ISSUE #7

PGCL NEWSLETTER

30 July 2025

THE BRIEFCASE

Bringing you voices that think, write and question!

Welcome to the July 2025 issue of The Briefcase-your go-to legal newsletter! Hot on the heels of last month's stellar edition, we're back with fresh perspectives, insightful opinion pieces, and bite-sized legal insights to brighten your day.

In honour of National Doctor's Day, celebrated annually on July 1st, this issue is themed around the ever-evolving intersection of Law and Medicine. These two disciplines have long intertwined, be it in the regulation of medical practice, ethical dilemmas, or the lived experiences of doctors and future medical professionals.

This month, we dive into how AI is reshaping healthcare, the role of preventive medicine in Indian policy, and the medico-legal issues that resonate across the country. We spotlight everything from the misapplication of laws against doctors, to legal protections that support and sustain medical careers.

As we navigate these intersections, we celebrate the vital role that healthcare professionals play in our lives. In a field that's advancing at lightning speed, it's more important than ever to craft legal frameworks that not only protect doctors but also foster innovation and excellence.

This month is about recognition, protection, and about honouring those who save lives every single day. So grab your coffee, settle in, and explore this special edition of The Briefcase.

Let the fun begin!

The Editorial Board x

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THE BINDER

Your essential collection of the latest legal updates, neatly organised for a quick reference.

Prevention Over Cure: Strengthening Health Through the Law

Preventive healthcare focuses on averting disease rather than merely treating it and is a cornerstone of a strong public health system. In India, where there is a dual burden of communicable diseases (such as tuberculosis, malaria, and dengue) and non-communicable lifestyle diseases (like diabetes, hypertension, and cancer), preventive measures play a crucial role. Yet, the Indian healthcare system continues to allocate a significant portion of its resources to curative care, while preventive initiatives remain underfunded and inconsistently implemented.

Judicial Recognition and Mandate –
The judiciary has repeatedly emphasised preventive healthcare as an essential part of the 'Right to Life' guaranteed under Article 21 of the Constitution. In the landmark judgement of *Consumer Education and Research Centre v. Union of India*, 1995 (3 SCC 42), the Supreme Court held that "the right to health and medical care is a fundamental right under Article 21." This includes the obligation to ensure safe working conditions and health facilities, and extends to preventive measures like periodic health check-ups and early detection.

Similarly, in *Deepa Sanjeev Pawaskar & Anr. v. State of Maharashtra*, 2018 (AIRONLINE 2018 BOM 432), the Bombay High Court emphasized that "failure to provide timely post-operative monitoring, which is a preventive measure, amounted to criminal negligence under §304A under the IPC."

Failure to prioritise preventive healthcare leads to catastrophic outcomes, both medically and legally, and overburdens the Indian healthcare system. In the landmark judgement of *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) (4 SCC 37), the petitioner suffered due to the denial of timely medical treatment by multiple hospitals, which were either ill equipped or overcrowded. The Supreme Court held that the state has constitutionally obligation to ensure adequate facilities for treatment and cannot escape liability by citing lack of infrastructure. This case highlights how a lack of preventive infrastructure such as regular health check-ups, primary care centers, and emergency response systems results in delayed treatment and deterioration of patients' health.

Conclusion –
Preventive healthcare forms the backbone of any efficient public healthcare system, as it focuses on avoiding diseases before they occur rather than treating them afterwards. However, Indian healthcare system continues to allocate a disproportionate share of its resources to curative care rather than preventive, despite the judiciary's repeated emphasis on the importance of preventive care.

When primary care and early detection are neglected, more individuals end up requiring emergency or advanced treatment, which puts an enormous burden on the hospitals. It's evident that prevention is not just sound medical practice, but also a legal and moral obligation. Preventive healthcare saves lives, reduces suffering and protects the dignity of patients. India urgently needs to shift from a policy of treating the damage after it's done, to preventing the damage from happening in the first place.

-Ms. Shaili Sheth
Student, 3rd year

THE BINDER

Your essential collection of the latest legal updates, neatly organised for a quick reference.

Artificial Intelligence in Healthcare: Promise and Precaution

Artificial Intelligence is rapidly reshaping the global healthcare landscape. From AI-powered clinical documentation tools to chatbots and diagnostic systems, countries like China and India are integrating AI in both urban and rural healthcare infrastructure. While these innovations improve efficiency, reduce workload, and enhance diagnostics, they also raise critical concerns related to data protection, accountability, and regulatory gaps.

China – AI Implementation in Governance

Initiatives like Healthy China 2030 and the 2030 China AI Strategy are adopting AI in healthcare. DeepSeek-powered AI tools are used in radiology, pathology, and diagnostics even in tertiary hospitals. Additionally, rural platforms like Tencent-backed WeDoctor are using AI chatbots to enhance remote healthcare. WeDoctor collects patient data, including blood pressure readings and clinical notes from farmers, for AI-assisted diagnoses.

These initiatives seem progressive at first glance; however, insufficient data protection still exists at large, which is a challenge under China's domestic data laws. In response to these challenges, China's Cyberspace Administration has put in place a multi-layered governance system to regulate the use of AI in medicine, with provisions such as:

- **Algorithm Recommendation Regulation –** It includes generation and synthesis, personalised push, sorting and selection, retrieving and filtering, and scheduling-related decision making.
- **Deep Synthesis Regulation –** Governs AI-generated content including chatbots, with obligations on providers, platforms, and users.
- **Generative AI Regulation –** This regulation applies to all generative AI technologies that are publicly accessible in China, but does not cover those still in development or used privately without public access.
- **Draft Ethical Review Measure –** Once enforced, this draft measure will apply to any scientific or technological activity involving humans, lab animals, or activities that pose ethical risks.

India – Innovation Amidst Regulatory Uncertainty

In India, AI in healthcare is emerging through private innovation rather than central planning. Apollo Hospitals in India, with over 10,000 beds, is leading the use of AI technology to help alleviate workforce issues. In early 2025, Apollo announced increased investment in AI to help save doctors and nurses 2–3 hours of administrative duties per person. Their systems now automate the analysis of electronic medical records and discharge summaries, prescription of antibiotics, as well as planning for the shifts of the nurses.

Additionally, India's first AI-powered Precision Oncology Centre located at Bengaluru offers personalised cancer diagnostics utilizing AI for tailored cancer diagnosis and treatment. Another example includes the AI-based patient monitoring system which is said to have lowered in-hospital 'Code Blue' events by 80% Hospital Management Asia.

However, these advancements are taking place within a regulatory void. India's Digital Personal Data Protection Act, 2023 offers an overarching framework relating to health data privacy, but does not cover provisions for the accountability of the algorithms used, the clinical safety assessment of the AI systems, or the AI-driven algorithms used. The Ayushman Bharat Digital Mission supports the shift towards digital records but does not enforce stringent regulations to govern the use of AI technologies.

THE BINDER

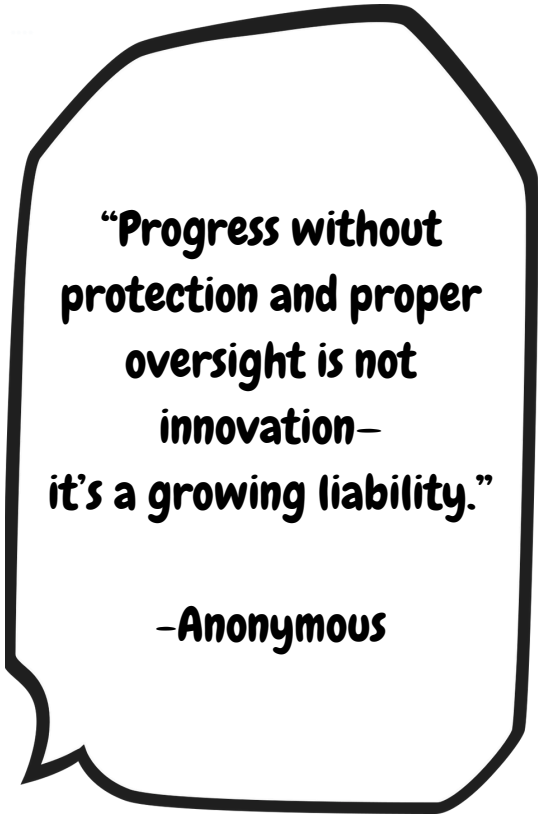
Your essential collection of the latest legal updates, neatly organised for a quick reference.

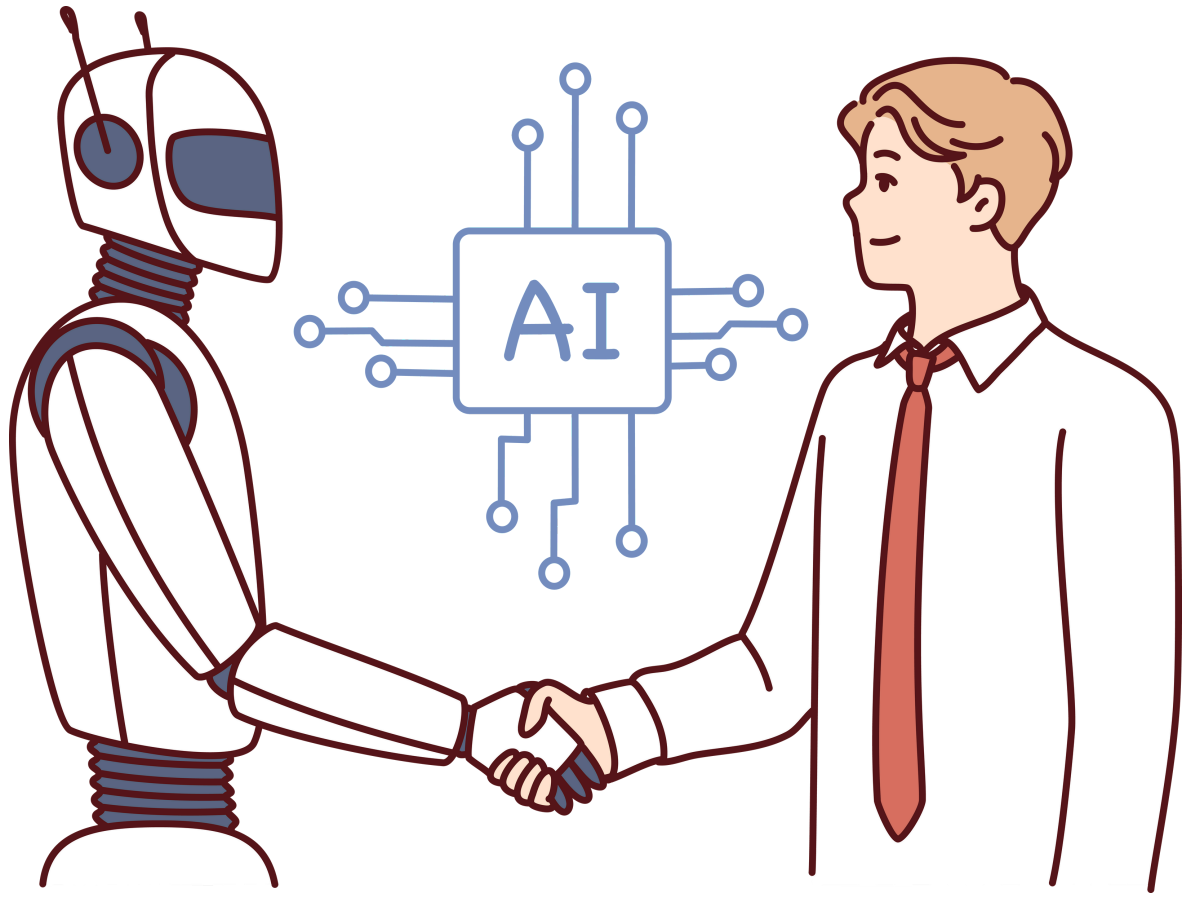
Judicial intervention has somewhat bridged this gap. Some important judicial decisions on this subject includes, for example, *Mrs. Arpana Dutta v. Apollo Hospitals Enterprises ltd, Madras*, [2002 ACJ 954, AIR 2000 Mad 340, (2000) IIMLJ 772], have used *res ipsa loquitur* and vicarious liability principles to impose culpability on hospitals for their attendant technological negligence, principles that will be critical as AI tools become core to hospital operations.

Conclusion –

As clinics start to routinely use AI tools, the law must adapt just as quickly. Medicine's potential AI application may be hindered by lack of transparency, inconsistent policies, or damage without stringent governance. Be it through policy like in China, or court-led evolution as in India, the need remains urgent: adapting legislation to keep pace with machine intelligence.

-Ms. Nikita Muddalgundi
Student, 2nd Year





THE GAVEL

The strike of the mallet, in recent judgements, summarised for easy reading.

Neeraj Sud & Anr. v. Jaswinder Singh (Minor) & Anr., 2024 INSC 825

The Supreme Court of India, on 25th October 2024, clarified the criteria for proving medical negligence in the case of *Neeraj Sud & Anr. v. Jaswinder Singh (Minor) &Anr.* (2024 INSC 825). Punishable under various laws, medical negligence involves the breach of duty by a medical practitioner and the injury caused by such negligent actions. Other landmark verdicts on the subject are Basant Seth v. Regency Hospital O P (1994), Pooja Sharma & Ors. v. Maharaja Agrasen Hospital & Ors., 2019.

Background-

In this case, a minor, Jaswinder Singh, was diagnosed with PTOSIS (drooping eyelid) and underwent surgery in June 1996. Dr. Neeraj Sud, an ophthalmologist at PGI performed the surgery. After the surgery, the child's PTOSIS worsened, and he started experiencing double vision. The Complainant (the child's father) filed a complaint before the State Commission against Dr. Sud (Respondent) alleging medical negligence.

Procedural History-

The State Commission dismissed the complaint, citing that the recurrence of the child's condition was a known complication of the surgery, and it could be treated by performing the surgery again. It did not hold Dr. Sud liable for medical negligence.

However, the Complainants filed an appeal to the National Consumer Disputes Redressal Commission (NCDRC). NCDRC overturned the order of the State Commission and declared the Respondent negligent. The Commission ruled that Dr. Sud failed in providing adequate treatment and did not perform follow-up corrective surgery; subsequently, it declared both Dr. Sud and PGI jointly and severally liable for a compensation of Rs. 3,00,000, with additional costs. The Respondents contended that after 1997, the Complainants had not returned to PGI for further treatment and had instead chosen to seek treatment elsewhere. Aggrieved by the decision of the NCDRC, the Respondents filed an appeal in the Supreme Court.

Issues -

1.Whether the deterioration of the patient after surgery constituted medical negligence?
2.Whether the Respondent (Dr. Sud) had complied with the accepted standards of medical care and treatment in this case?

Ruling -

The Supreme Court ruled in favour of the Respondent, stating that a doctor who complies with the accepted professional practice will not be held liable for complications following that procedure.

The Court notably applied the Bolam test, originally created and applied in the landmark English case of *Bolam v. Friern Hospital Management Committee* (1957); accordingly, the bench held that the Respondent's actions complied with the practice deemed acceptable by a group of medical experts. Further considering the '*Res ipsa loquitur*' principle, the bench held that since the evidence did not show that the doctor failed to exercise the necessary skill during his practice, the absence of evidence was not proof of his guilt, therefore absolving him of guilt.

The SC reiterated that the burden of proof lies on the complainant to prove the three key elements for medical negligence:

- A duty to exercise due care,
- A breach of that duty, and
- Damage resulting from the breach.

Conclusion-

This judgment is of paramount importance as it clarifies the criteria for establishing medical negligence, while underscoring how substantial evidence is crucial in such cases. The Court emphasised that lack of evidence does not amount to evidence itself. It also brought various aspects of medical duty into focus, stressing the need for periodic review and revision of the legal standards governing the medical profession, to accommodate the complexities and evolving nature of medical procedures. By reinforcing the professional autonomy of medical practitioners while maintaining accountability, this case forms a critical addition to India's consumer protection and medical law jurisprudence.

- Ms. Tanaya Damle
Student, 2nd year

THE GAVEL

The strike of the mallet, in recent judgements, summarised for easy reading.

Dr. Mohan V. State Of Tamil Nadu & Anr.

In a notable decision concerning medical negligence and criminal liability, the Supreme Court of India, on 12th February 2025, clarified the criminal threshold applicable to medical professionals in cases involving patient deaths. The case of *Dr. Mohan v. State of Tamil Nadu & Anr.* reaffirmed the standard laid down in *Jacob Mathew v. State of Punjab* (2005), distinguishing between professional error and culpable homicide.

Background-

Dr. Mohan, a practicing medical professional, was charged under Section 304 Part I IPC (culpable homicide not amounting to murder). It was alleged that the patient he treated passed away because of a reaction to a purportedly improperly administered injection, by a nurse on the instruction of Dr. Mohan on the phone. The matter was heard by the Sessions Court after a chargesheet was submitted.

Issues-

1. Whether the continuation of criminal prosecution under Section 304 Part I IPC amounted to misuse of judicial process.
2. Whether Dr. Mohan's alleged conduct amounted to gross negligence attracting criminal liability.
3. Whether the High Court erred in refusing to quash the proceedings under Section 482 CrPC.

Ruling-

Dr. Mohan contended that his conduct did not meet the threshold of intent or knowledge required under Section 304 Part I IPC. He argued that, at most, the incident amounted to professional error or ordinary negligence. Further, he emphasised that the nurse who had actually administered the injection had already been discharged by the High Court. He stressed on the landmark judgment in *Jacob Mathew v. State of Punjab* (2005), where the Supreme Court held that doctors can only be criminally prosecuted for gross negligence or recklessness, and not for ordinary lapses in judgment.

The Supreme Court accepted Dr. Mohan's arguments and set aside the order of the Madras High Court. The Court observed that there was no material evidence to indicate that Dr. Mohan possessed the requisite intent or knowledge to foresee death as a likely consequence of his instruction to administer the injection. As a result, the offence alleged did not fall within the ambit of Section 304 Part I IPC. Instead, the court ruled that, that if facts were proved, it would fall under Section 304A IPC, which deals with causing death by negligence. The Court directed that the matter be transferred from the Sessions Court to the Magistrate's Court, which has jurisdiction over offences under Section 304A IPC, which carries a maximum punishment of two years.

Conclusion -

The Supreme Court's in its ruling, reinforces the principle that criminal liability in cases involving medical professionals must be approached with caution. The judgement reclassified the charge from culpable homicide under Section 304 Part I IPC to causing death by negligence under Section 304A IPC. The decision aligned with the precedent set in *Jacob Mathew v. State of Punjab* and ensured that doctors are not subjected to unwarranted criminal prosecution for professional lapses that do not meet the threshold of criminal intent. This judgment is a significant contribution to India's evolving jurisprudence at the interface of law and medicine.

-Ms. Priyal Doshi
Student, 4th year

THE COMMENTARY

Straight from the commentary box of our editorial board, curated reads to expand your legal mind.

Digitalization of Healthcare- Challenges to Right to Privacy

Published in Healthcare on 11th Feb 2025

Integrating technology and data into the healthcare system has led to rapid digitization of healthcare system. This digitalization will lead to an enhancement of patient care, increased efficiency, and delivery of improved outcomes. The impetus to the digitalization of the healthcare sector in India is provided by the Ayushman Bharat Digital Mission (ABDM) which aims to create a nationwide digital health ecosystem by integrating healthcare service providers and patients. There are four features of ABDM, namely, creation of a unique identifier- Health ID, a database of healthcare professionals- Healthcare Professionals Registry (HPR), a repository of healthcare facilities- Health Facility Registry (HFR), and a network facilitating health services- Unified Health Interface (UHI).

However, digitalization of the healthcare sector poses unique challenges. In a time where medical records are still retained in physical formats, asking medical professionals and facilities to shift to complete digitalization will require a large-scale, time-consuming, and massive economic effort. There is a shortage of infrastructure, and technological expertise to meet such a huge demand. Another major challenge that ABDM faces is data security. There is apprehension in the minds of the people regarding sharing of sensitive health information like information regarding mental health. No system of advanced security measures can guarantee that data will remain secure all the time. The potential misuse of such health data is immense. In a world where data is the biggest power one can possess, procuring data and using it for one's benefit will lead to several attempts at breaching data security.

Privacy concerns, regarding the handling of sensitive data, create a significant barrier in the implementation and fulfilment of ABDM. There is a need for a strong data protection framework. People may be provided with an optional data-sharing mechanism. Although ABDM boasts of a federated architecture, where there is no centralized storing of data, the risk of data theft cannot be ignored. Unless the privacy concern is addressed, achieving complete digital healthcare will be a distant dream.

Click here to read the Article

This Article is recommended by,
Ms. Prajnee Sahoo
Assistant Professor, PGCL

Refusal to Mandate Medical Examination for Retrospective Capacity Assessment

Judgement by Hon'ble Bombay High Court

If you're interested in how Indian courts approach mental incapacity and guardianship in civil disputes, this Bombay High Court decision is a must-read. In IA No. 708 of 2023 and IA No. 133 of 2024 in Suit No. 1151 of 2019, Justice N.J. Jamadar addressed key issues under Order XXXII Rule 15 of the Code of Civil Procedure, 1908, on appointing a guardian ad litem (a legal representative for those mentally incapable of managing their affairs).

The case involved claims that Defendant No. 3 (PC), reportedly suffering from Alzheimer's and dementia, lacked mental capacity during property transactions. Plaintiffs sought a retrospective medical exam to prove incapacity, while PC's daughter (Defendant No. 5) asked to be appointed guardian ad litem. The Court ruling: First, it refused the retrospective exam, noting such exams can't conclusively establish past mental state. Plaintiffs must present strong evidence to prove incapacity. Second, it denied the daughter's appointment due to possible conflict of interest and instead appointed a neutral court officer.

This decision reinforces that courts must balance autonomy, dignity, and procedural fairness when dealing with mental infirmity.

Click here to read the Judgement

This Article is recommended by,
Mr. Anas Dhorajiwala
Student, 5th Year

THE BLACK & THE WHITE

A legal chessboard of diverse opinions, which shade of justice are you going to checkmate?

The NEET Scam: A Cracked System Beneath a Competitive Dream

When merit becomes a commodity, and justice is an option, a nation loses its faith in fairness itself.

The National Eligibility Cum Entrance Test (Undergraduate), or NEET-UG, is the only entrance exam for studying medicine in India. It is conducted by the National Testing Agency (NTA), a government organisation which holds some of India's biggest exams. The exam is conducted once a year, and millions of students take the test. Despite the high number of students taking the exam, only a small percentage secure the grades needed to enter the nation's top medical colleges. However, that wasn't the case for the year 2024, when an unprecedented number of 67 students scored a perfect score of 720, a feat only achieved by a handful in previous years. What followed the release of these numbers was a nationwide reckoning of the flaws of the country's most esteemed examination system.

Starting May 5th 2024, NEET-UG faced allegations of question paper leaks. The consequences were swift. FIRs were filed, people were arrested, and the matter reached the courts. However, the NTA's handling of the case was severely criticised. While caution was initially expressed, the agency declared results, provided counseling, and proceeded with admissions without a clear idea of how many students might have been inappropriately assisted.On 23 July 2024, the Supreme Court of India noted that at least 155 students had directly benefited from the paper leak. The Supreme Court observed inconsistencies, stating in open court that the "sanctity of the exam" had been disturbed, and directed limited re-tests. However, no re-test was held, nor was an exhaustive audit of scores conducted. The Court also dismissed claims of a large-scale NEET-UG 2024 paper leak and refused to order a re-examination, citing a lack of credible proof of widespread irregularities.

Legally, the episode was also brought to the fore a prevailing lacuna: the absence of a robust legislative framework to address exam-related malpractice. At the time of the NEET scam, India did not have a central law to address organised cheating or paper leaks. Although sections of the Indian Penal Code were invoked, they were not robust enough to check systematic malpractice. It was only in February 2024 that the Public Examinations (Prevention of Unfair Means) Act was enforced, with enhanced penalties. However, it arrived too late to meaningfully impact the NEET-UG 2024 debacle.

Socially, the scam created a feeling of injustice among students—particularly those from rural or economically backward classes who had worked hard, often at great personal cost. Many students lost their medical seats due to artificially raised cut-offs and manipulated merit lists. Even those who received admissions subsequently remained in constant anxiety and frustration. Several High Court petitions challenging the results and counselling process are still pending. The lack of overt redressal has only postponed uncertainty for thousands.

Meanwhile, public faith in the NTA has been shaken. The organization, established in 2017 as an agency to bring standardization and professionalism to national entrance examinations, now faces calls for structural reform. Although committees were set up within the agency and some procedural changes have been implemented (such as increased digital surveillance and logistics screening), these are just administrative fixes. There has been no external review of the NEET-UG 2024 process by an independent expert, nor has any public report been issued detailing the failures or outlining steps for prevention. Since the fraud, there has also been a shift in public opinion. There is, at last, a growing consensus among policy analysts and educationists that India cannot continue.

THE BLACK & THE WHITE

A legal chessboard of diverse opinions, which shade of justice are you going to checkmate?

relying on single-shot, high-stakes exams like NEET and JEE. The pressure of clearing one all-India exam generates not only unwarranted mental stress, but also fuels an underground market for fraud. Alternatives like multiple exams, greater weightage to board performance, or region-based quotas are being considered, although political consensus remains off the table.

A year on, the NEET-UG 2024 scam is a reminder of how tenuous the promise of meritocracy can prove to be if institutions lack transparency, accountability, and are legally empowered. In a nation where education is one of the few possible avenues of mobility, such failures are not administrative but profoundly social and political. Without substantive structural reform, these failures can become institutionalized.

The question now is whether the NEET scandal will be just another scandal in the long saga of education controversies in India, or whether it will serve as a turning point for lasting institutional reform. For now, the signs remain ambiguous, and we can only hope for a stronger educational infrastructure—one where students and parents don't have to sacrifice their dreams in the face of systemic flaws, where merit is genuinely rewarded, and where trust in the process is not a privilege, but a given.

- Ms. Shrishti Shastry
Student, 4th Year

"Merit becomes a fading illusion, when corruption and cunning hands decide who rises and who is left behind."
-Anonymous

THE BLACK & THE WHITE

A legal chessboard of diverse opinions, which shade of justice are you going to checkmate?

RG Kar case: Was the "Rarest of the rare" Criteria Fulfilled?

What should have been a place of safety and protection turned into one of the most brutal crime scenes-the seminar hall of R.G. Kar Medical College in West Bengal. A young trainee doctor was raped and murdered by strangulation and blunt force trauma. She was found partially clothed, with multiple physical injuries on her limbs and private parts. The brutality of the crime shocked the entire nation.

Despite the pleas of the Central Bureau of Investigation and the State, the Hon'ble Supreme Court did not rule in favour of the death penalty. Why? Because, in the opinion of the judiciary, the crime did not fall under the "rarest of the rare" category.

If a crime of such brutality and moral depravity does not fall within the ambit of the "rarest of the rare", it inevitably raises concerns about the uncertainty surrounding the doctrine.

According to Justice Shri Anirban Das, while the crime was unquestionably heinous, capital punishment is meant to be an exception, with life imprisonment as the norm. He asserted that the case did not meet the standards of capital punishment by judiciary. He reiterated the doctrine of *Bachan Singh v. State of Punjab* (1980), in which the Supreme Court laid down that life imprisonment is the norm and death sentence an exception—to be selectively applied, with judicial wisdom, and not populist sentiment. The "rarest of the rare" doctrine was articulated to protect sentencing from populist fervour and to ensure reformative justice, based on both the criminal's potential for reform and the nature of the offence.

The case, however, presents a troubling dilemma. In *Machhi Singh v. State of Punjab* (1983), in which 17 people were murdered in cold blood as a measure of caste revenge, including women and children, the death penalty was upheld. Ruthlessness, premeditation, and callousness were held sufficient to warrant the maximum penalty. But in the R.G. Kar case, although the court acknowledged the horror of the crime, it was reluctant. Sanjay Roy, the accused, was sentenced to life imprisonment on the ground that he was not a habitual offender and was found to be capable of reform.

But should the potential for reform override the magnitude of the offence?

The "rarest of the rare" doctrine was not intended to weaken punishment in the face of undeniable enormity; it was intended to prevent arbitrary sentencing. And yet, it appears to be required to justify itself in ways that leave victims' families and society at large wondering: where is the justice?

What happened at R.G. Kar Medical College is not merely a crime; it is a societal failure. If reform is always prioritised over retribution, if procedural doctrines continue to overshadow lived horror, then where do we draw the line? How can a crime as barbaric and diabolical as rape and murder fall short of deserving capital punishment? And perhaps the most heartbreaking question of all: if this is not the "rarest of the rare", then what is?

Click here to read the Judgement.

-Ms. Manasvi Shah
Student, 2nd year

THE BLACK & THE WHITE

A legal chessboard of diverse opinions, which shade of justice are you going to checkmate?

Indian Medical Schemes for Cheaper Healthcare: A Boon or a Bane for Indian Doctors?

India is a country where millions are pushed into poverty due to out-of-pocket medical expenses. Against this backdrop, government initiatives like Ayushman Bharat aim to provide affordable healthcare and serve as a lifeline for these people. However, an essential question still exists: Are these initiatives truly a boon for the country's healthcare ecosystem, or are they a silent bane for the doctors working within it?

The Boon

The main aim of these initiatives has been to provide access to quality healthcare for the bulk of the Indian population. The PM-JAY provides cashless access to healthcare services, thereby significantly alleviating the financial burdens of the beneficiaries. Studies indicate that these schemes translate into greater utilisation of private healthcare service providers by the populace. For doctors and private hospitals, this can potentially results into a new patient base which previously did not exist due to a lack of financial backing provided by the government. Thus, it increases the operational viability of medium and small-scale healthcare units.

The Bane

The most significant challenge is that of financial viability. The reimbursement rates offered under these schemes have often been criticised as being too low, often being only 30-40 % of the market costs. These rates are sometimes even lower, and the revision of rates also does not take place regularly. This results in hospitals and doctors being forced to operate at breakeven rates or, at times, even at a loss. This in turn may reduce the quality and care of the patients being treated under such schemes.

Another significant issue under such schemes is the issue of delayed and rejected claims. Doctors and patients report a harsh reality where payment for services rendered has been delayed for months and at times even for years. A recent RTI report revealed that a staggering Rs. 1.21 lakh crore worth of unpaid claims affects more than 60 lakh cases. This results in a significant cash flow problem for smaller healthcare facilities, which might result in the closure of such small-scale healthcare facilities. India's government healthcare schemes now run online, including hospital registration, treatment approvals and claim settlements. While this digital setup aims to streamline processes, it creates serious challenges for doctors and hospitals in rural and semi-urban areas. Limited internet access and lack of trained staff make it hard to manage these systems. The paperwork is also complex and time-consuming, adding to the burden on the already overburdened administration.

These pressures also take a toll on doctors' mental health. Many face burnout, depression, and, in extreme cases, even suicide, driven by overwork, lack of sleep, and overwhelming expectations from society.

Reconciling the Dichotomy

The majority of economically disadvantaged Indians view these government initiatives as a boon as they gain inexpensive access to quality healthcare. Although they are a boon for these people, the doctors view them as a bane. The low rates and delay in reimbursements leave them burdened financially and the tedious claims process adds an administrative burden on them. Burnout, unethical behaviour, and poor work environment are rampant. Without systemic changes, the disparity between provider hardship and patient benefit raises serious questions about the long-term viability of such initiatives.

To make healthcare schemes more effective, the government must listen to doctors, both before and after policies are made. Reimbursement rates should be updated regularly, and claim processing timelines clearly defined. The paperwork should be simplified to reduce administrative burden. Doctors' well-being must be supported through mental health programs, better work hours, and legal protections against violence. A successful healthcare system must balance public needs with the health and safety of its medical professionals.

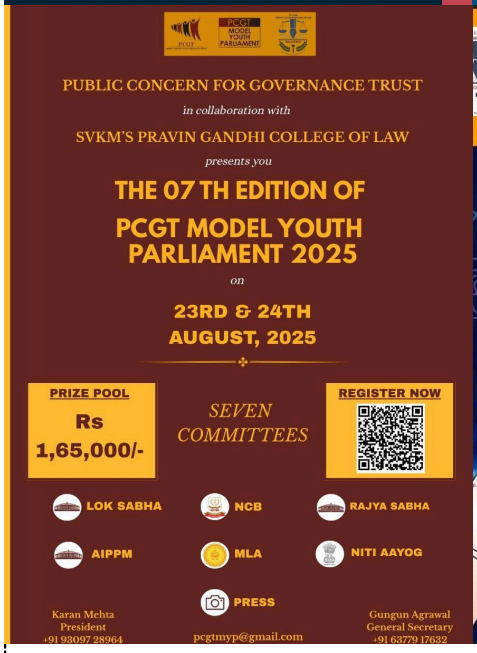
-Mr. Aryan Shah
Student, 4th year

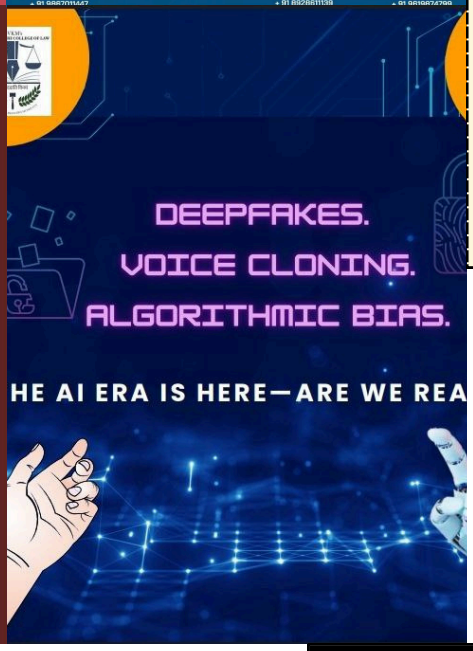
THE CAUSELIST

The Newsletter's schedule for all things high and happening around the world.

June Answer Reveal!

1. Netherlands
2. England & Wales
3. Nepal
4. Argentina
5. Sweden
6. Scotland
7. Brazil
8. India





Experiential Learning Program (ELP)
Batch of 2025-26
Beginning August 1st

AUGUST 2025

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17	18	19	20	21	22	23
24	25	26	27	28	29	30
31				Mid - terms		

THE WIG & THE WIT

Simple and fun puzzles to judge your wit!

Clinical Missteps or Legal Breaches?

Read the case below and write your diagnosis

CASE No. 01

DIAGNOSIS:

FACTS:

A doctor prescribes penicillin without checking the patient's allergy history. The patient develops a rash but recovers.

_____ **VERDICT**

CASE No. 02

DIAGNOSIS:

FACTS:

A private dental clinic refuses to treat a patient after discovering their HIV-positive status, citing "infection risk to staff."

_____ **VERDICT**

CASE No. 03

DIAGNOSIS:

FACTS:

A radiologist misreads a brain CT and misses an early intracranial bleed. The patient is managed conservatively by the physician and deteriorates overnight. The next day, an MRI confirms a bleed.

_____ **VERDICT**

CASE No. 04

DIAGNOSIS:

FACTS:

A psychiatrist discusses a patient's mental health diagnosis with the patient's employer without the patient's written consent, citing workplace safety concerns.

_____ **VERDICT**

Tune in Next Month for the Answer Reveal!

THE POST-ITS

Sticky Notes to tack up some fun legal facts.

India's Robotic Surgery Breaks Continental Barriers

An Indian surgeon successfully performed the world's first intercontinental robotic bariatric surgery, operating from France on a patient in Indore, over 10,000 km away. Using the indigenously developed SSI Mantra robot.

01

China's First Stem Cell Breakthrough Ends Insulin Dependence

For the first time in medical history, a 25-year-old with Type 1 diabetes was cured of insulin dependence using her own stem cells.

02

UK's Lab-Grown Blood Enters Human Trials

Scientists from Bristol and NHS Blood and Transplant conducted the first human transfusion of lab-grown red blood cells, aiming to help people with rare blood types or complex transfusion needs.

03

Until Next Time...

As we close this issue of '*The Briefcase*', we want to thank you for flipping through these pages and joining us on this exciting journey. We hope this edition added a spark of curiosity, a pinch of knowledge, and maybe even a smile to your day.

But don't worry, this is just the seventh chapter. Next month, we'll be back with more legal insights, fresh opinions, exciting games, and surprises to keep you coming back for more. We're just getting started, and there's so much more we can't wait to share with you!

So, until we meet again, stay curious, stay inspired, and keep questioning the world around you. Remember, *The Briefcase* is always here to pack your mind with the essentials. See you in next month's issue—trust us, you won't want to miss it!

With gratitude,
The Editorial Board

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Thank you for reading!

We'd love to hear from you! Share your thoughts, ideas, or suggestions to help us make this newsletter even better. Tell us what you loved or what you'd like to see in our next edition!

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