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Consumer Law and the Medical Profession in India: Post–CPA Inclusion and the Transformation of Care

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ABSTRACT

The inclusion of health care services under the Consumer Protection Act (CPA) through the landmark V.P. Shantha judgment (1995) fundamentally altered the ethos of medical practice in India. By reclassifying patients as consumers and doctors as service providers, the judgment transformed the fiduciary doctor–patient relationship into a contractual and commercial one. This shift has fostered defensive medicine, excessive reliance on documentation and technology, and fragmentation of care into specialties and super-specialties. While the CPA strengthened patient rights and accountability, it also created inequities, eroded holistic healing, and burdened practitioners with litigation risks. This paper critically examines the judicial and medical consequences of CPA inclusion, highlighting the resulting "cauldron of chaos" in Indian health care, and proposes legal, institutional, and ethical safeguards to restore balance between accountability and compassion.

KEYWORDS

• Consumer Protection Act (CPA) • V.P. Shantha Judgment • Medical Negligence In India • Doctor–Patient Relationship • Defensive Medicine • Evidence-Based Practice • Health Care Litigation • Medical Ethics • Judicial Accountability • Fragmentation of Care

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INTRODUCTION

The V.P. Shantha judgment (1995) marked a seismic shift in Indian medical jurisprudence by including health care services under the Consumer Protection Act, 1986 (CPA), redefining patients as "consumers" and doctors as "service providers."[1] This ruling, arising from Civil Appeal No. 688 of 1995 before the Supreme Court, overturned prior exclusions and imposed strict liability for service deficiencies, transforming the traditionally fiduciary doctor-patient relationship into a contractual, commercial one. Pandey, SK., *et al.* (2023),[2] highlight the alarming surge in consumer court cases and medical malpractice claims against ophthalmologists in India, often resulting in hefty compensations despite reported complications being inherent risks of procedures like intravitreal injections or cataract surgeries. They cite NCDRC data from 2002–2018 showing 30 ophthalmology-related negligence cases, with 73.3% proven deficient and awards up to Rs 10 million, frequently due to poor documentation, inadequate consent, uncontrolled comorbidities (e.g., diabetes), or postoperative lapses rather than surgical errors. The proposed safeguards include excluding medical services from the Consumer Protection Act, establishing specialized medical tribunals, mandatory professional indemnity insurance, rigorous preoperative checklists, empathetic communication, and ethical training to curb defensive practices while upholding accountability. While empowering patients against negligence, it has spurred defensive medicine, over-reliance on documentation and technology, and fragmentation of care into specialties creating a "cauldron of chaos" in practice ethos.[3]

This paper critically dissects these transformations, analyzing judicial reordering of relationships, litigation-driven adaptations, and inequities. It highlights how patient expectations, now legally enforceable via summary CPA trials, demand super-specialty care and evidence-based interventions, often at the expense of holistic healing.

There has been a gradual increase in doctor-patient disputes within India's healthcare system over the years. A recent study published in Indian J Med Ethics. 2023 Oct-Dec; VIII(4):273-278 by Sanjay Sukumar (2023) et al., assesses the speciality-wise prevalence of medical negligence in 253 cases decided by the National Consumer Disputes Redressal Commission (NCDRC) from 2015 to 2019, alongside factors contributing to it. Cases were categorized by compensation awarded, involved speciality, payout amounts, and error types; negligence was upheld in 135 (53%) cases, highest in surgery [37 (27%)] and obstetrics-gynecology [29 (21%)], with peak payouts of Rs 1.38 crore (pediatrics) and Rs 1.1 crore (OBG). Common errors included lack of skill/care in treatment [62 (36%)] and poor record-keeping [38(22%)]. Studying such adverse events can enhance patient care quality, as many are preventable through improved skills, meticulous documentation, and systemic safeguards.[4] Proposing legal, institutional, and ethical safeguards, the analysis seeks to restore balance between accountability and compassion in India's evolving medico-legal landscape.

Table 1: Pre and Post-V.P. Shantha Landscape

Aspect	Pre-V.P. Shantha (Fiduciary Model)	Post-V.P. Shantha (Contractual Model)
Relationship	Trust-based, empathetic; moral duty primary.	Commercial contract; patient as client, doctor as vendor.
Expectations	Realistic, guided by ethics; no summary redress.	Legally enforceable rights; quick CPA compensation.
Care Delivery	Holistic, experience-driven; generalist-led.	Fragmented; specialty/super-specialty silos, referrals mandatory.
Evidence Standard	Clinical judgment sufficient.	"What is not documented is not done"; tech/AI-dominant.
Litigation Risk	Rare, criminal/civil courts; high proof burden.	Frequent, consumer forums; strict liability, low threshold.
Impact on Practice	Autonomy, compassion-focused.	Defensive medicine; cost inflation, empathy erosion.

DISCUSSION

The V.P. Shantha judgment fundamentally altered medical culture by commercializing care, fostering defensive practices, and fragmenting holistic treatment.[1] Traditionally rooted in trust and empathy echoing the Indian Medical Council's (IMC) Code of Ethics, 2002 the doctor-patient bond was fiduciary, not transactional.[5] Post-1995, courts enforced patient expectations as rights, equating non-compliance with "deficiency in service" under

Sections 2(1)(g) and 14 of the CPA, enabling swift compensation via consumer forums.[6]

Shift to Contractual Dynamics and Defensive Medicine

Patients paying for treatment became "clients" hiring vendors, with each intervention requiring specific consent and documentation. Judicial evolution, as in Jacob Mathew v. State of Punjab (2005), distinguishes negligence from complications but upholds "what is not documented is not done," compelling exhaustive records to counter CPA claims.[7] This drives defensive medicine: over-testing, AI-reliant diagnostics, and specialist referrals to mitigate liability, inflating costs by 20-30% per estimates. A 2024 European Journal of Medicine article by Satvik N Pai, *et al*., analyzes India's escalating medical malpractice crisis, estimating 5.2 million annual cases a 110% incidence rise and 400% litigation surge post-V.P. Shantha (1995), which brought healthcare under the Consumer Protection Act. It critiques defensive medicine's consequences: 20-30% cost inflation from over-testing, specialist referrals, and documentation obsession driven by the judicial maxim "what is not documented is not done." The paper highlights surgical (27%) and obstetrics-gynaecology (21%) as high-risk specialties per NCDRC data, with peak awards like Rs 1.38 crore (paediatrics). Key errors include lack of skill/care (36%) and poor records (22%). Authors warn of practitioner burnout, empathy erosion, and inequities favoring "paid patients," urging specialized tribunals, guideline safe harbors, and ethical reaffirmation to avert a "litigation pill" overwhelming compassionate care.[8]

Fragmentation of Care

Demand for "best treatment" warehouses patients into specialties, then super-specialties, dismembering the "whole person" approach. Failure to refer seen as negligence in cases like Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka (2009) creates referral cascades, eroding continuity.[9] Empirical judgment yields to evidence-based practice, with courts favoring machine-generated data over clinical acumen, as in Kusum Sharma v. Batra Hospital (2010).[10] A privileged "paid patient" class emerges, deepening inequities; indigent care falls outside CPA, exacerbating access divides.

The Cauldron of Chaos

This judicial-medical collision yields chaos: eroded empathy, trust deficits, and practitioner burnout, with CPA cases surging 5.2 million medical malpractice cases annually post-Shantha.[11] Hospitals morph into legal fortresses, prioritizing compliance over healing.

Q. With placement of health care under CPA by V P Shantha judgment (1995), the ethos and culture of practice of medicine has progressively changed.

- One who pays for treatment is not a patient, but a client, who contracts medical services and hires medical professionals from a health-care-service-vendor.
- The relationship between the patient and a medical professional is contractual and commercial; every service (medical intervention) the vendor agrees to provide is a paid for, individually and specifically consented and contracted transaction.
- A special class of paid patients is created by the judgment that is entitled to best treatment, commanding compliance against a sanction of quick compensation by summary trial under CPA.
- The privileged patient's expectations are treated as a legal right of the patient.

To keep pace with the legal requirements, the fast changing and advancing medical services have molded to escape the medical negligence onslaught.

- With increasing demand and expectation that a paid patient is treated by a discipline specialist, the patient is 'ware housed' to a specialty.
- With further demand for super-specialty treatment, the patient is pigeon-holed to an organ specialty. The patient is fragmented and dismembered to receive the expected and demanded grade of standard treatment facilities.
- With insistence of evidence based treatment the experience based empirical treatment is not acceptable to the patient and the judiciary. Every intervention decision is to be supported by evidence from tests and investigation reports. The evolved judicial principle is 'what is not documented is not done'.

- AI based sophisticated equipment provides accurate and legally acceptable evidence compared to the clinical acumen and judgment of the physician. A host of specialists participate in the treatment.
- For every complaint and suspected comorbidity, the patient is expected and required to be referred to a specialist or super specialist; Failure to provide the same is a deficiency in service, equated under CPA with negligence.

Our critical and considered comments, based on judicial and medical context specifically in India, on the cauldron of chaos?

Our framing of the "cauldron of chaos" captures the profound shift that the *V.P. Shantha* judgment (1995) triggered by bringing health care under the Consumer Protection Act (CPA). Let's unpack this critically in the Indian judicial and medical context:

1. Transformation of the Doctor–Patient Relationship

- **From fiduciary to contractual:** Traditionally, medicine in India was rooted in trust, empathy, and professional duty. The CPA reclassified this into a commercial contract, where the patient becomes a "client" and the doctor a "service provider."
- **Legal enforceability of expectations:** What was once a moral obligation is now a legally enforceable right. This has elevated patient expectations to the level of entitlement, backed by the threat of compensation through summary trial.

2. Fragmentation of Care

- **Warehousing into specialties:** To avoid negligence claims, hospitals increasingly push patients into specialty silos. This protects practitioners legally but dismembers holistic care.
- **Super-specialty pigeonholing:** Patients are reduced to organ systems, losing continuity of care. The "whole person" approach is sacrificed for defensive medicine.
- **Evidence over experience:** Clinical intuition, once valued, is now legally vulnerable. Courts demand documented evidence, leading to over-testing, over-referral, and reliance on machines rather than judgment.

3. Judicial Principles Driving Practice

- **"What is not documented, is not done":** This principle, evolved through case law, has made paperwork and investigations central to medical defense.
- **AI and technology dominance:** Sophisticated equipment provides legally acceptable evidence, overshadowing human acumen. The law indirectly incentivizes technology over bedside skill.
- **Referral culture:** Failure to refer to a specialist is equated with negligence. This creates a cascade of referrals, inflating costs and fragmenting responsibility.

4. Consequences: The Cauldron of Chaos

- **Defensive medicine:** Doctors practice to avoid litigation rather than to heal. This inflates costs and erodes trust.
- **Inequity:** A privileged class of "paid patients" emerges, entitled to super-specialty care and quick compensation. Poor patients, who cannot pay, remain outside CPA's ambit, deepening inequality.
- **Judicial overreach vs. medical autonomy:** Courts, in seeking accountability, have inadvertently reshaped medical culture into a compliance-driven, risk-averse system.[12]
- **Erosion of empathy:** The human touch in medicine is replaced by contractual obligations, investigations, and documentation.

5. Critical Reflection

India's judiciary sought to protect patients from negligence, but the unintended consequence has been:

- **Legalization of expectations** → chaos in medical practice.
- **Commercialization of care** → erosion of trust.
- **Fragmentation of treatment** → loss of holistic healing.

The challenge now is to **balance accountability with autonomy**. Without reform, the CPA framework risks turning hospitals into legal fortresses and doctors into technicians, rather than healers.

In short: The *V.P. Shantha* judgment democratized patient rights but also unleashed a culture of defensive, fragmented, and commercialized medicine. The "cauldron of chaos" is real born of judicial intent colliding with medical ethos.

Q. Please sketch out possible reforms or safeguards (legal, institutional, or ethical) that could restore balance, keeping Indian situation in focus.

Here's a structured sketch of reforms and safeguards that could help restore balance in India's medico-legal landscape after the *V.P. Shantha* judgment and the CPA inclusion of health care:

1. Legal Reforms

- **Separate Medical Tribunals:** Establish specialized medical negligence tribunals with judges trained in medical jurisprudence. This would prevent summary consumer forums from oversimplifying complex medical decisions.
- **Differentiation of Negligence vs. Complication:** Codify clear statutory definitions distinguishing "expected complications" from "negligence." This would protect doctors from liability for adverse outcomes inherent to medical risk.
- **Safe Harbor for Evidence-Based Practice:** Introduce statutory protection for doctors who follow accepted clinical guidelines, even if outcomes are poor. This would reduce defensive medicine.
- **Tiered Compensation Framework:** Create graded compensation linked to severity and proven negligence, avoiding disproportionate awards that fuel litigation culture.
- **Mandatory Mediation:** Before CPA trials, require mediation panels (with medical experts) to resolve disputes, reducing adversarial litigation.[13]

2. Institutional Safeguards

- **Medical Documentation Standards:** National Medical Commission (NMC) could mandate uniform documentation templates, ensuring "what is not documented" doesn't become a trap but a standardized safeguard.
- **Hospital Legal Cells:** Every hospital should have medico-legal cells staffed with trained professionals to handle documentation, patient communication, and litigation defense.
- **Integrated Care Models:** Encourage multidisciplinary boards (like tumor boards in oncology) to provide holistic care, reducing fragmentation into specialties.
- **Insurance Coverage Expansion:** Promote professional indemnity insurance for doctors and malpractice insurance for patients, creating a buffer against litigation shocks.
- **Audit & Compliance Units:** Regular medico-legal audits within hospitals to ensure adherence to statutory and ethical standards.

3. Ethical & Professional Safeguards

- **Reaffirm Fiduciary Ethos:** Reinforce through medical education that despite CPA's contractual framing, the doctor patient relationship is fundamentally fiduciary, rooted in trust.
- **Transparent Communication:** Train doctors in risk disclosure and empathetic communication. Many litigations arise from poor communication rather than poor care.
- **Ethics Committees:** Institutionalize ethics committees to review complex cases, providing both moral and legal defense.
- **Balanced Use of Technology:** Encourage AI and diagnostic tools as supportive evidence, but reaffirm clinical judgment as central.
- **Patient Education:** Public campaigns to educate patients about the limits of medicine, risks of procedures, and the difference between negligence and complication.

4. Systemic Balancing Measures

- **Dual Track Justice:** Consumer forums for clear-cut service deficiencies (billing errors, denial of facilities), but medical tribunals for clinical negligence.
- **CSR & Public Health Safeguards:** Ensure poor patients outside CPA's ambit are not left behind link hospital CSR obligations

to free legal aid and grievance redressal.

- **Judicial Training:** Continuous sensitization of judges on medical science, risk, and uncertainty to avoid unrealistic expectations.
- **Policy Dialogue:** Ongoing dialogue between judiciary, medical councils, and patient groups to recalibrate expectations and responsibilities.

Critical Note

India's challenge is to **balance accountability with compassion**. Over-legalization risks turning doctors into defensive technicians, while under-regulation risks patient exploitation. The path forward lies in **specialized tribunals, institutional safeguards, and ethical reaffirmation** so that medicine remains a healing art, not just a contractual service.

CONCLUSION

The *V.P. Shantha* judgment democratized accountability but unleashed commercialization, defensiveness, and fragmentation, birthing a "cauldron of chaos" that burdens India's health care. Reforms are imperative: specialized medical tribunals to supplant consumer forums; statutory safe harbors for guideline-adherent practice; mandatory mediation with expert panels; NMC-mandated documentation standards and hospital legal cells; and ethical reaffirmation of fiduciary ethos via education. Dual-track justice CPA for service lapses, tribunals for clinical Numbers coupled with judicial training and patient awareness campaigns, could recalibrate balance. Ultimately, these safeguards would preserve judicial intent while restoring medicine as a compassionate art, mitigating inequities and fostering sustainable practice.

REFERENCES

1. Supreme Court of India. V.P. Shantha v. India Cement Capital Finance Ltd. (1995) 6 SCC 651.
2. Pandey SK, Sharma V. Alarming rise in consumer cases/medical malpractice claims with huge compensation: How to safeguard medical professionals?. Indian J Ophthalmol. 2023 Mar;71(3):1041-1043. doi: 10.4103/IJO.IJO_2530_22. PMID: 36872741; PMCID: PMC10229969. https://pmc.ncbi.nlm.nih.gov/articles/PMC10229969/
3. Kabra, SG. Verma, V. Medical Negligence and Judicial Overreach, Redflower. 2025.
4. Sathiyabama K, Suresh Kumar P. Medical negligence in cases decided by the National Consumer Disputes Redressal Commission: a five-year review. Indian J Med Ethics. 2023;8(4):289-97. https://pubmed.ncbi.nlm.nih.gov/36945851/
5. Indian Medical Council. Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Gazette of India. 2002.
6. Consumer Protection Act, 1986 (India), Sections 2(1)(g), 14.
7. Supreme Court of India. Jacob Mathew v. State of Punjab. (2005) 6 SCC 1.
8. Philip S. Swallowing the litigation pill: medical lawsuits in India. Eur J Med. 2024;4(9):e1900. https://pmc.ncbi.nlm.nih.gov/articles/PMC11482048/
9. Supreme Court of India. Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka. (2009) 6 SCC 1.
10. Supreme Court of India. Kusum Sharma v. Batra Hospital. (2010) 3 SCC 480.
11. Mahajan D. 5.2 million medical malpractice cases annually: litigation surge impacts Indian healthcare. Medical Buyer. 2025. Available from: https://medicalbuyer.co.in/5-2-million-medical-malpractice-cases-reported-in-india-annually/
12. Press Information Bureau, Government of India. National Consumer Disputes Redressal Commission along with ten States records over 100% disposal rate. 2025 Nov 19. Available from: https://www.pib.gov.in/PressReleasePage.aspx?PRID=2157241.
13. Department of Consumer Affairs, Government of India. Annual Report 2024-25. New Delhi: DoCA; 2025. Available from: https://consumeraffairs.gov.in/pages/annual-report.