NCML NATIONAL CONVENTION ON MEDICINE & LAW

Institute of Medicine & Law
Value Driven. Evidence Based.

WHITE PAPER

'Privileging' In Medical Practice - Need For Quick Action

8th NATIONAL CONVENTION ON MEDICINE & LAW 2023

Sunday, 17th December 2023

White Paper on

Privileging in Medical Practice – Need for Quick Action

THIS WHITE PAPER documents the deliberations and recommendations of the 8th National Convention on Medicine & Law 2023, organized by the Institute of Medicine & Law on 17th December 2023. This document is intended for Indian policymakers, regulators, statutory authorities, and Members of Parliament. It identifies and discusses the legal, social, and systemic issues arising from the lack of regulation in clinical privileging and proposes practical, legally appropriate, and India-specific solutions.

Privileging in Medical Practice – Need for Quick Action

CHAIRPERSON:

Dr. Shivkumar Utture
Member: National Medical Commission

MODERATOR:

Dr. Parag Rindani
CEO: Maharashtra - Wockhardt Hospitals Ltd

SPEAKERS:

Justice Ajay Kumar Mittal
Former Chief Justice: Meghalaya and Madhya Pradesh High Courts (2019-2020)

Prof. (Dr.) Anil Kumar Chillimuntha
Chief Operating Officer: AWR 360 Health, USA

Dr. B C Gupta
Member: National Consumer Disputes Redressal Commission (2013-2018)

Dr. Dhvani Mehta
Co-Founder: Vidhi Centre for Legal Policy

Dr. Gurbir Singh
Professor Emeritus: Chitkara University

Dr. Hemant Dhusia
Dean (Academics) & Professor Emeritus of Dentistry: LT Medical College

Mr. K M Arya
Deputy Legal Advisor: Department of Legal Affairs, Ministry of Law & Justice

Prof. M Mariappan
Professor: Centre for Hospital Management - Tata Institute of Social Sciences (TISS)

Adv. Mahendrakumar Bajpai
Advocate: Supreme Court of India
Hon. Director: Institute of Medicine & Law

Justice Manmohan Sarin
Chief Justice: Jammu & Kashmir High Court (2008)

Adv. Mayank Kshirsagar
Advocate-on-record: Supreme Court

Dr. Ratna Devi
CEO & Co-founder: Daksham Health and Education

Justice Ravi Tripathi
Chairman: Gujarat State Human Rights Commission

Dr. Suvin Shetty
Vice-Chair, Quality Health Professionals & Member, Governing Committee: Consortium of Accredited Healthcare Organizations (CAHO)

Ms. Vashuda Khanna
Senior Consultant (Legal): National Health Systems Resource Centre

Dr. Vijay Agrawal
President: Consortium of Accredited Healthcare Organizations (CAHO)

TABLE OF CONTENTS

1. Executive Summary & Problem Statement

1.1. Scope & Purpose

The Indian healthcare ecosystem is undergoing a structural transition marked by rapid technological advancement, increasing specialization and super-specialization, and a rising burden of medical litigation. At this critical juncture, the 8th National Convention on Medicine & Law 2023 convened a collaborative, non-adversarial forum comprising jurists, doctors, administrative pioneers, and patient safety advocates. The objective was to identify a critical systemic vulnerability in current healthcare governance: the absence of a standardized, comprehensive, statutory national guideline for "Privileging" in medical practice. The deliberations provided a comprehensive, 360-degree view of this conundrum.

The Indian healthcare regulatory paradigm stands on an obsolete, fragile framework known as "Credentialing", the static single-instance verification of medical degrees upon entry into the profession. As medical science advances into hyper-specialization, the absence of a dynamic, site-specific system for granting "Clinical Privileges" has induced severe systemic crises.

The regulatory hypocrisy is stark: while highly trained allopathic doctors are restricted from utilizing their cross-specialty skills, government policies explicitly allow AYUSH (non-MBBS) practitioners to practice modern medicine "to the extent of their training" to address rural doctor shortages. Similarly, under the PCPNDT Act, an MBBS graduate with a mere six-month training course is permitted to perform ultrasounds, yet a fully trained gynaecologist performing a pelvic sonography may face legal scrutiny if challenged.

Furthermore, "turf wars" between specialties are rampant. Dental and medical fields frequently clash over overlapping procedures. Dental professionals point out that freshly graduated dentists often illegally advertise themselves as implantologists, while oral and maxillofacial surgeons are increasingly encroaching into medical domains by performing hair transplants and oncology surgeries. Without regulatory boundaries, these inter-specialty conflicts ultimately compromise patient safety.

This regulatory vacuum has precipitated an urgent crisis. The National Medical Commission (NMC) has yet to give due importance to the nuanced aspect of medical privileging, leading to a scenario where courts and consumer forums are forced to take inconsistent views on medical negligence cases based on qualifications. The National Consumer Disputes Redressal Commission (NCDRC) has recently been compelled to direct the regulator to formulate guidelines on this very aspect.

Medical errors and incidents of negligence have raised concerns about patient safety and the quality of care. In this context, medical privileging emerges as a critical mechanism to ensure that only qualified and competent practitioners are authorized to perform specific clinical services, thereby enhancing patient safety and care quality.

This White Paper translates the Convention’s expert deliberations into a formal policy roadmap. The central question raised and addressed is: How can India design and implement a flexible, tiered, and institution-specific privileging framework that protects patient safety, empowers competent doctors, curbs medical malfeasance, and withstands legal scrutiny, without collapsing the fragile healthcare infrastructure of rural Bharat? It addresses the regulatory gap between an individual’s static academic qualifications ("Credentialing") and their dynamic, verified

clinical competence to perform specific high-risk procedures ("Privileging"). Designed explicitly for lawmakers, regulators, and members of statutory bodies, this document establishes the urgent need for structural, stratified legal interventions to protect patients, safeguard doctors, and ensure systemic resilience in India's healthcare system.

1.2. Credentialing vs. Privileging

A foundational confusion persists across regulators, including the National Medical Commission (NMC) and State Medical Councils (SMCs), the judiciary, and even within the medical fraternity itself regarding the definitions of credentialing and privileging. These terms are best described as:

- **Credentialing**

  The administrative process of verifying a doctor's core qualifications, legal licensure, and educational background. This is a static assessment, typically conducted at the point of entry into the profession, when a doctor registers their MBBS, MD, MS, DM, or MCh degrees with a statutory authority such as the State Medical Council.

- **Privileging**

  The formal authority granted to a doctor to perform specific clinical skills, interventions, and procedures within a defined institutional setting, commensurate with their current training, documented experience, and demonstrated competence. This authority requires continuous re-evaluation.

The current regulatory landscape assumes that core credentials automatically guarantee clinical competence across all sub-specialised domains within a broad discipline. Unfortunately, this structural oversight overlooks the reality of modern medicine, where specialised techniques such as advanced endoscopy, interventional cardiology, robotics, and targeted oncology require distinct, continuously validated skill sets.

1.3. The Policy Gap

The National Medical Commission Act 2019 and the current regulatory framework, the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, do not contain explicit provisions that define or regulate clinical privileging. While Sections 1.4.2 and 7.20 of the 2002 Regulations require that a physician shall not claim to be a specialist unless they possess "special qualifications" in that branch, the term "qualification" has historically been interpreted as a university degree or diploma recognized in the statutory schedules.

1.4. Consequences & Urgency

The absence of a statutory privileging framework is causing severe problems across the three core pillars of the healthcare system.

1.4.1. Inconsistent & Conflicting Judicial Pronouncements

In the absence of clear regulatory guidelines from the NMC, courts have issued conflicting rulings. Consumer forums, High Courts, and even regulators have taken opposing views on whether a broad-speciality physician, such as an MD in General Medicine, can perform super-speciality procedures, such as interventional cardiology or advanced dialysis management. This legal inconsistency leaves the medical profession in a state of constant anxiety, unable to determine what is legally permitted in daily practice.

1.4.2. Rise of Defensive Medicine

To mitigate the risk of litigation in an unpredictable legal environment, doctors increasingly practise defensive medicine. This shift manifests in two ways: over-investigation and outright refusal to serve. Doctors order non-essential, expensive diagnostic tests, such as mandatory CT scans or MRIs for straightforward clinical presentations, solely to create an unassailable paper trail for potential court scrutiny. Furthermore, high-risk patients, particularly in critical care or oncology, face delays or

treatment refusals because doctors fear that an adverse outcome will lead to legal proceedings for practising outside their speciality.

1.4.3. "India vs. Bharat" – The Dichotomy

India's healthcare infrastructure is highly fragmented. Urban centres boast advanced tertiary corporate hospital chains, while rural districts rely on an under-resourced network of Primary Health Centres (PHCs) and Community Health Centres (CHCs). The national doctor-to-population ratio is approximately 0.89 per 1,000 citizens, well below the optimum of one.

If a rigid, uniform, Western-style privileging model is mandated across the entire country, it will instantly paralyze rural healthcare delivery. In many rural areas, broad-speciality surgeons routinely perform emergency obstetric procedures, and general MBBS doctors manage complex intensive care presentations out of absolute necessity. A blind, unstratified application of strict privileging rules would halt these lifesaving interventions, exacerbating the rural-urban divide and denying millions of citizens basic access to emergency medical care.

2. Ground Reality: Perspectives from Stakeholders

An effective policy framework balances the competing yet legitimate interests of all key stakeholders. These interests can be grouped into four distinct categories, and their viewpoints are as follows:

2.1. Doctors & Healthcare Professionals

An overly micromanaged, bureaucratic privileging process undermines clinical autonomy and demotivates the medical workforce. Privileges should ideally be based on actual clinical outcomes, peer validation, and logbook entries. The operational friction caused by the progressive fragmentation of medical practice into narrow specializations, together with rigid institutional and judicial boundaries, has therefore created numerous problems. Two of them need to be mentioned specifically.

2.1.1. Speciality Silos

The continuous emergence of highly specific super-specialities risks reducing medicine to inefficient silos. Clinical realities require frequent overlap. For example, in maxillofacial surgery, surgeons routinely work across head and neck oncology, cleft palate repairs, and aesthetic facial procedures such as hair transplantation. Under a rigid qualification-based model, these overlaps trigger turf wars between competing professional associations, leading to disciplinary action by State Medical Councils despite the doctor's extensive training and successful clinical track record.

2.1.2. Retroactive Disqualification

Senior doctors who entered practice before the introduction of modern MCh or DM degrees face a significant challenge. For decades, general surgeons (MS) and general physicians (MD) developed specialised competencies in urology, plastic surgery, or gastroenterology, laying the foundation for these specialities in India. The introduction of new statutory degrees risks retroactively disqualifying these highly

experienced doctors. This dynamic is evident in academic medicine, where senior general surgeons are permitted to teach and examine MCh colorectal students for a transitional period of ten years, yet are theoretically barred from performing those same surgeries in private institutional settings once a dedicated MCh graduate enters the market.

2.2. Law & Judiciary

The legal and judicial community approaches privileging through the lenses of constitutional rights, liability assessment, and statutory compliance.

2.2.1. Constitutional Parameters - Discrimination & Right to Life

Any statutory framework for privileging must satisfy the constitutional requirements of Article 14, namely equality before the law. The State is constitutionally prohibited from arbitrary discrimination and is also mandated to practise positive discrimination, permitting reasonable classification based on an ‘Intelligible Differentia’ that bears a rational nexus to the objective. Law must differentiate between dissimilar situations to ensure justice.

Applying this to privileging, the legal system must recognize that a corporate tertiary hospital in a metropolitan city and a 50-bed facility in a remote district are fundamentally different environments. Therefore, a legally sound privileging framework must allow for differentiated standards, permitting broader clinical privileges in resource-scarce zones to preserve the right to life under Article 21, while enforcing strict standards in urban corporate centres where specialists, super-specialists, and super-super-specialists are readily available.

2.2.2. Hurdles in Medical Negligence Adjudication

From a judicial perspective, judges face significant difficulties in resolving medical negligence claims related to this issue without clear guidelines from statutory or regulatory authorities. When an adverse

event occurs, courts must determine whether the treating doctor possessed the requisite skill and exercised a reasonable standard of care. Currently, when a doctor presents a core qualification degree along with certificates of short-term residency or fellowship training, the courts have no statutory or regulatory benchmark to assess the legitimacy of those advanced skills.

Consequently, courts have issued inconsistent rulings, sometimes conflating the absence of a formal super-speciality degree with actionable medical negligence. A structured, statutorily validated privileging framework would therefore serve as a vital objective guide for the judiciary in litigation.

2.3. Patient Safety Advocates & Civil Society

Patient safety advocates approach the issue through the lenses of patient trust, transparency, and safety.

2.3.1. Information Asymmetry

A strong healthcare system should be built on doctor-patient trust, which, unfortunately, is depleting very fast. A deep information asymmetry exists between healthcare providers and patients.

A patient entering a clinical facility faces a confusing array of acronyms, fellowships, and international society memberships displayed on a doctor's letterhead. There is no accessible way to verify whether these titles reflect genuine competence or merely short-term attendance certificates.

2.3.2. Self-Proclaimed Specialization

This problem is further compounded by the rise of self-proclaimed specialists, such as general MBBS graduates or dentists who complete weekend certificate courses and market themselves as diabetologists, endocrinologists, or advanced trichologists. This unregulated commercial landscape puts patients at serious risk of substandard care,

with hidden malpractice exposed only when an adverse event causes severe injury or death.

2.3.3. The Right to Informed Choice

A clear, publicly verifiable repository of clinical privileges is a fundamental right of patients. Patients should be empowered to make an informed choice of their treating physician, moving away from the current opaque system in which hospitals assign doctors based on internal criteria that may not align with patients' specific needs or preferences.

2.4. Industry Leaders & Hospital Administrators

Hospital CEOs and healthcare administrators regard privileging as an operational requirement tied to quality assurance, institutional liability, and economic viability.

2.4.1. Institutional Risk & Accreditation Compliance

For major hospitals, credentialing and privileging are already established as core components of risk management, largely driven by voluntary quality standards such as those of the National Accreditation Board for Hospitals & Healthcare Providers (NABH). Administrators use internal Credentialing and Privileging Committees to assess a doctor's competence before granting access to operating theatres or interventional suites. However, in India, this process is largely informal and restricted to the bigger hospitals.

However, industry leaders emphasise that these practices lack statutory backing. If a hospital restricts a consultant's privileges based on quality data, it faces internal pushback because there are no clear national guidelines. Conversely, if an accredited hospital grants privileges to an experienced broad-speciality surgeon without a formal super-speciality degree, the institution risks liability if legal proceedings are initiated.

2.4.2. State-sponsored Schemes (PM-JAY & ABDM)

A significant policy fallacy is evident in the structural barriers within State-sponsored healthcare schemes such as the Pradhan Mantri Jan Arogya Yojana (PM-JAY) and the Ayushman Bharat Digital Mission (ABDM). Under current PM-JAY guidelines, financial reimbursement for specialized packages, such as complex oncology or cardiac interventions, is strictly limited to institutions where the operating doctor holds a formal, scheduled super-speciality degree.

This creates a severe operational barrier in tier-2 and tier-3 towns. Even if a local hospital has the necessary physical infrastructure and an experienced general surgeon fully competent to perform the procedure, the facility cannot access government funding because the surgeon lacks the specific scheduled credential. This financial restriction forces vulnerable rural patients to travel long distances to metropolitan centres, driving up costs and placing an undue burden on public resources.

3. Evidence, Data, & Precedents

A policy framework is legally robust and practical when grounded in discussions and analyses of existing judicial precedents, statutory and regulatory gaps, and comparative international frameworks.

3.1. Evolution of Jurisprudence in India

The Indian judiciary has consistently relied on established common law principles to determine liability in medical malpractice cases. However, recent trends indicate an urgent need for regulatory clarity.

3.1.1. Bolams Test - Standard of Reasonably Competent Care

The baseline standard for evaluating medical negligence across India remains the classic Bolam Test, originating from the British Queen's Bench ruling in Bolam v. Friern Hospital Management Committee (1957). The judgment established that a doctor is not negligent if they act in accordance with a practice accepted as proper by a responsible body of medical professionals skilled in that particular art. The law does not require a doctor to possess the highest possible expert skill; it is legally sufficient if they exercise the ordinary skill of a competent doctor in that specific art.

3.1.2. Supreme Court’s Shift Toward Skills

The Hon’ble Supreme Court has steadily shifted from evaluating purely formal university degrees to focusing on documented clinical skills and peer-accepted practices, although this is not explicitly pronounced. In its recent decision delivered on October 19, 2023, [M.A. Biviji v. Sunita & Ors - (2024) 2 SCC 242], the Supreme Court reiterated that a higher threshold of proof is required to hold a doctor liable for negligence. It emphasised that doctors should be evaluated against the standard of a reasonably competent doctor in that field, taking into account the surrounding circumstances and available infrastructure.

Furthermore, the National Consumer Disputes Redressal Commission (NCDRC), which currently handles nearly all medical negligence cases in India, has explicitly and repeatedly directed central regulatory bodies to formulate clear, objective guidelines on clinical privileging to address the ongoing wave of litigation arising from cross-speciality disputes.

3.2. Key Case Studies – Ground Realities

The Convention discussed and analysed several real-life cases illustrating the negative impact of the current regulatory vacuum. Two of them need to be discussed to understand the true nature and enormity of the problem.

3.2.1. The Madhya Pradesh Obstetric Emergency Case

A powerful example came from a case heard before the NCDRC, involving an Ayurvedic doctor (BAMS) posted in a remote rural district of Madhya Pradesh. The doctor performed an emergency Caesarean section on a patient in critical condition, which led to a medical negligence claim arising from surgical complications.

When questioned by the court about his authority to perform a major surgical procedure outside his registered system of medicine, the doctor offered a compelling defence - no other doctor was available within a 20-kilometre radius, and the patient arrived in a life-threatening condition. Had he refused to act, the patient would have died, and he would have been accused of abandonment.

This real-life case underscores the need for area-specific, context-sensitive privileging. A strict, unyielding law that fails to account for realities, especially in remote areas, will ultimately harm patient survival.

3.2.2. The 1979 Obstetric Delay Case

In contrast, a historical mishap in England, [Rajan v. General Medical Council (1980) 1All ER 450], demonstrated how a lack of formal

privileging can harm patients in urban settings. A prominent gynaecologist built a large practice and an "aura of competence" in obstetric care yet lacked experience and confidence in performing a caesarean section. Faced with a patient exhibiting clear signs of post-maturity and severe foetal distress, the doctor delayed performing a necessary C-section out of surgical hesitation, attempting to prolong normal labour until the foetus died in utero.

This case highlights that a formal, institutional privileging process is essential to ensure that a doctor’s actual surgical capabilities align with their public claims, preventing individuals from operating beyond their true competence.

3.3. De Facto Exceptions

Various state governments and even certain central laws in India already recognize the impracticality of an unyielding, qualification-only model. They have quietly implemented pragmatic exceptions that parallel the concept of privileging.

3.3.1. PCPNDT Act

Under the central law, the Pre-Conception & Pre-Natal Diagnostic Techniques Act 1994, a general MBBS graduate who completes a certified, documented six-month training program in ultrasound imaging is legally authorized and privileged to operate a diagnostic sonography centre, a domain otherwise restricted to post-graduate radiologist specialists.

3.3.2. Dialysis Centre Protocols

Due to a severe national shortage of super-specialized nephrologists, guidelines issued by statutory authorities routinely authorize and privilege MDs in General Medicine who complete one year of dedicated training to independently manage advanced haemodialysis units.

3.3.3. NMC's Exceptions

Under the National Medical Commission's own framework, when a new super-speciality qualification is officially launched (such as the MCh in Colorectal Surgery), existing post-graduates (MS General Surgery) with a documented track record of specialized training are formally empowered to perform these surgeries and act as teachers and examiners for a transitional ten-year period.

3.3.4. State Council's Proactive Interventions

The Maharashtra Medical Council has previously issued specific, documented certificates of privilege to senior doctors lacking formal super-speciality degrees, explicitly authorizing them to perform advanced oncology or cardiothoracic procedures after validating their institutional logbooks and long-standing clinical success.

3.4. International Frameworks vs. Indian Realities

In Western countries (such as the United States under the Joint Commission Standards or the United Kingdom under the NHS Guidelines), clinical privileging is managed at the institutional level. Hospitals are independently empowered to grant, modify, or revoke a doctor's clinical privileges based on continuous data tracking, including morbidity rates, surgical logbooks, and peer-review systems.

However, in India, the Supreme Court in Samira Kohli v. Dr. Prabha Manchanda [(2008) 2SCC 1] has explicitly warned against the blind, uncritical importation of Western systems. The institutional model assumes several prerequisites that are completely absent in the Indian context:

- **Balanced Doctor-to-Population Ratio**
  Western nations average 3 to 6 doctors per 1,000 citizens, whereas India operates at a fraction of that capacity. In rural areas, the ratio is even lower.
- **Centralized Data Ecosystem**

India lacks a unified national registry of medical doctors. If such a system were functional, it could track clinical outcomes or verified procedural logs in real time.

- **Homogeneous Infrastructure**
  Unlike the standardized environment of Western hospitals, Indian healthcare ranges from advanced, five-star urban corporate facilities to rural public health centres that lack reliable electricity supply or basic diagnostic equipment.

It can therefore be safely stated that India requires a unique, stratified approach to privileging that upholds high standards in advanced facilities without compromising vital medical access for underprivileged populations.

4. Actionable Policy Recommendations

To address the regulatory vacuum and build a safer, more equitable healthcare system, lawmakers and regulators should adopt a comprehensive, phased, and multi-layered policy framework for healthcare privileging.

4.1. Statutory Framework under NMC Act

The scope of the National Medical Commission Act 2019 must be widened to formally recognise and integrate clinical privileging as a core pillar of governance.

4.1.1. Bifurcation of Clinical Scope

The proposed framework must explicitly delineate a doctor's scope of practice into Core and Non-Core Privileges:

- **Core Privileges**
  Automatically align with a doctor's registered academic credentials and postgraduate degrees. For example, a general MS in Surgery possesses core privileges for basic appendectomies, hernia repairs, and open trauma management.
- **Non-Core Privileges**
  Covers advanced, specialised, or interventional procedures requiring independent, documented validation, such as the use of advanced surgical lasers, deep cryoablation, or interventional endovascular stenting. It should include provisions for validating institutional training and peer-reviewed logs.

4.1.2. Formal Recognition of Certified Training Pathways

The NMC must establish an administrative pathway to recognize institutional fellowships and structured training programs from accredited non-scheduled entities (such as college fellowships or corporate hospital programs). Doctors who complete these documented, peer-reviewed programs must be permitted to apply for specific

secondary clinical privileges, ensuring they are legally protected without needing a formal, university-issued DM or MCh degree.

4.2. Two-Tier Governance Model – "India vs. Bharat"

To account for regional and infrastructure differences, regulators must adopt a stratified approach to enforcing clinical privileges.

Tier / Healthcare Environment	Mandatory Staffing & Specialization Requirements	Permissible Clinical Privilege Flexibility
Tier 1: **Urban Corporate & Tertiary Care Settings** *(Institutions claiming advanced, comprehensive specialty care)*	**Strict Enforcement:** All specialized and super-specialized interventions must be performed exclusively by credentialed, specifically privileged doctors.	**Zero Flexibility:** Institutions face vicarious liability and financial penalties if an adverse event occurs during a specialized procedure performed by an unprivileged doctor.
Tier 2: **Rural, Semi-Urban, & Emergency Public Health Settings** *(PHCs, CHCs, and tier-3 facilities with limited specialist access)*	**Pragmatic Flexibility:** Broad-specialty general doctors and surgeons are authorized to perform vital, cross-specialty interventions.	**Full Safe Harbor Protection:** Doctors acting in good faith during an emergency or in resource-scarce zones are legally protected from charges of practicing without a specialty credential or privilege.

4.3. Mandatory Institutional Standardization

Every healthcare facility in India with a capacity of 50 beds or more must be mandated to establish a formal, internal administrative structure to govern medical practice standards:

4.3.1. Credentialing & Privileging Committee (CPC)

Hospitals must be directed to establish an internal, multi-disciplinary CPC. This committee must be legally responsible for granting and reviewing all consultant onboarding requests, verifying primary educational sources, logbooks, and formally issuing site-specific, time-bound sheets of clinical privilege.

Privileges should be site-specific, ensuring that a doctor is granted privileges only for procedures that the facility has the infrastructure and support staff to handle safely.

4.3.2. Standardized Evaluation Cycles

Hospitals must adopt two clinical evaluation frameworks modelled on international quality standards and tailored to local workflows:

- **Focused Professional Practice Evaluation (FPPE)**
  Applies to all newly onboarded doctors and existing consultants seeking new clinical privileges. The CPC will implement a time-bound period of direct peer monitoring or logbook audits to verify competency before granting full autonomy.
- **Ongoing Professional Practice Evaluation (OPPE)**
  A mandatory, recurring review cycle capped at two years. Privileges cannot be renewed automatically; doctors must provide documented proof of current competence, active procedural volumes, and acceptable patient outcome data.

This mandate should be introduced at a later stage, a few years after the establishment and successful implementation of CPC.

4.3.3. Mandatory Digitalized Logbooks

Regulators must mandate that all clinical doctors maintain standardized, digital logbooks. These records must document every high-risk intervention, diagnostic tap, or surgical procedure performed, and be verified by institutional deans or medical superintendents, serving as primary evidence for privilege renewals or reviews.

4.4. Addressing Information Asymmetry

The Ministry of Health and Family Welfare, in coordination with the National Health Authority (NHA), should leverage the Ayushman Bharat Digital Mission (ABDM) infrastructure to enhance public transparency.

4.4.1. National Registry of Verified Competencies

The government must expand the current Healthcare Professionals Registry (HPR), managed directly by the National Health Authority (NHA) under the Ayushman Bharat Digital Mission (ABDM), into an open, public-facing, searchable database. Every registered doctor’s profile should display not only their basic university degrees but also their active, state-council-validated clinical privileges and institutional listings. This will allow citizens to instantly verify a doctor's scope of practice within a specific radius, reducing information asymmetry and building public trust.

4.4.2. Standardization of Clinical Signatures

Doctors should be strictly prohibited from listing unaccredited fellowships, distant society memberships, or confusing acronyms. These must be standardised to display only NMC-recognised qualifications and state-validated privilege categories. Although the IMC Regulations 2002, the current professional code for doctors practising modern medicine, contain relevant provisions, stricter norms with penalties are needed.

4.5. Involving Professional Bodies - The Bottom-Up Approach

Rather than relying on a top-down, bureaucratic approach controlled by state administrators, the policymaking process should adopt a collaborative, bottom-up model driven by doctors and their professional bodies.

4.5.1. Association-Led Skill Standards

National medical associations such as the Federation of Obstetric and Gynaecological Societies of India (FOGSI) and the Association of Physicians of India (API) must be legally mandated to develop detailed, skill and procedure-specific competency criteria for their respective fields. These documents must specify the exact training hours, quantitative procedural volumes, and logbook milestones required to transition from basic core access to advanced clinical privileges. This ensures that clinical standards are authored by domain experts rather than bureaucratic theorists, allowing regulations to adapt swiftly to advances in medical science and practice.

4.5.2. Codification into National Schedules

Once finalized by these speciality bodies, the NMC should formally codify these matrices into official regulatory schedules. Once these standardized legal baselines are established across specialities, they will serve as objective benchmarks in medical malpractice cases. This will eliminate the current trend of ad hoc and subjective assessments by courts in medical negligence cases.

This bottom-up approach ensures that guidelines remain grounded in clinical reality, providing courts with objective, profession-validated standards to replace subjective judicial interpretations of negligence.

4.6. Out-of-the-box Approach

To prevent the rise of defensive medicine and eliminate harassment of healthcare professionals acting in good faith, the legal system must

establish robust administrative safeguards without compromising accountability and transparency. Two specific recommendations, not directly connected with privileging, must nevertheless be seriously considered by the lawmakers:

- **Establishment of Specialized Medical Tribunals**

Lawmakers should enact legislation to establish dedicated Medical Tribunals, analogous to the Central Administrative Tribunal (CAT) or the Motor Accidents Claims Tribunals (MACT). These specialized forums must have exclusive jurisdiction over all medical malpractice disputes against doctors and hospitals.

- **No-Fault Liability Protections**

The current legal system has limitations that call for reforms worldwide. Some countries have introduced ‘No-Fault Liability Laws / Schemes’, and the results are encouraging. Indian policymakers should explore a phased No-Fault Liability Insurance Framework for ultra-high-risk settings, such as emergency trauma care or advanced neonatology. Under this system, patients who suffer adverse outcomes receive immediate, fixed compensation from a central fund, eliminating the need for lengthy litigation against healthcare providers.

5. Conclusion

The 8th National Convention on Medicine & Law 2023 has made it clear that the era of relying solely on primary medical credentials has passed. As medical science advances into highly specialized domains, the absence of a structured privileging system is a critical vulnerability in India's healthcare architecture. It compromises patient safety, unfairly exposes competent doctors to legal harassment, and creates crippling ambiguity within the judicial system. India must bridge this regulatory gap by empowering institutional committees, mandating continuous competency tracking, creating transparent digital registries, and providing legal safeguards for doctors and hospitals.

A statutory framework for clinical privileging is no longer a theoretical option; it is an urgent requirement that will help preserve the integrity of the Indian healthcare system and ensure its smooth and efficient functioning. It benefits healthcare stakeholders and removes a major obstacle facing the healthcare delivery system nationwide.

- **For Patients**
  It replaces a system of unverified claims of privileges with structural transparency, guaranteeing that any doctor performing a procedure has been independently vetted for competence. This transparent mechanism ensures and enhances patient safety.
- **For Doctors**
  It replaces the fear of unpredictable lawsuits with clear legal safe harbours, providing the professional confidence needed to innovate and make critical, lifesaving decisions without fear of harassment.
- **For the Judiciary**
  It provides reliable, professionally validated standards to resolve complex medical disputes fairly and efficiently.

At the same time, it should be remembered that any rigid, imported system that impedes access to medical care for rural or socio-

economically backward classes should be outrightly rejected. By adopting a stratified, two-tier model that respects the unique operational realities of both ‘India’ and ‘Bharat’, lawmakers can build a healthier, fairer, and more legally empowered nation, safeguarding patient lives while supporting the healthcare providers who serve them. Privileging must be leveraged as a vital safety mechanism that protects both doctors and patients.

Appendix: Jurisprudential & Policy Milestones

To assist policymakers in understanding the historical background of credentialing and privileging regulations in India, the following chronological timeline outlines the key judicial rulings and administrative policy decisions discussed during the Convention:

1957

The Landmark Bolam Ruling (United Kingdom)

The Queen's Bench laid down the foundational Bolam Test (Bolam v. Friern Hospital Management Committee), which governs medical malpractice litigation worldwide today. It holds that a doctor is not guilty of medical negligence if they act in accordance with an accepted practice supported by a responsible body of medical professionals skilled in that speciality. This ruling forms the bedrock of medical malpractice law across common law jurisdictions, including India.

1979

The Obstetric Civil Litigation Case (United Kingdom)

A landmark medical negligence case, Whitehouse v/s Jordan [1980] 1 All ER 650, involving an urban gynaecologist who lacked surgical confidence and delayed a necessary Caesarean section despite clear signs of foetal distress, resulting in an in-utero death. The case highlights the severe lack of institutional oversight, underscoring the need for structured privileging mechanisms from the outset.

2002

Notification of the IMC Code of Medical Ethics

The Medical Council of India (MCI) notifies the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Sections 1.4.2 and 7.20 lay down that registered medical doctors cannot claim to be specialists unless they possess specialized qualifications,

though the regulations remain vague about dynamic, non-degree clinical privileges.

2005

Jacob Mathew Case (Supreme Court)

A three-judge bench of the Supreme Court of India delivered the landmark judgment in Jacob Mathew v. State of Punjab. The Court directed that the police should compulsorily obtain a medical expert's opinion before proceeding against a doctor charged with medical negligence under the IPC.

2008

Samira Kohli Case (Supreme Court)

In Samira Kohli v. Dr. Prabha Manchanda, the Supreme Court issued definitive guidelines on patient consent. Most importantly, in the context of the current discussion, the Court warned against blindly importing Western, American-style medical-legal frameworks, stating that regulatory and liability protocols must be tailored to Indian realities.

2010

Kusum Sharma Case (Supreme Court)

The Supreme Court reinforced doctors' protections in Kusum Sharma v. Batra Hospital. The Court ruled that an adverse medical outcome or an error of judgment does not automatically constitute actionable negligence, provided the treating doctor followed a peer-accepted line of treatment.

2014

MCI Structural Clarification

The Medical Council of India (MCI) issued a formal administrative clarification that had the greatest impact on clinical privileging. It did not debar a doctor from working in a specialized field if they possess "proper documented certified adequate training exposure in an institution

recognized by the MCI, thereby gaining competency and experience." In practice, it stripped all structural legitimacy from non-MCI-recognized diplomas. Hospitals were forced to revoke specialized privileges from general doctors relying on these certificates. If a hospital grants "cross-privileges", both the doctor and hospital management face severe legal liability. Clinical privileging became dependent only on the State or National Medical Councils.

2019

The National Medical Commission (NMC) Act 2019

The Parliament of India passes the National Medical Commission Act, 2019, dissolving the old MCI and establishing a new central regulatory framework. However, the new Act leaves a significant policy gap by failing to establish a formal mechanism for defining, auditing, or granting clinical privileges.

2023

Dr. Usha Mukhi Case (National Consumer Commission)

The National Consumer Disputes Redressal Commission (NCDRC) formally directs medical regulators to issue clear guidelines on clinical privileging.

NMC Code of Ethics (in abeyance)

NMC introduces the Registered Medical Doctor (Professional Conduct) Regulations, 2023, but places them in abeyance following professional pushback against rigid speciality restrictions.

M. A. Biviji Case (Supreme Court)

The Hon’ble Supreme Court emphasises that doctors should be evaluated against the standard of a reasonably competent doctor in that field, taking into account the surrounding circumstances and available infrastructure. This case highlights the urgent need for a structured national policy.

NCML

NATIONAL CONVENTION ON

MEDICINE & LAW

Institute of Medicine & Law

Institute of Medicine & Law

Value Driven. Evidence Based.