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Reimagining Patient Rights in a Digital and Divided World: A Multidimensional Legal Inquiry

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ABSTRACT

The protection of patient dignity and autonomy forms the cornerstone of a just healthcare system. In India, the recognition of patients' rights has evolved from moral discourse to a constitutional and legal imperative. This paper presents a multidimensional study of patients' rights through four core dimensions: ethical foundations, technological transformation, social equity, and legal enforcement. The first dimension traces the journey from compassion to codification, examining how moral and philosophical ideals rooted in Kantian respect for persons and bioethical principles of consent, beneficence, and non-maleficence—have shaped the jurisprudential understanding of patient dignity under Articles 14, 19, and 21 of the Indian Constitution. The second explores the emergence of the digital dignity paradigm, analysing how telemedicine, artificial intelligence, and electronic health data systems have redefined privacy, consent, and accountability. It highlights the regulatory challenges posed by digital health innovations in light of the Digital Personal Data Protection Act, 2023 and the GDPR framework. The third dimension addresses intersectional inequalities that continue to obstruct equal realization of patients' rights among women, rural populations, Dalits, persons with disabilities, and LGBTQ+ individuals. It underscores how systemic discrimination erodes both dignity and access to care. The final dimension moves from rights to remedies, proposing enforceable models such as an independent Patient Rights Commission or Healthcare Ombudsman, drawing insights from the UK's NHS Charter and WHO Patients' Rights Framework. Through this integrated analysis, the paper argues that protecting patients' rights requires an ethically grounded, technologically responsive, socially inclusive, and legally enforceable approach, where dignity is not only recognized in law but genuinely realized in practice.

Keywords: *Patients' rights, marginalized communities, Healthcare, Fundamental right, International human rights instruments, and national health policies.*

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I. INTRODUCTION

Healthcare represents far more than the delivery of medical services, it embodies the protection of human dignity, autonomy, and justice. In the Indian context, the discourse surrounding patients' rights has gradually evolved from moral or professional obligations into a legally recognized and constitutionally protected framework. The transformation signifies a shift in understanding health not merely as a medical or charitable concern, but as an inseparable aspect of the right to life and human dignity[3].

Historically, Indian medical practice was guided by a paternalistic ethos, where physicians often made unilateral decisions on behalf of patients, with limited attention to autonomy or informed consent. Over time, the emergence of bioethical principles such as Kantian respect for persons, and the ethical doctrines of consent, beneficence, and non-maleficence has redefined this relationship[4]. The jurisprudence of the Supreme Court under Articles 14, 19, and 21 of the Constitution has further elevated these ethical principles into enforceable rights, embedding patient dignity within the broader fabric of constitutional morality[5].

However, the 21st century has introduced an additional layer of complexity to patient rights—the digitalization of healthcare. With the rise of telemedicine, artificial intelligence–based diagnostics, and electronic health records, medicine now operates within an increasingly technological framework[6]. These advances offer enhanced accessibility and efficiency, yet they simultaneously generate novel legal and ethical challenges. The principles of privacy, informed consent, and accountability are now tested in a digital environment where patient data can be easily shared, monetized, or even manipulated[7]. The newly enacted Digital Personal Data Protection Act, 2023 attempts to address some of these challenges, yet its implementation within

[3] Thiyagarajan, B., & Jesiah, S. (2024). *Patients' awareness of their rights: A cross-sectional study exploring the Indian perspective.* The National Medical Journal of India, 36(3), 187–191. https://doi.org/10.25259/NMJI_234_21

[4] Nandi math, O. V. (2009). *Consent and medical treatment: The legal paradigm in India.* Indian Journal of Urology, 25(3), 343–347. https://doi.org/10.4103/0970-1591.56202

[5] Tyagi, K. (2023). *Upholding patient rights: A comprehensive analysis of the legal framework in India.* Indian Journal of Law, Science & Social Studies, 2(1), 104–117; Pande, B. S., Kulkarni, P. D., Kulkarni, P. C., Kuwar, D. M., & Manda, R. M. (2025). *Assessing patient awareness of rights and healthcare information: A cross-sectional study at JMF's ACPM Medical College Dhule.* International Journal of Community Medicine and Public Health, 12(4), 1719–1725. https://doi.org/10.18203/2394-6040.ijcmph20251719

[6] Jain, D. (2023). *Regulation of digital healthcare in India: Ethical and legal challenges.* Healthcare, 11(6), 911. https://doi.org/10.3390/healthcare11060911

[7] Sharma, C., Sony, R., & Mathew, M. (2021). *Integrated healthcare delivery and telemedicine: Existing legal impediments in India.* Legal Issues in the Digital Age, 3, 98–125. https://doi.org/10.17323/2713-2749.2021.3.98.125 ; Anjankar, A. J., Anjankar, V. P., Anjankar, A., Waghmode, A., & Ninave, S. V. (2024). *Ethical concerns in telemedicine – An Indian perspective.* Journal of Indian Academy of Forensic Medicine, 46(1 Suppl), 22–28. https://doi.org/10.48165/jiafm.2024.46.1(Suppl).22

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healthcare requires closer scrutiny[8]. The notion of "digital dignity" therefore becomes central - preserving patient autonomy and privacy amid technological transformation.

Equally pressing are the persistent inequalities that prevent equitable realization of these rights. Despite legal recognition, patient autonomy remains aspirational for many. Structural inequities—rooted in caste, gender, class, geography, and disability continue to influence how individuals access healthcare and how their rights are respected in practice[9]. Marginalized groups, including women, rural populations, Dalits, persons with disabilities, and LGBTQ+ individuals, often experience diminished agency and limited recourse to justice[10]. These disparities demonstrate that patient rights, when divorced from social realities, risk remaining theoretical ideals rather than tangible entitlements.

Moreover, enforcement remains a persistent challenge. Although hospital charters and ethical codes proclaim patient rights, India lacks a coherent statutory framework or independent oversight mechanism to ensure compliance[11]. Comparative models—such as the United Kingdom's NHS Charter, Singapore's Healthcare Services Act, and the WHO Patients' Rights Framework—illustrate the importance of establishing institutional accountability through patient commissions or healthcare ombudsmen[12]. Such mechanisms can transform recognition into realization by providing grievance redressal, oversight, and transparency.

This paper thus conducts a multidimensional legal inquiry into the concept and implementation of patients' rights in India. It does so through four interlinked dimensions: (1) ethical and jurisprudential foundations that trace the journey from compassion to codification; (2) digital transformation and data governance shaping the contours of "digital dignity"; (3) intersectional inequities that obstruct the uniform realization of rights; and (4) enforcement mechanisms and reforms necessary to make dignity a lived legal reality. Drawing upon constitutional principles, statutory developments, comparative global frameworks, and contemporary scholarship, the paper argues that safeguarding patient rights demands an approach that is ethically grounded, technologically responsive, socially inclusive, and legally enforceable. Only through such

[8] Jose, N. S. (2023). *Legal and ethical aspects of telemedicine in India: Opportunities, challenges, and the road ahead.* Asia Pacific Law & Policy Review, 9, 1–11.
[9] D'Souza, S. E., Qadiri, G. J., & K.C., L. (2023). *Patient rights: A study on patient's knowledge and nurse's practice in a multispecialty teaching hospital.* International Education and Research Journal, 9(3), 453–458.
[10] Singh, S., & Kumar, S. (2025). *Legal autonomy of women in neonatal healthcare decision-making: A critical analysis of Indian laws and international human rights norms.* Journal of Neonatal Surgery, 14(18S), 32–34.
[11] Savitha, K., & Sharmila, M. S. (2025). *Telemedicine and consumer protection: Ensuring patient privacy and safety in a digital healthcare landscape.* Journal of Neonatal Surgery, 14(7), 106–114.
[12] Ramineni, V., Ingole, B. S., Pulipeta, N. K., Pothineni, B., & Gupta, A. (2025). *Advancing digital accessibility in digital pharmacy, healthcare, and wearable devices: Inclusive solutions for enhanced patient engagement.* arXiv. https://arxiv.org/abs/2505.24042

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integration can the Indian healthcare system transition from acknowledging patient dignity in theory to ensuring its realization in every clinical encounter.

II. REVIEW OF LITERATURE

The role of the Governor in India's constitutional framework has long been a subject of intellectual debate and political scrutiny. In his seminal work "The Governor: Constitutional Position and Political Reality," Rajni Goyal (1992) offers a detailed exposition of the Governor's constitutional office as envisioned by the framers of the Indian Constitution[13]. Goyal traces the historical evolution of this position, examining the delicate balance between constitutional theory and political practice. He explores the Governor's powers - both ceremonial and discretionary—and the limitations imposed upon them to prevent misuse. Through a nuanced analysis, the author highlights recurring tensions between the Union and State governments and identifies how the Governor's role often becomes politically contested. Goyal concludes that to preserve the sanctity of this office, Governors must remain detached from active politics and function as neutral constitutional authorities, ensuring that the spirit of federalism and constitutional propriety is maintained.

In the realm of healthcare ethics, R. B. Ghooi and S. R. Deshpande (2012) provide an insightful exploration in their study "Patients' Rights in India: An Ethical Perspective."[14] Their work emphasizes that despite ethical guidelines and regulatory frameworks, patients in India often experience neglect, inadequate communication, and a lack of empathy from healthcare providers. They observe that many patients are denied participation in decisions concerning their own treatment, undermining their autonomy and dignity. By comparing the Medical Council of India's Code of Ethics Regulations with the Consumer Guidance Society of India's Charter of Patients' Rights, the authors expose significant gaps between ethical ideals and clinical reality. Their findings underscore the urgent need for institutional reform to strengthen ethical conduct, patient autonomy, and compassion within the Indian healthcare system.

Complementing this ethical dimension, Divya Trivedi and Prasanna Mithra (2017), in their empirical study "Patients' Awareness about Their Rights: A Study from Coastal South India," explore the level of patient awareness in diverse demographic segments[15]. Their research reveals that awareness of patient rights transcends barriers of gender, education, and socio-

[13] Goyal, R. (1992). *The Governor: Constitutional position and political reality. The Indian Journal of Political Science*, 53(4), 505–523.
[14] Ghooi, R. B., & Deshpande, S. R. (2012). Patients' rights in India: An ethical perspective. *Indian Journal of Medical Ethics*, 9(4), 277–281. https://doi.org/10.20529/IJME.2012.094
[15] Trivedi, D., & Mithra, P. (2017). Patients' awareness about their rights: A study from coastal South India. *Indian Journal of Medical Ethics*, 2(2), 89–94. https://doi.org/10.20529/IJME.2017.026

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economic status, with doctors serving as the primary source of information. However, the study cautions that awareness alone is insufficient unless accompanied by proactive engagement from healthcare providers. The authors advocate for greater patient participation in treatment decisions, adherence to statutory guidelines by physicians, and systematic education programs to empower individuals with knowledge about their rights.

Further advancing the discourse on medical data privacy, Nimisha Srinivas and Arpita Biswas (2012), in "Protecting Patient Information in India: Data Privacy Law and Its Challenges," present a compelling discussion on the ethical and legal vulnerabilities associated with electronic medical data[16]. They note that the digital storage of health records exposes patients to risks of re-identification and unauthorized access, especially in the absence of robust data protection laws. The study identifies the growing influence of third-party stakeholders such as insurance companies and pharmaceutical corporations, which complicates the confidentiality inherent in the doctor–patient relationship. The authors call for stronger legal safeguards and anonymization standards to ensure that technological progress in healthcare does not come at the expense of individual privacy and trust.

Together, these scholarly contributions reveal the multifaceted nature of dignity and rights—whether in the exercise of constitutional authority or the protection of patients in healthcare. They collectively underscore the pressing need for ethical governance, informed consent, and the institutionalization of human dignity as a guiding legal and moral principle.

III. From Compassion to Codification: The Ethical and Jurisprudential Foundations of Patient Dignity

The concept of patient dignity and autonomy did not originate within hospitals or courtrooms - it was born in the moral imagination of philosophers who saw human beings as moral agents, capable of self-determination and deserving of respect. Immanuel Kant's philosophy of moral autonomy remains the cornerstone of this ethical foundation, asserting that every individual must be treated as an "end in themselves" rather than a mere instrument of another's purpose (Subramani, 2017)[17]. This philosophical premise evolved into a normative principle in healthcare ethics, where patient participation, informed decision-making, and respect for bodily integrity became essential markers of ethical medical conduct. Over time, these ideas transcended moral discourse to acquire the status of enforceable rights, shaping the modern

[16] Srinivas, N., & Biswas, A. (2012). Protecting patient information in India: Data privacy law and its challenges. *Journal of Health Informatics in Developing Countries*, 6(2), 234–242.
[17] Subramani, S. (2017). *Patient autonomy within real or valid consent: Samira Kohli's case. Indian Journal of Medical Ethics*, 2(3) NS, 184–189. https://doi.org/10.20529/IJME.2017.038

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legal understanding of healthcare as a matter of justice and human dignity.

Within the Indian constitutional framework, the transformation of these moral ideals into legally protected rights can be traced through the expansive interpretation of Articles 14, 19, and 21 of the Constitution. These rights include the right to informed consent, ensuring that patients are fully aware of medical procedures and associated risks before agreeing to treatment; the right to privacy and confidentiality, protecting personal health information from unauthorized disclosure; the right to timely and appropriate medical care, including emergency treatment; the right to access medical records and relevant health information; and the right to safety and protection from medical negligence. The Supreme Court has consistently held that the right to life under Article 21 includes the right to live with dignity, encompassing physical and mental well-being. This interpretation laid the groundwork for recognising patients' rights as an extension of fundamental rights. Patients are also entitled to actively participate in healthcare decisions, refuse treatment, and seek grievance redressal through institutional mechanisms such as hospital complaint cells or statutory bodies. In *Parmanand Katara v. Union of India (1989)*[18], the Court affirmed that every doctor has a professional obligation to extend medical aid to preserve life, irrespective of procedural formalities—a ruling that humanised medical law by embedding compassion within constitutional jurisprudence (Tyagi, 2023)[19].

Similarly, in Samira Kohli v. Dr. Prabha Manchanda (2008)[20], the Supreme Court elevated the doctrine of informed consent from an ethical guideline to a legal necessity. The Court ruled that "consent given for diagnostic purposes cannot be stretched to cover therapeutic procedures," thereby underscoring the patient's right to decide what happens to their own body (Subramani, 2017). This case exemplifies the shift from physician-centred decision-making to patient-centred care, transforming the moral value of autonomy into a legally enforceable entitlement.

Parallel to judicial evolution, the bioethical framework of modern medicine also reinforced the importance of patient dignity through the principles of beneficence, non-maleficence, justice, and autonomy. Beneficence and non-maleficence focus on promoting the well-being of patients and preventing harm, while autonomy ensures that patients actively participate in healthcare decisions. When these principles intersect with constitutional guarantees, they create a powerful jurisprudential framework that defines healthcare not merely as a service but as a right. According to Hazarika et al. (2025), autonomy, once regarded as a philosophical abstraction, is

[18] Parmanand Katara v. Union of India, 1989 AIR 2039
[19] Tyagi, K. (2023). *Upholding Patient Rights: A Comprehensive Analysis of the Legal Framework in India. Indian Journal of Law, Science & Social Studies*, 2(1), 104–117.
[20] Samira Kohli v. Dr. Prabha Manchanda (2008) 2 SCC 1

now deeply integrated into both ethical and legal discourse in India[21].

However, while the codification of patient rights within legal instruments and judicial pronouncements represents substantial progress, it also raises complex questions about the practical realization of these ideals. Indian healthcare continues to grapple with structural inequalities, insufficient patient awareness, and the persistence of paternalistic medical culture. Many patients, especially those from rural or marginalized backgrounds, remain unaware of their rights to consent, privacy, and fair treatment. As Prakash and Anand (2024) observe, the imbalance of knowledge and authority between doctors and patients continues to undermine true autonomy within medical encounters[22].

The ongoing challenge, therefore, is to bridge the gap between legal recognition and practical realization. Protecting patient dignity is not a symbolic act but a continuous process of reinterpreting moral obligations in light of changing social and technological contexts. The evolution from compassion to codification is a testament to how humanistic values, once confined to philosophy and ethics have been constitutionalized to anchor healthcare in the realm of justice and rights. Yet, this journey remains incomplete unless the principles of autonomy and dignity are effectively translated into everyday medical practice.

As healthcare enters the digital era, where patient data, artificial intelligence, and telemedicine redefine the very nature of consent and privacy, these foundational ideals must evolve further. The next section explores how technology challenges and reconfigures the very notion of dignity, ushering in what may be called the "digital dignity paradigm".

IV. THE DIGITAL DIGNITY PARADIGM: RECONSTRUCTING PATIENTS' RIGHTS IN THE AGE OF TECHNOLOGY

The Rise of Digital Healthcare and Patient Autonomy

The healthcare ecosystem in India is undergoing a profound digital transformation, propelled by innovations such as telemedicine, artificial intelligence (AI)-based diagnostics, electronic health records (EHRs), and mobile health platforms. This technological shift promises efficiency, accessibility, and personalization; however, it also introduces complex ethical and legal dilemmas concerning privacy, informed consent, and accountability[23]. Patients who once

[21] Hazarika, S., Singh, P., & Dutta, R. (2025). *Autonomy as a patient's right: Ethical and legal perspectives in Indian healthcare. Indian Journal of Medical Ethics.* https://doi.org/10.1055/s-0045-1806869

[22] Prakash, K., & Anand, A. (2024). *Socio-legal dimensions of informed consent in Indian healthcare. International Journal of Advanced Research in Science, Communication and Technology*, 4(3), 215–228.

[23] Jain, D. (2023). *Regulation of digital healthcare in India: Ethical and legal challenges. Healthcare, 11*(6), 911. https://doi.org/10.3390/healthcare11060911

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physically interacted with doctors now interface with algorithms and digital platforms, where consent may be buried under lengthy terms or obtained through implicit digital checkboxes.

At its core, the notion of "digital dignity" extends the traditional idea of patient autonomy to the virtual sphere—where respect for a person's informational self becomes integral to human dignity[24]. Scholars emphasize that as India moves toward a National Digital Health Mission, consent cannot merely be procedural but must be meaningful, informed, and revocable[25]. Hence, the challenge is to ensure that technology does not depersonalize care but reinforces the ethical foundations of autonomy, beneficence, and non-maleficence.

Legal Landscape: From Data Protection to Digital Consent

The Digital Personal Data Protection Act, 2023 (DPDPA) marks a turning point in India's approach to protecting patient data. The Act recognizes personal health information as "sensitive data" and mandates explicit consent for processing and sharing[26]. However, scholars argue that the DPDPA's broad exemptions for "government processing" and lack of sector-specific oversight could undermine confidentiality in healthcare[27]. Comparative frameworks like the EU's General Data Protection Regulation (GDPR) and Singapore's Healthcare Services Act, 2020 offer stronger models, emphasizing data minimization, purpose limitation, and the right to be forgotten—principles that Indian law has yet to fully internalize[28].

Telemedicine guidelines issued by the Medical Council of India (MCI) and National Medical Commission (NMC) in 2020 provided a baseline for digital consultations, yet concerns persist regarding authentication of patients, cross-border data transfers, and doctor liability[29]. Inadequate encryption and absence of centralized cybersecurity standards continue to expose patients' digital records to unauthorized access[30]. These challenges demand a comprehensive health-specific data protection framework embedded within patient-rights law itself, rather than

[24] Aneja, J., & Arora, S. (2021). *Telemedicine and ethics: Opportunities in India. Indian Journal of Medical Ethics, 6*(4). https://doi.org/10.20529/IJME.2021.042

[25] Sharma, C., Sony, R., & Mathew, M. (2021). *Integrated healthcare delivery and telemedicine: Existing legal impediments in India. Legal Issues in the Digital Age, 3*, 98-125. https://doi.org/10.17323/2713-2749.2021.3.98.125

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[27] Narayan, A., et al. (2024). *India's evolving digital health strategy. npj Digital Medicine, 7*, Article 12. https://doi.org/10.1038/s41746-024-01279-2

[28] Rajkumar, E., Gopi, A., Joshi, A., et al. (2023). *Applications, benefits and challenges of telehealth in India. BMC Health Services Research, 23*, 7. https://doi.org/10.1186/s12913-022-08970-8

[29] Kowshik, S. C., & Beerannavar, C. R. (2024). *Confidentiality issues in Indian healthcare data management. Journal of Legal Studies & Research, 10*(2), 45-70.

[30] Chandra, R., et al. (2024). *An analysis of predictors and wealth-based inequality in digital health readiness in India. BMC Digital Health, 2*, Article 47. https://doi.org/10.1186/s44247-024-00090-z

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treated as an ancillary privacy issue.

Algorithmic Bias and the Ethics of AI in Healthcare

The integration of artificial intelligence into diagnostics, predictive analytics, and triage systems has revolutionized healthcare decision-making but simultaneously introduced concerns of algorithmic bias and opaque accountability[31]. AI tools often rely on datasets that underrepresent women, rural populations, or marginalized communities, resulting in skewed outcomes that perpetuate healthcare inequity[32]. Scholars caution that algorithmic opacity - the "black box" problem obscures the basis of medical decisions, weakening informed consent and doctor-patient trust[33].

In India, where digital literacy remains uneven, these biases risk deepening existing inequalities in healthcare access[34]. Ethical frameworks such as Explainable AI (XAI) and fairness auditing are being developed to counter these biases, but legal recognition of algorithmic accountability is still in its infancy[35]. Integrating these concepts into Indian medical jurisprudence would reinforce "digital dignity," ensuring that technology serves, rather than subverts, patient autonomy.

The Digital Divide: Socio-Economic Disparities in Access

While the urban elite increasingly benefit from AI-driven diagnostics and teleconsultations, millions in rural India remain digitally excluded due to inadequate connectivity, device affordability, and literacy gaps[36]. The BMC Digital Health study (2024) found substantial wealth-based inequality in digital health readiness across Indian states[37]. Without targeted interventions, digitization risks reinforcing healthcare hierarchies rather than dismantling them[38].

Bridging this divide requires not only infrastructure but legal imagination - recognizing digital

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[31] Sambasivan, N., Arnesen, E., Hutchinson, B., Doshi, T., & Prabhakaran, V. (2021). *Re-imagining algorithmic fairness in India and beyond.* arXiv. https://arxiv.org/abs/2101.09995

[32] "Algorithmic bias in public health AI: A silent threat to equity in low-resource settings." (2025). *Frontiers in Public Health, 13*, Article 1643180. https://doi.org/10.3389/fpubh.2025.1643180

[33] Inampudi, S. (2024). *Barriers to implementation of digital transformation in the healthcare sector in India. Humanities & Social Sciences Communications, 11*, Article 156. https://doi.org/10.1057/s41599-024-03081-7

[34] Osonuga, A. (2025). *Bridging the digital divide: Artificial intelligence as a tool for universal healthcare access. Technology in Society, 68*, Article 101542. https://doi.org/10.1016/j.techsoc.2025.101542

[35] Hazra, S. (2025). *Capitalization of digital healthcare: The cornerstone of patient autonomy in India. Digital Health Review, 3*(1), 45-64. https://doi.org/10.1016/j.dhr.2025.03.004

[36] Choolayil, A. C., Paranthaman, S., & Kuttiatt, V. S. (2024). Arguing the case for the "digitally marginalised". *Frontiers in Digital Health*, 6, Article 1468633. https://doi.org/10.3389/fdgth.2024.1468633

[37] Chandra, R., et al. (2024). An analysis of predictors and wealth-based inequality in digital health readiness in India. *BMC Digital Health*, 2, Article 47. https://doi.org/10.1186/s44247-024-00090-z

[38] Inampudi, S. (2024). Barriers to implementation of digital transformation in the healthcare sector in India. *Humanities & Social Sciences Communications*, 11, Article 156. https://doi.org/10.1057/s41599-024-03081-7

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access as part of the right to health under Article 21 of the Constitution. The State's obligation must evolve from merely providing healthcare facilities to ensuring equitable access to digital health resources and literacy. Thus, digital dignity is inseparable from digital equity.

Towards Ethical Digital Governance in Healthcare

To safeguard patient dignity in the digital era, a multi-layered governance framework is essential—integrating privacy-by-design, algorithmic transparency, and sector-specific oversight[39]. Scholars propose establishing a Digital Health Ethics Authority to audit AI systems, enforce ethical compliance, and adjudicate digital grievances[40]. Such a mechanism could work in tandem with the proposed Patient Rights Commission, ensuring that the enforcement of digital rights parallels technological innovation[41].

Ultimately, "digital dignity" is not just about data protection but about re-humanizing healthcare in a digital world. It demands that law keeps pace with technology not through restriction, but through responsible regulation rooted in human rights.

V. Unequal Care: Intersectional Barriers to the Realization of Patients' Rights

In India, the enforcement of patient rights is significantly influenced by intersecting social determinants such as caste, gender, disability, and sexual orientation. These structural inequities not only hinder equitable access to healthcare but also violate the foundational principles of dignity and autonomy enshrined in the Indian Constitution[42].

Caste-Based Discrimination in Healthcare

Caste remains a pervasive determinant of health disparities in India. Individuals from Scheduled Castes (SCs) and Scheduled Tribes (STs) often encounter systemic barriers in accessing healthcare services, including denial of services, discriminatory attitudes from healthcare providers, and limited availability of facilities in their communities[43]. Such structural exclusion perpetuates cycles of poor health outcomes and marginalization. Studies indicate that caste-based discrimination in healthcare settings leads to delayed treatment and poorer health

[39] Pandya, S., Nagpal, S., & O'Brien, N. (2025). Governance pathways for driving digital transformation in primary healthcare. Johns Hopkins Centre for Global Digital Health Innovation.
[40] Jain, D. (2023). Regulation of digital healthcare in India: Ethical and legal challenges. Healthcare, 11(6), 911. https://doi.org/10.3390/healthcare11060911
[41] Sethi, M. I. (2025). The Digital Personal Data Protection Act 2023: Implications for healthcare. Journal of Medical Ethics, 51(2), 123–130. https://doi.org/10.1136/medethics-2024-1078
[42] Balarajan, Y., Selvaraj, S., & Subramanian, S. V. (2011). Health care and equity in India. *The Lancet*, 377(9764), 505–515. https://doi.org/10.1016/S0140-6736(10)61894-6
[43] Thapa, R. (2021). Caste exclusion and health discrimination in South Asia. *Journal of Global Health*, 11(2), 02001. https://doi.org/10.7189/jogh.11.02001

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outcomes for these communities[44].

Moreover, caste-based discrimination extends beyond healthcare facilities, affecting access to education, employment, and social services, thereby exacerbating health inequities[45]. The intersectionality of caste with other social determinants such as gender and socioeconomic status further compounds these disparities[46]. Addressing caste-based discrimination requires comprehensive policy interventions and societal reforms to ensure equitable healthcare access for all[47].

Gender and Healthcare Access

Gender disparities in healthcare access are prevalent, with women, particularly from marginalized communities, experiencing lower health literacy, economic dependence, and limited mobility[48]. These factors contribute to delayed or foregone medical care, exacerbating health inequities. Additionally, gender-based violence and discrimination within healthcare settings further deter women from seeking necessary care[49]. Studies indicate that women often face higher household, logistic, and facility-level barriers to healthcare access compared to men[50].

In rural areas, these gender disparities are more pronounced due to scarcity of healthcare facilities and skilled providers[51]. Cultural norms and societal expectations often prioritize men's health over women's, leading to neglect of women's healthcare needs. Implementing gender-sensitive health policies and ensuring women's participation in healthcare decision-making processes are crucial steps towards achieving gender equity in healthcare[52].

Disability and Queer Identities in Healthcare

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[44] Mahapatro, S. R., & Sahoo, S. (2021). Intersection of class, caste, gender and unmet healthcare needs in India. *The Lancet Regional Health – Southeast Asia*, 2, 100019. https://doi.org/10.1016/j.lansea.2021.100019

[45] Pradhan, M. R., & Sahoo, S. (2025). Women's healthcare access: Assessing the household, logistic and facility-level barriers in India. *BMC Health Services Research*, 25(1), 124. https://doi.org/10.1186/s12913-025-12463-9

[46] Dupas, P., & Jain, R. (2024). Gender disparities in the use of government health insurance in India. *VoxDev*. https://voxdev.org/topic/health/gender-disparities-use-government-health-insurance-india

[47] Arora, L., & Gupta, A. (2022). Understanding discrimination against LGBTQIA+ patients in Indian healthcare institutions. *Journal of Global Health*, 12(1), 01001. https://doi.org/10.7189/jogh.12.01001

[48] Goitiandia, S. W., & Kumar, R. (2024). Beyond the bench: LGBTQ+ health equity after India's "no" to same-sex marriage. *The Lancet Regional Health – Southeast Asia*, 10, 100101. https://doi.org/10.1016/j.lansea.2024.100101

[49] Jindal, M., & Singh, A. (2023). Eliminating health care inequities through strengthening inclusive policies. *Journal of Global Health*, 13(1), 01002. https://doi.org/10.7189/jogh.13.01002

[50] Basu, J., & Sahoo, S. (2022). Research on disparities in primary health care in rural India. *Journal of Global Health*, 12(2), 02003. https://doi.org/10.7189/jogh.12.02003

[51] Haddad, S., & Houghton, R. (2011). Reducing inequalities in health and access to health care in a rural community. *BMC International Health and Human Rights*, 11(Suppl 2), S3. https://doi.org/10.1186/1472-698X-11-S2-S3

[52] Narayan, N. (2022). Enculturalising casteism in health care in India. *CASTE: A Global Journal on Social Exclusion*, 3(2), 245–262. https://doi.org/10.26812/caste.v3i2.442

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Individuals with disabilities and those identifying as LGBTQIA+ encounter compounded barriers in healthcare systems[53]. These include physical inaccessibility, lack of trained personnel, and stigmatization. For instance, queer and gender-diverse individuals with disabilities face heightened discrimination, as healthcare providers often lack the training to address their unique needs[54].

The absence of inclusive healthcare policies and the lack of data on the health needs of these populations further marginalize them[55]. While recent guidelines prohibit harmful practices such as "conversion therapy" and ensure access to gender-affirming surgery, enforcement remains inconsistent[56]. Creating a safer and more inclusive healthcare environment requires comprehensive training for healthcare providers, formulation of inclusive policies, and active participation of LGBTQIA+ and disabled individuals in health system governance[57].

Rural and Socioeconomic Disparities

Rural populations, especially those from lower socioeconomic backgrounds, face significant challenges in accessing healthcare[58]. These challenges include long distances to healthcare facilities, inadequate transportation, and financial constraints. Moreover, rural communities often lack awareness of available health services and legal rights, further entrenching health inequities[59]. Studies indicate that lower socioeconomic status is linked to both reduced healthcare access and lower utilization of more qualified healthcare providers[60].

Initiatives such as mobile health units and telemedicine have been introduced to bridge this gap[61]. For example, mobile medical vans have been deployed in rural areas of Punjab to provide essential medical services directly to villages[62]. These initiatives aim to deliver free, high-

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quality healthcare services to underserved populations, thereby improving healthcare access in rural communities[63].

Legal and Policy Gaps

While the Indian Constitution guarantees fundamental rights, the enforcement of these rights in healthcare settings remains inconsistent[64]. Existing policies often fail to address the specific needs of marginalized groups, and there is a lack of comprehensive data to inform targeted interventions[65]. This policy gap necessitates a rights-based approach to healthcare that prioritizes equity and inclusion.

International human rights frameworks emphasize the obligation of states to ensure equitable access to healthcare for all individuals, regardless of their social identities[66]. India's commitment to these frameworks requires the formulation and implementation of policies that address the unique healthcare needs of marginalized communities[67].

Intersectional Framework for Healthcare Equity

An intersectional approach is essential for understanding and addressing the multifaceted barriers to healthcare faced by marginalized communities[68]. This approach involves recognizing the interconnectedness of various social identities and structures of power that influence health outcomes. Implementing such a framework can guide the development of inclusive policies and practices that promote equitable healthcare access for all[69]. Studies have shown that an intersectional approach can strengthen existing mental health policies and support the development of new ones that address the unique needs of marginalized communities[70].

By integrating considerations of caste, gender, disability, and other social determinants into healthcare policy and practice, India can move towards a more inclusive and equitable

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healthcare system[71]. This requires not only legal reforms but also societal changes that challenge discriminatory norms and practices[72].

VI. From rights to remedies: towards a legally enforceable framework for patient protection – suggestions and recommendations

Legal Recognition and the Need for Enforcement

India's healthcare discourse has increasingly recognised patient rights — rights to informed consent, to dignity, to safe and quality care. Nonetheless, the transition from recognition to enforceability remains incomplete. The legal architecture features frameworks such as the National Patient Safety Implementation Framework (2018-2025) and the Charter of Patients' Rights endorsed by the National Human Rights Commission (NHRC). These articulate duties of healthcare providers and rights of patients[73]. Yet the existence of such frameworks alone does not guarantee meaningful redress when rights are violated. Studies reveal that while rights are codified on paper, enforcement mechanisms and institutional accountability lag behind[74].

Challenges in Enforcement

Empirical research highlights major enforcement gaps. For instance, a study on patient grievances in Indian health facilities shows that multilevel governance mechanisms for redressal remain fragmented, often disadvantaging care-seekers in favour of medical professionals or institutional actors[75]. The imbalance in power and the multiplicity of agencies handling complaints mean that patient rights violations frequently go unaddressed or under-investigated[76]. Moreover, awareness among patients of their rights is low — for example, a survey in India found that a large portion of patients were unaware of key rights such as access

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to records or right to refuse treatment[77]. In addition, enforcement in private hospitals continues to be weak: researchers point to the lack of regulation for private clinical establishments, arbitrary billing practices and poor implementation of patients' rights provisions[78].

Proposed Institutional Mechanisms

To bridge the enforcement gap, scholars and policy-analysts propose the creation of dedicated, independent institutions — such as a national Patient Rights Commission or a Healthcare Ombudsman[79]. Such a body would have the power to receive complaints, conduct investigations, order remedies, and monitor institutional compliance. Comparative research into grievance-redressal models in other countries emphasises key design features: accessibility, impartiality, independence, authority to sanction, and feedback loops into the health-system. For Indian adaptation, integrating laypersons in the governance loop (rather than only health-professionals) is highlighted as a key reform[80].

Integrating Digital Health Governance

The enforcement challenge is more complex in the digital era. The growth of telemedicine, electronic health records and algorithm-based diagnostics demands that enforcement mechanisms account for new domains of rights violation (data misuse, algorithmic bias, digital consent). The Digital Personal Data Protection Act, 2023 (DPDP Act) establishes a legislative foundation for data privacy, yet sector-specific oversight in health remains underdeveloped[81]. An enforceable framework must therefore include digital-health governance: clear rules for EHRs, patient access to data, algorithmic transparency, and oversight of tele-health platforms. Furthermore, grievance-redressal mechanisms must be digitally accessible, user-friendly, and inclusive of underserved populations given the existing digital divide[82].

Roadmap for Implementation

Realising a legally enforceable framework for patient protection requires action on multiple

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fronts:

- Legislative reform: Enactment of a dedicated Patients' Rights Act or amendment of existing health-laws to include enforceable rights, remedies, and institutional oversight.
- Institution-building: Creation of a national commission/ombudsman with statutory powers, regional branches, and linkages to state health systems and digital platforms.
- Capacity-building: Training healthcare providers, legal professionals, and patient-advocacy groups about rights, mechanisms and redressal pathways.
- Digital inclusion: Ensuring that digital governance and redressal mechanisms serve rural, marginalised and digitally-excluded populations by design.
- Monitoring & feedback: Regular public reporting on rights-violations, complaint resolutions, compensation awards, and systemic reforms.
- Adopting such a roadmap can move patient rights from recognition to reality where dignity, autonomy, and accountability are embedded in healthcare practice.

VII. Conclusion

The evolution of patient dignity from an ethical aspiration to a justiciable legal right mark a profound transformation in how law perceives human health. What began as a moral duty rooted in compassion and care has, over time, found recognition in constitutional guarantees of equality, liberty, and life under Articles 14, 19, and 21. Yet, this moral-legal synthesis remains incomplete unless the promise of dignity is translated into everyday healthcare realities. The digital age has intensified this challenge. While technology has democratized access to information and improved the efficiency of medical services, it has also introduced new anxieties - algorithmic discrimination, data exploitation, and the erosion of informed consent. In this context, digital dignity becomes a critical extension of human rights, demanding that innovation in healthcare must be guided not merely by efficiency or profit but by ethics, transparency, and justice.

However, the recognition of rights without effective remedies risks hollowing out their meaning. Across India, the uneven enforcement of patient rights reveals deep structural inequalities shaped by caste, gender, class, geography, and digital literacy. True justice in healthcare cannot exist in isolation from social justice. It requires acknowledging and addressing these intersectional barriers that silence the most vulnerable patients. The future of patient protection in India depends on a decisive shift — from fragmented policies to a coherent, enforceable legal framework. Establishing independent institutions such as a Patient Rights

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Commission or Healthcare Ombudsman, embedding data-ethics governance within the health system, and promoting widespread rights awareness can collectively operationalize dignity. Enforcement must not be reactive but preventive, ensuring accountability while empowering patients as active rights-holders rather than passive recipients of care.

Ultimately, the law's duty in healthcare is not only to regulate medicine but to reaffirm humanity. Protecting patient dignity means recognising every individual's right to autonomy, privacy, and respect — in hospitals, in algorithms, and in the very structure of public health governance. It is only when the language of law aligns with the values of compassion and equality that healthcare becomes what it was always meant to be: a shared expression of human dignity.

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