might resolve the conflict; however, with a significant backlog of cases, the resolution time would be extremely long, accompanied by high litigation costs. Moreover, although it does not involve medical negligence in the traditional sense, repeated cancellations can lead to late diagnosis and, consequently, late treatment of potentially serious health conditions.

Moreover, Judges at Consumer Courts may not necessarily have specialised knowledge of health issues, and accordingly, their perceptions can lead to different interpretations of the gravity of the situation. If the judge believes that repeated cancellations are a minor issue, he may downplay the neglect caused and award less damages, whereas if he believes it constitutes negligence, he may award higher compensation. These skewed interpretations can not only confuse patients as to what constitutes a minor issue and what actually constitutes deficiencies in services, but also deter them from taking such issues to the consumer courts.

What can solve this problem is coming up with a substitute, perhaps an Alternative Dispute Resolution mechanism like arbitration, by way of which an arbitrator with specialised knowledge in the field of medicine can be appointed to assess and evaluate findings and evidence and resolve the issue thereon. It will lead to uniform outcomes and will also reduce the time and costs involved in strenuous litigation proceedings. One such mechanism can be adding a Pre-Treatment Arbitration clause to the patient intake form, granted that the implications of the clause are explained to the patient in detail and in simplified language, making sure that the patient's informed consent is taken. Pre-treatment Arbitration clauses have been widely recognised in the United States as overriding other laws, by way of passing of separate legislation, expressly recognising their enforceability. But applying the same to a complex country like India is not that simple.

This paper aims to illustrate what makes India different from other countries in terms of socio-economic and cultural factors and how these differences affect the viability of the application of ADR mechanisms on medical negligence cases. The further sections will

mention "medical negligence cases" repeatedly, so it is crucial to define the paper's scope. In India, medical negligence can either result in a civil liability (a deficiency of service under the Consumer Protection Act, 2019) or in criminal liability (such as under Section 106 Bharatiya Nyaya Sanhita). Criminal matters involve rights in rem, which makes them non-arbitrable. The mechanisms proposed in this paper will exclusively focus on civil negligence, and the legal reasoning behind the non-arbitrability of criminal negligence will be elucidated further in the following sections.

THE ISSUE OF UNDERREPORTING

Official data from the National Crime Records Bureau (NCRB) show that in the years 2017, 2018 and 2019, there have only been a total of 626 reported deaths due to medical errors in all of India.[1] This figure seems unreliable and unrealistic, as research suggests that there are as many as 5.2 million cases of medical errors annually in the country. Moreover, a British Medical Journal article reported that the US accounted for more than 251,000 deaths annually due to negligence. The National Health Service (NHS) in the year 2021-22 received 15,078 new claims of medical negligence in the UK, which is a whopping 133 per cent increase compared to 12,629 cases in 2020-21. Out of an estimated 237 million cases of medical negligence annually in the UK, 712 to 1708 lead to deaths. Australia accounts for almost 140,000 cases of diagnostic errors every year, amongst which 2000 to 4000 cases lead to deaths.[2]

One look at all this data makes one wonder how India, despite its huge population, is doing better than so many developed nations with arguably much better resources, especially the UK and Australia, equipped with Universal Health Coverage (UHC). This wide gap cannot simply be attributed to a superior healthcare system, which leaves us with the most plausible explanation that there are flaws in the reporting and redressal mechanisms. There is a lack of comprehensive data on medical malpractice cases in India. The only source of information is the sporadic data in news articles and the NCRB website, but the data on the website is

[1] Sunil Khattri, 'Stats on Medical Negligence Cases in India in Comparison to Other Countries' (*Dr. Sunil Khattri & Associates*, 29 May 2023) <https://www.delhimedicalnegligence.com/post/stats-on-medical-negligence-cases-in-india-in-comparison-to-other-countries> accessed 20 October 2025
[2] *Ibid*

limited to the year 2022, with just 118 cases reported during the year 2022, indicating that cases of medical negligence in India are grossly underreported.[3]

WHAT MAKES INDIA DIFFERENT

The underreporting issue stems from the fact that there is a unique blend of certain socio-economic and structural factors, along with inadequacies in the current legal mechanisms in India. India has a significant portion of its population that resides in the rural area, that lacks not just awareness of their rights but also accessibility to a legal recourse, due to factors such as exorbitant legal fees and taking out the time to travel to courts as a lot of them live in remote areas, which discourages a major chunk of the population from pursuing such cases. Moreover, Indians view doctors as 'saviours' and not service providers, which again discourages them from taking legal action against a person whom they view in high regard.

Singh[4] in her paper, has discussed how 'India' is different from '*Bharat*' with the caste and class disparities leaving a substantial portion of the population, with inadequate access to justice due to the lower literacy rates, despite the Right to Education being a fundamental right, unaware of their rights and the legal recourse they can take in cases of medical negligence. She has also discussed how the lengthy court proceedings also deter people from reporting cases or seeking redressal. This is true especially for rural areas, as there isn't exactly proximity to courts, making just travelling to the courts expensive, which pushes them to waive their right to legal recourse.

She considers the Criminal Justice System in India to be largely accused-centric, one that focuses more on the rights of the accused than the victim, leading to bias in the delivery of justice.[5] Singh, with her 'accused centric' argument has overlooked the actual issue at hand, which is that there are several mechanisms in place to seek redress for the victims and they are designed in a way to have effective outcomes, but the actual issue is the shortcomings of traditional courts, primarily the time and costs involved, and the stigma attached with going against their 'saviours', that deter them from taking legal action.

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[3] *Crime in India 2022: Statistics* NCRB (vol 3, 2022) 1045

[4] Poornima Singh, 'Medical Negligence and Justice Dispensation System in India' (2021) 3(1) Indian Journal of Law and Legal Research <https://www.ijllr.com/post/medical-negligence-and-justice-dispensation-system-in-india> accessed 20 October 2025

[5] *Ibid*

The people who do have access to taking legal action freely, can do so by either pursuing a suit for damages, which will be a lengthy and not so economical civil suit, a criminal case if there is gross negligence but they are a lot harder to prove considering the high burden of proof, a complaint under the Consumer Protection Act, 2019, which again can lead to procedural delays along with inconsistency in the interpretations and the compensation awarded, and lastly, by filing a complaint at the Medical Council of India which can suspend or cancel licenses of the responsible medical professional but such a recourse can be inefficient considering the MCI is likely to prolong the investigations with an intent to protect the doctor as he is one of their own.

THE CONSUMER PROTECTION ACT, 2019 TO ADDRESS MEDICAL NEGLIGENCE

Verma[6] has discussed the implications of the inclusion of healthcare services under the ambit of the Consumer Protection Act, 2019. The act does not explicitly mention the term healthcare services under deficiency in services, but has largely been developed through judicial analysis. She has discussed the case of ***Malay Kumar Ganguly v Sukumar Mukherjee***[7], in which the Supreme Court laid down principles to determine deficiency in services by a healthcare professional. The court opined that a medical practitioner gives no guarantee that the treatment will cure the patient.

Shinde[8] mentions how, in the case of the ***Indian Medical Association v V. P. Shantha***[9], the apex Court has held that "just because the operation did not succeed, the doctor cannot be held negligent". This might seem reasonable, but it increases the burden of proof on the patient, who is not specialised in the medical field and lacks the required knowledge, in serious cases of gross negligence, as he and even the Judges at the Consumer Court would not be able to effectively assess if the doctor has fallen short of the standard of reasonable medical care. Moreover, Verma[10] has talked about *'just, fair and satisfactory level of skill'* in the

[6] Jasmita Verma, 'Liability Under Consumer Protection Act In Case Of Medical Negligence: An Analysis' (2022) 4(3) Indian Journal of Law and Legal Research <https://www.ijllr.com/post/liability-under-consumer-protection-act-in-case-of-medical-negligence-an-analysis> accessed 20 October 2025

[7] *Malay Kumar Ganguly v Sukumar Mukherjee and Ors* (2009) 9 SCC 221

[8] Dr. VG Shinde, 'Medical Negligence Liability under Consumer Protection Act: Judicial Approaches in India' (2017) 3(5) International Journal of Law <https://www.lawjournals.org/archives/2017/3/5/3-5-127> accessed 20 October 2025

[9] *Indian Medical Association v V P Shantha and Ors* (1995) 6 SCC 651

[10] Verma (n 6)

context of the ***Malay Kumar*** judgement. Shinde's[11] discussion on ***Laxman B. Joshi v T.B. Godbole and Anr,***[12] discusses something similar, emphasising that the health practitioner must exercise a reasonable degree of care and competence, not the highest or a very low degree. This might seem reasonable, but unlike other services, healthcare services need to be viewed through a different lens as they affect the life and limb of a person and hence must require the highest possible threshold.

Most judgments on these themes are inconsistent in terms of judges' interpretation of the severity of the 'deficiency in the service' and the compensations awarded. This leads to inconsistent outcomes, which can be confusing for not just the patients but also the health practitioners and hospitals whose reputation is at stake.

ALTERNATIVE DISPUTE RESOLUTION TO ADDRESS MEDICAL NEGLIGENCE IN INDIA

Singh[13] argues for resorting to alternative dispute mechanisms like Panchayat, Lok Adalats or Gram Nyalayas to address cases that are not serious, which is a good idea at the village level, but will have several implications as they are likely to be arbitrary with no formal procedures like there are in arbitration.

Mediation: The 'doctor-patient' relationship is considered very important in the healthcare industry, and as Patel[14] puts it, owing to its flexible nature, it can provide a forum for open discussion and offer solutions while maintaining a relationship between parties, "which aligns with the ultimate purpose of medicine, which is to heal people."[15]

Goel and others[16] have discussed how, if there are elements of settlement present, such cases will be referred to a mediation cell, and they have presented it in their paper in a way that the non-binding nature of mediation is a good thing, as the parties can opt out of it if there is

[11] Shinde (n 8)
[12] *Laxman Balkrishna Joshi v Trimbak Bapu Godbole & Anr* AIR 1969 SC 128
[13] Singh (n 4)
[14] Mitshu Patel, 'Alternative Dispute Resolution in Medical Malpractice Disputes in India' (2021) 2(2) Indian Journal of Law and Legal Research <https://www.ijllr.com/post/alternative-dispute-resolution-in-medical-malpractice-disputes-in-india> accessed 20 October 2025
[15] *Ibid*
[16] Rohit Goel et al., 'Legal Mechanisms and Procedures in Alleged Medical Negligence: A Review of Indian Laws and Judgments' (2024) 37(1) National Medical Journal of India <https://nmji.in/legal-mechanisms-and-procedures-in-alleged-medical-negligence-a-review-of-indian-laws-and-judgments/> accessed 20 October 2025

no consensus reached. Now this can be favourable in some cases, but at the same time, it can be wasteful in terms of time and resources for the patients and can be bad for the reputation of the health practitioner in the long run, if the parties just decide to revert to litigation.

Sisodiya & Dwivedi[17] argue that ADR can be a lot more economical in terms of both time and costs if compared to conventional forms of litigation. They discuss how ADR mechanisms work in different countries throughout their paper, starting with the US, where some states have mandatory provisions for resorting to mediation and arbitration before going to court and how the US government encourages the use of such mechanisms, especially in cases of medical negligence. The US has concretised these efforts by establishing the Centre for ADR in the Department of Health and Human Services for providing assistance and resources to parties in a dispute.

Section 74 of the Consumer Protection Act 2019 provides for mediation cells as a mode of ADR mechanisms. These cells, contrary to lengthy legal proceedings at the court, can reach a speedy, economical and amicable resolution. But mediation has its own limitations. It being a non-binding form of ADR, though, allows parties to explore options and come to the realisation that mediation is not their best option; it enables the parties to withdraw from it whenever they please and revert to prolonged legal battles, which can become counterproductive. Moreover, in most cases of medical negligence, there is unequal bargaining power amongst the parties with big hospitals involved, and if they resort to mediation, the vulnerable patient is likely to feel pressured to settle for less than what they deserve, undermining the object of the Consumer Protection Act, 2019. Furthermore, mediators often lack specialised knowledge of the medical field, making them not apt for making a fair and informed decision. With their lack of knowledge, they are also not capable of assessing, evaluating and interpreting the medical evidence, again leading to unfair resolutions.

Arbitration: Arbitration can be the most cost-efficient and fastest ADR mechanism as it involves a lot fewer procedural measures. Moreover, the outcomes are a lot more uniform, consistent and predictable as they are binding in nature and are given by an arbitrator with

[17] Divyansh Singh Sisodiya and Satyam Dwivedi, 'The Role of ADR in Resolving Disputes related to Medical Negligence' (2023) 9(1) International Journal of Law and Social Sciences <https://www.journalsalliancepub.com/index.php/ijls/article/view/82> accessed 20 October 2025

specialised knowledge. Now, of course, not all medical negligence cases are arbitrable, as there exists a stark legal distinction between civil and criminal negligence.

ESTABLISHING THE SCOPE: CRIMINAL NEGLIGENCE AND ITS NON-ARBITRABILITY

Medical Negligence cases involving a civil liability involve a private dispute between parties, with one party (the patient) seeking compensation for a 'deficiency of service under the Consumer Protection Act, 2019. But if the negligence becomes 'gross' and 'reckless,' it needs to be looked at from a significantly higher standard, and thus, becomes a criminal offence, such as under Section 106 of the Bharatiya Nyaya Sanhita (earlier Section 304A of the Indian Penal Code).[18] Now this distinction becomes especially crucial because, as a matter of public policy and since criminal offences are rights in rem and not in personam, criminal negligence will be non-arbitrable.

The Supreme Court in the case of ***Booz Allen & Hamilton Inc. v SBI Home Finance Ltd***[19]**.** has also established that only disputes concerning rights in personam are arbitrable, and a dispute concerning a right in rem, an offence against society at large and the state, cannot be settled via arbitration. Matters ranging from repeated cancellation of appointments that caused inconvenience to the patient, or if they had not been cancelled, could have led to the discovery of a serious ailment, to something like failing to account for allergic reactions from certain medication, are all suitable for arbitration.

Where the line needs to be drawn is in matters where, say, a doctor leaves behind a surgical instrument in someone's abdomen, which in turn leads to an internal bleed, causing grievous hurt to the patient or say, a surgeon performing surgery in an intoxicated state, causing the death of a patient. This is where it falls under the ambit of criminal liability and becomes non-arbitrable. Having demarcated the scope of arbitration, limiting it to civil liability, and excluding criminal negligence, the focus can now shift to its practical application.

[18] *Jacob Mathew v State of Punjab and Anr* (2005) 6 SCC 1
[19] *Booz Allen & Hamilton Inc v SBI Home Finance Ltd & Ors* (2011) 5 SCC 532

PRE-TREATMENT ARBITRATION CLAUSE AND ITS VIABILITY IN INDIA

It has already been widely used in several states in the US in the form of a pre-treatment arbitration clause in patient intake forms, but even there are two sides to the coin. Sachs[20] has argued that, though most healthcare providers have started viewing arbitration as a cost-saving method, with many hospitals in the US discreetly placing pre-treatment arbitration clauses in their patient intake forms, it can act as a double-edged sword, especially negatively impacting the patient. He argues that big companies like e-commerce businesses, where pre-treatment arbitration clauses are common, are a lot different from hospitals, as they dictate patient-physician relationships, which are different from typical producer-consumer relationships. The former assumes inequality between the parties as the patient will always have a lack of access to specialised knowledge, compared to the latter, in which parties have equal bargaining power. If a pre-treatment arbitration clause is mandated in the US, it will transform the former into the latter, making their conflicts a contract law issue instead of a tort law issue, limiting the rights of the patients and their compensation options.[21]

If the same is to be applied to a complex country like India, and say, a mandatory pre-treatment arbitration clause is introduced, the gap between the bargaining parties would be even greater, rendering the patients helpless, especially with the binding nature of arbitration.

Furthermore, Section 7 of The Arbitration and Conciliation Act, 1996 mentions how parties 'submit' to arbitration by way of an arbitration agreement and for a person to submit to a pre-treatment arbitration clause, unlike other conventional arbitration, they must first fully understand what they are consenting to, as understanding it requires a certain level of specialised knowledge, which brings us to the problem of informed consent. When a patient is filling out a patient intake form, they are either sick themselves or are filling them out for a loved one, which puts them in a position where they are under immense stress and are unlikely to understand the severity of the health condition and what can go wrong once, say, they are operated on. In such situations, unless explained in detail what the clause is about,

[20] Sarah Sachs, 'The Jury is Out: Mandating Pre-Treatment Arbitration Clauses in Patient Intake Contracts' (2018) 16(2) Journal of Dispute Resolution <https://scholarship.law.missouri.edu/jdr/vol2018/iss2/16/> accessed 20 October 2025

[21] *Ibid*

it cannot be said to be the informed consent of the patient, and accordingly, there will be no 'submission', making the arbitration agreement void.

Now mandating a Pre-treatment Arbitration clause is completely out of the picture, as it would disproportionately affect the patient and prevent them from pursuing another legal recourse, given the binding nature of arbitration, even if it did not give them a just and fair outcome. Mandating such a clause in India, like in some states in the US, will go against public policy and will be extremely unfair. However, a directory pre-treatment arbitration clause, which can make it optional for the parties to use arbitration, can be a lot better suited. The optional nature of the clause will not limit the patients' options to go for an alternative recourse, making it a fair process without prejudicing either party. Moreover, there can be a clause prescribing a time period mentioned in the patient intake form itself, within which arbitration can be invoked, so that there is no prejudice caused to the healthcare providers either.

Another alternative: No-Fault Systems: Though not yet recognised in India, Sweden, France, and Belgium have implemented 'no-fault systems'[22] in which there is no requirement to prove a healthcare provider's negligence. Given India's lack of infrastructure, it is often the case that medical errors happen not because of the fault of the healthcare provider but due to circumstances out of their control. If India incorporates a no-fault mechanism within mediation or arbitration proceedings (only applicable to disputes concerning civil liability), granted that both parties privately agree to it being a no-fault liability, patients can quickly receive compensation from doctors and hospitals who are economically on a higher footing and hospitals and doctors can save up their time and other resources and protect their reputation.

For instance, a person 'X' goes to a multi-specialist hospital to get a common wart on the back of her hand checked out, and the dermatologist decides to use electrocautery to do the same. Suppose the tool malfunctions and causes a bigger and deeper burn than necessary on her hand, which is likely to leave a prominent scar. If 'X' wants compensation through traditional litigation, she would have to prove that either the doctor was at fault and set the machine

[22] Kenneth Watson and Rob Kottenhagen, 'Patients' Rights, Medical Error and Harmonisation of Compensation Mechanisms in Europe' (2018) 25 European Journal of Health Law <https://repub.eur.nl/pub/103658/REPUB_103658-OA.pdf> accessed 20 October 2025

incorrectly, that the hospital itself was at fault for not maintaining the cautery machine or that the machine's manufacturer was at fault for a defective product. This would become a tedious and expensive legal battle just about who was at fault. Under a "No Fault" System, however, the focus would shift away from the 'fault' and onto the injury. A neutral expert, maybe another doctor, would simply review the case and decide whether an injury has been caused and whether the injury was a direct result of the medical treatment. Such systems aim to offer the patient compensation for immediate corrective treatment and the doctor relief from long, reputation-damaging legal proceedings.

CONCLUSION

Traditional litigation for medical negligence cases can be burdensome for not just the victims, but also the doctors whose reputation, an integral part of their profession, is at stake and consequently falls during the subsistence of the suit, and the already overburdened courts. This is when Alternative Dispute Resolution mechanisms appear as a knight in shining armour, a potential viable alternative, to tackle such cases as long as they stay within the ambit of civil liability and don't involve death or grievous hurt. These mechanisms are a lot more accessible for all strata of society, give quicker outcomes and fairer compensation awards as arbitrators specialised in the field of medicine can be appointed to adjudicate the matter. This lessens the burden on both the patient and the healthcare professional. But at the same time, just because a mechanism like a mandatory pre-treatment arbitration clause works in the US, it does not mean it is well-suited for a complex country like India.

This paper calls for such clauses to be directory or optional in nature instead, so that there is more flexibility and so that the patients retain the right to pursue other options. This paper also calls for healthcare providers to put in efforts to make the patient understand the severity of the condition and the meaning of the clause in layman's terms, to ensure that they give their informed consent and that they don't just submit to the terms because they were under immense stress. Moreover, like many European countries, India can also adopt some elements of 'no-fault systems', which can be both economical and equitable as their focus is on the 'injury' and not the 'fault'. Lastly, though ADR mechanisms can be extremely beneficial for all parties involved, it is important that they are implemented taking into account India's complex socio-economic conditions, especially the unequal power dynamics between patients and healthcare professionals.