ANALYSING THE LIABILITY OF DIGITAL MEDICAL PLATFORMS FOR MEDICAL NEGLIGENCE BY DOCTORS

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Medical platforms have witnessed a massive rise since the beginning of the COVID-19 pandemic. In order to introduce clarity and certainty to the field of telemedicine, the Telemedicine Practice Guidelines were introduced. While it has addressed liability in different respects, the question of platform liability for the negligence of doctors remains unanswered. Liability for a doctor's negligence can be considered under both tort law and intermediary regulation. Under tort law, the standard test for vicarious liability is when there is an employer-employee relationship. However, courts have modified this test in the context of hospitals and now hold commercial hospitals vicariously liable for all negligence of their doctors. If this test is extended to medical platforms, it will lead to unreasonable over-regulation by holding all platforms liable. This paper suggests a three-part framework to assess the liability of these platforms under tort law that is fair and equitable. Under intermediary liability, the plain application of the law results in no liability for any medical platform. While this is a reasonable outcome, it highlights the lack of certainty in regulating medical platforms. To ensure that innovation is not stifled, this paper argues that liability of suchplatforms should be clarified.

Table of Contents

I. *Introduction* ... 185
II. *History of Telemedicine in India* ... 186
III. *An Overview of Digital Medical Platforms* ... 189
IV. *Tort and Vicarious Liability* ... 191
V. *A Three-Part Test for Tortious Liability of Digital Medical Platforms* ... 195
A. *The Legal Basis for the New Framework* ... 195
B. *Developing a Three-Part Liability Framework* ... 198
VI. *Intermediary Liability* ... 202
VII. *Conclusion* ... 206

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I. INTRODUCTION

The onset of the COVID-19 pandemic has led to a monumental change in the regular functioning of society. The Healthcare sector has been one of the most affected, not only because of the strain of coronavirus, but also due to the redefining of doctor-patient interactions. One of the most momentous changes has been the meteoric rise of teleconsultations and the telemedicine sector.[1] Recognising the scope for growth, the Central Government notified the Telemedicine Practice Guidelines ('TPG') on March 25, 2020 to provide legal clarity for the field.[2] The TPG confirmed the legality of telemedicine,[3] outlined its scope,[4] and laid down guidelines that had to be followed by both medical practitioners as well as digital platforms.[5] For instance, telemedicine platforms must ensure that their practitioners are duly registered with their respective medical councils,[6] conduct due diligence as to their authenticity,[7] and create a grievance redressal mechanism, among others.[8]

Telemedicine is mainly provided by digital platforms. These digital platforms provide a wide variety of services: Some restrict themselves to online appointment booking, others on board doctors and fix consultations, and some even provide a comprehensive solution by delivering prescribed medicines to the patient's house after consultation.[9] While this variety in business models provides diversity in the market, the rise of digital medical platforms has also given rise to a new set of legal concerns. These usually include concerns about privacy and confidentiality of patient information, the standard and quality of treatment, informed consent, licensing and credentials of doctors, amongst others.[10] However, most of these are sufficiently addressed by existing rules like the TPG.[11]

One of the most contested legal issues in this respect is the question of the liability of medical platforms for the negligence of their doctors. The existing legal obligations do not directly address the extent to which platforms

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1 Mihir Dalal, *The Coming of Age of E-health Platforms,* May 25, 2020, available at https://www.livemint.com/news/india/the-coming-of-age-of-e-health-platforms-11590324836814.html (Last visited on July 21, 2022).

2 Telemedicine Practice Guidelines (March 25, 2020).

3 Nitish Desai Associates, *Telemedicine in India: The Future of Medical Practice?,*October, 2020, available at https://www.nishithdesai.com/fileadmin/user_upload/pdfs/Research_Papers/Telemedicine-in-India.pdf (Last visited on August 26, 2022) at 9-10.

4 Telemedicine Practice Guidelines (March 25, 2020) Cl 1.1-1.4.

5 *Id.*, Cls. 3.1-3.7, 5.1-5.7.

6 *Id.*,Cl. 5.1.

7 *Id.*,Cl. 5.2.

8 *Id.*,Cl 5.6.

9 See *infra* Part III on "An Overview of Digital Medical Platforms".

10 Karen Barreto & Neha Mehta, *Telemedicine 2020: An Outlook on The Impediments and Future of Telemedicine in India,*June 22, 2020, available at rsrr.in/2020/06/22/telemedicine-in-india/ (Last visited on July 21, 2022).

11 Nitish Desai Associates, *supra* note 3.

are liable in this regard.[12] While platforms are squarely liable for their own omissions and actions, like breaches of privacy,[13] liability for the actions of their doctors remains unclear. Doctors can face individual sanctions from State or Central Medical Councils,[14] but whether there can exist an additional liability on the platform is unclear. Moreover, the standard of vicarious liability under tort law traditionally applies to employees and not independent contractors.[15] It remains unclear whether medical platforms can be vicariously liable for the actions of their employees. There is also doubt surrounding the applicability and standard of intermediary liability that applies to these platforms. All of this is further exacerbated by the sheer variations in business models. Therefore, it has been difficult to delineate a uniform standard of liability.

This paper seeks to address the question of the liability of digital medical platforms in India for their doctors' negligence. Part II provides an overview and history of the telemedicine sector. Part III characterises the various types of platforms and the variations in their business models. Part IV discusses vicarious liability and explores whether platforms can be held liable under tort for the negligence of their doctors. Currently, if the rules for vicarious liability under tort are applied directly to these platforms, all of them will be liable for the negligence of doctors. Part V suggests an alternative framework that regulates liability based on differences in the business model and is, therefore, a more proportionate framework. Part VI highlights the law relating to intermediaries and the liability of platforms under the same, and Part VII concludes with suggestions and highlights the need for clarity.

II. HISTORY OF TELEMEDICINE IN INDIA

While telemedicine has only taken off recently, it has been in existence for decades before the COVID-19 pandemic.[16] In India, the beginning of telemedicine was strongly influenced by the requirement for specialist care in rural India and saw extensive involvement from the Indian Space Research Organisation ('ISRO').[17] In 2001, the Telemedicine Pilot Project began between ISRO and Apollo Hospitals, where the Apollo Hospital in Chennai was linked to the Apollo Rural

12 Telemedicine Practice Guidelines, *supra* note 4.

13 *Id.*, Cl. 3.7.1.

14 Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, R. 8.2.

15 John Dwight Ingram, *Vicarious Liability of an Employer-Master: Must There Be a Right of Control?* Vol. 16,Northern Ilinois University Law Review, 93 (1995); Debanshu Mukherjee & Anjali Anchayil, *Vicarious Liability of The State in Tort in India*, June, 2015, available at https://vidhilegalpolicy.in/wp-content/uploads/2015/06/VidhiReportonStateLiabilityinTort.pdf (Last visited on July 21, 2022); J.W. Neyers, *A Theory of Vicarious Liability*, Vol. 43(2), Alberta Law Review, 287, 293 (2005); Ayushi Singh, *Critical Analysis of Vicarious Liability*, Vol. 4(3),International Journal of Law Management & Humanities, 2581 (2021).

16 Vinoth G. Chellaiyan et al., *Telemedicine in India: Where do we Stand?* Vol. 8(6), Journal of Family Medicine and Primary Care, 1872 (2019).

17 A. Bhaskaranarayana et. al., *Indian Space Research Organisation and Telemedicine in India*, Vol. 15(6),Public Medicine, 586 (2009).

Hospital in Aragonda village, Andhra Pradesh.[18] Telemedicine services there were routed through ISRO's Indian National Satellite System ('INSAT') satellite series to provide connectivity.[19] Over time, this network has expanded, and more stakeholders have become involved in the process.[20] ISRO connects forty-five rural, remote hospitals and fifteensuper-speciality hospitals across the country.

Moreover, the private sector is meaningfully involved in the field. Major hospital brands like Narayan Hrudayalaya and Apollo Medicine have made significant contributions to telemedicine by connecting their hospitals to the network.[21] Presently, reputed institutions like AIIMS and SGPIMS are connected to Rohtak, Shimla, and Cuttack medical centres.[22]

The State had also been active during the early development of telemedicine. In 2005, the Government of India setup a National Telemedicine Taskforce that eventually drafted several important policies.[23] These policies included various projects like National e-Health Authority ('NeHA'), and Village Resource Centres ('VRCs').[24] NeHA was envisaged to set up a national health system for improving the efficiency of healthcare delivery.[25] VRCs provide updated telemedicine services to remote areas, and in Tripura, this setup has been implemented in over twentyhospitals.[26] The State also has services like the National Cancer Centre ('ONCONET') for dealing with cancer and the National Medical College Network for linking medical colleges.[27]

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18 Indian Space Research Organization, *Pilot Project on Telemedicine*, November 16, 2000, available at https://www.isro.gov.in/update/16-nov-2000/pilot-project-telemedicine (last visited on July 21, 2022); Varun Verma, Vijaya Krishnan & Chhaya Verma, *Telemedicine in India – An Investment of Technology for a Digitized Healthcare Industry: A Systematic Review*, Vol. 31(4),Romanian Journal of Information Technology and Automatic Control, 33 (2021).

19 *Id*.

20 Chellaiyan, *supra* note 16; Neema Agarwal et al., *Telemedicine in India: A Tool for Transforming Health Care in the Era of COVID-19 Pandemic*,Vol. 9, Journal of Education and Health Promotion, 190 (2020).

21 Aparajita Dasgupta & Soumya Deb, *Telemedicine: a New Horizon in Public Health in India*,Vol. 33(1), Indian Journal of Community Medicine, 3(2008); Krishnan Ganapathy &Aditi Ravindra, *Telemedicine in India: The Apollo Story*,Telemedicine and E-Health, 576(2009).

22 *Id*.

23 Maninder Pal Singh Pardal et al., *Telemedicine in the Era of COVID-19: The East and the West*, Vol.22,Journal of Marine Medicine Society, 32 (2020); Sambit Dash & Aarthy Ramasamy, *COVID-19: Telemedicine Is a Good Idea – But Not Without Access*, May 5, 2020, available at https://science.thewire.in/health/telemedicine-privacy-internet-covid-19/ (Last visited on July 21, 2022); Swarna Priya B et. al., *Advancement of Existing Healthcare Setting Through Tele-medicine: The Challenges Faced in India*, Vol. 8(1),International Journal of Community Medicine and Public Health, 502 (2021).

24 Chellaiyan, *supra* note 16.

25 Manisha Wadhwa, *National Health Authority (NeHA)* (Centre for Sustainable Development, Columbia University, ICT India Working Paper #29; Ministry of Health and Family Welfare, Placing the Concept Note on National e-Health Authority (NeHA) on public domain for comments/views-reg, F. No. Z-18015/10/2013-eGov (Notified March 16, 2015).

26 Pankaj Mathur et. al., *Evolving Role of Telemedicine in Health Care Delivery in India*, Vol. 7(1),Primary Health Care (2017).

27 Sambit Dash et. al., *Telemedicine during COVID-19 in India— A New Policy and its Challenges*, Vol. 42, Journal of Public Health Policy, 501(2021).

Despite this impressive growth in the early 2000s, the momentum and visibility of telemedicine eventually fizzled out.[28] Statements demonstrating the intention to expand the scope of telemedicine in India were floated, but these did not come to fruition.[29] Most of these projects were either state-led or based on limited cooperation between the State and a major hospital. The primary purpose of these projects was to ensure that individuals in rural areas, who have less access to medical infrastructure and quality medical professionals, had greater access to useful medical advice.[30] NeHA, for example, was an authority setup to effectively facilitate the creation of new telemedicine networks.[31] Other initiatives were direct connections between reputed private hospitals and smaller rural clinics.

These initiatives eventually fizzled out because of the limited scope of these projects. Most of these were highly localised and geographically limited in scope. In most of these projects, a rural healthcare provider is linked to an urban hospital. An example is Andaman and Nicobar's telemedicine project,which links Port Blair's G.B. Pant Hospital to the Shri Ramachandra Medical College in Mumbai.[32] These centres can only serve patients in their immediate vicinity and not cover a wider area.[33] The patchwork benefits received from these programs meant that they were not pursued as the benefits did not scale with costs.[34] Moreover, the primary catalysts in the process were hospital brands which only involved themselves in the field in an ancillary capacity. As a result, interest in the field gradually decreased over the years.

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[28] Anurag Khosla, *Increase in Acceptance and Recognition of Telemedicine by Stakeholders Post-Covid*, November 25, 2021, available at https://www.financialexpress.com/healthcare/healthtech/increase-in-acceptance-and-recognition-of-telemedicine-by-stakeholders-post-covid/2376214/ (Last visited on July 21, 2022); Wadhwa, *supra* note 25.

[29] Staff Reporter, *Govt. Focuses on Telemedicine*, The Hindu,March 14, 2015, available at https://www.thehindu.com/news/cities/Delhi/govt-focuses-on-telemedicine/article6992510.ece# (Last visited on August 27, 2022).

[30] K. Ganapathy, *Telemedicine in the Indian Context: An Overview*, Vol. 104, Studies in Health Technologies and Informatics, 178 (2004); Amrita Pal et. al., *Telemedicine Diffusion in a Developing Country: The Case of India*, Vol. 9(1), IEEE Transactions on Information Technology in Biomedicine, 59 (2005).

[31] Wadhwa, *supra* note 25.

[32] PharmaBiz, *BEL Links Port Blair Hospital with SRMC & RI, Chennai through Telemedicine*, July 6, 2002 available at http://test.pharmabiz.com/news/bel-links-port-blair-hospital-with-srmc-ri-chennai-through-telemedicine-1592 (Last visited on September 22, 2022).

[33] Kumar B.A. Praveen & Syed Sadat Ali, *Telemedicine in Primary Healthcare: The Road Ahead*,Vol. 4(3), Inernational Journal of Preventive Medicine, 377 (2013); National Institution for Transforming India ('NITI Aayog'), *The Telemedicine Experience of Care Hospitals*,8-9, available at https://www.niti.gov.in/planningcommission.gov.in/docs/reports/sereport/ser/stdy_ict/14_telemed.pdf (Last visited on October 4, 2022).

[34] Computer Weekly, *India Warms to Telehealth Amid Pandemic*,February 18, 2022, available at https://www.computerweekly.com/news/252513585/India-warms-to-telehealth-amid-pandemic (Last visited on September 22, 2022); Entrepreneur, *How Digital Penetration will Lead the Way to Increased Telemedicine Practice in India?*, March 19, 2018, available at https://www.entrepreneur.com/en-in/news-and-trends/why-increased-telemedicine-practice-is-the-need-of-the-hour/310620 (Last visited on September 22, 2022).

The turning point came with the pandemic, where the demand for remote healthcare drove immense growth in the sector.[35] The telemedicine sector is now dominated by start-ups and companies dedicated to providing remote services to customers.[36] The benefits of remote consultation, which include increased accessibility, cheaper medical services, and comfort,would mean that many will choose to opt for telemedicine-based solutions.[37] Moreover, telemedicine would also continue to be crucial during future pandemics.[38] This is especially salient in rural areas, where accessibility to quality medical areas has exponentially increased during the pandemic, and the demand is likely to remain.[39] The sector's viability is further ensured by massive investment from investors and venture capital funds.[40] As a result, it is important to address the question of platform liability.

III. AN OVERVIEW OF DIGITAL MEDICAL PLATFORMS

As noted in Part II, telemedicine has been dominated by entrenched private players and the Government. Post the pandemic, several new market players operating in the digital sphere emerged. The Indian telemedicine market was worth $1.3 billion in 2021[41] and is estimated to be worth $5.5 billion by 2025.[42] These companies can be called 'digital medical platforms' as they provide medical services online. The companies can be divided based on the scope of services they provide.[43] As we will see, this will have crucial implications when determining their liability.

First, certain platforms like Cure Mantra only provide online appointments.[44] These do not on board the doctor themselves but merely act as a conduit between the patient and doctor. These can be called 'appointment-based platforms'.The second type of platform is those that provide only online

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38 Asim Kichloo et. al., *Telemedicine, the Current COVID-19 Pandemic and the Future: A Narrative Review and Perspectives Moving Forward in the USA*, Vol. 8(3), Family Medicine and Community Health (2020); Sam Kim & Vrishti Beniwal, *Why Telemedicine Could Remain Popular Across Asia even After Covid is Controlled*,July 24, 2020, available at https://theprint.in/health/why-telemedicine-could-remain-popular-across-asia-even-after-covid-is-controlled/467174/ (Last visited on August 27, 2022).

41 Vikram Thaploo, *Steady Growth Ahead*, March 2, 2020, available at https://www.businessworld.in/article/Steady-Growth-Ahead-/02-03-2022-421820/ (Last visited on July 21, 2022).

42 PTI, *Telemedicine Market in India to Reach USD 5.5 Billion by 2025: EY-IPA Study*, September 8, 2020, available at https://www.financialexpress.com/lifestyle/health/telemedicine-market-in-india-to-reach-usd-5-5-billion-by-2025-ey-ipa-study/2078029/ (Last visited on July 21, 2022); EY-IPA, *Healthcare Goes Mobile: Evolution of Teleconsultation and E-pharmacy in New Normal*,September, 2020, available at https://assets.ey.com/content/dam/ey-sites/ey-com/en_in/topics/health/2020/09/healthcare-goes-mobile-evolution-of-teleconsultation-and-e-pharmacy-in-new-normal.pdf (Last visited on July 21, 2022).

43 Neeraj Agarwal & Bijit Biswas, *Doctor Consultation through Mobile Applications in India: An Overview, Challenges and the Way Forward*,Vol.26(2),Healthcare Informatics Research, 153 (2020).

44 CureMantra, *About Our Company*,available at https://www.curemantra.com/about (Last visited on July 21, 2022).

consultations. These go a step further from appointment-based platforms, and on board doctors in the process. Examples of these 'consultation-based platforms' are Just Doc and Medimetry.[45] Third, the vast majority of platforms provide both online consultation and doorstep medicine delivery. This type of platform offers both facilities for higher user convenience, but they do not tie both these services. Examples of such 'delivery and consultation platforms' are MFine, Zoylo, 1mg, and Practo.[46] Finally, there are 'comprehensive care platforms' that provide the option of comprehensive packages to users. Bajaj Finsery Health offers a variety of 'packages' for customers to choose from.[47] Upon selecting one, the platform assigns doctors for video consultations and delivers the prescribed medicines to the customer. The entire payment, including the cost of medications, is collected up front. These four models encompass the majority of companies that are presently found in the market.

Aside from these standard business models, there are some platforms that have creative models which do not squarely fall under one of these four categories. Lybrate, for example,provides not only online consultation but also provides a forum where doctors can answer user queries.[48] Such platforms represent trickier questions when addressing their liability, an issue that will be addressed in subsequent sections.

Therefore, we can conclude that platforms have significant variation in the amount of involvement in doctor-patient interactions. Some merely facilitate the process by providing easier access to consultations while others control the interaction between patients and doctors by having a comprehensive process. However, the variation does not only end here: there is also considerable divergence in the payment system of these platforms. Most platforms collect the dues directly from the customer and then pass on the doctor's share to them later, keeping a small commission for themselves.[49] However, there are some platforms with a very creative payment model – Bajaj Finsery uses a unique EMI Card that automatically pays money to the platform in instalments.[50] Broadly, most platforms

[45] JustDoc, *Ask a Doctor Online*, available at https://justdoc.com/ (Last visited on July 21, 2022); Medimetry, *Consult Doctor*,available at https://medimetry.com/ (Last visited on July 21, 2022).

[46] MFine, *Consult Doctor*,available at https://www.mfine.co/ (Last visited on July 21, 2022); Zoylo, *Online Corporate Medical Hub*, available at https://www.zoylo.com/(Last visited on July 21, 2022); 1mg, *Online Pharmacy India*,available at https://www.1mg.com/ (Last visited on July 21, 2022); Practo,*Practo*, available at https://www.practo.com/ (Last visited on July 21, 2022).

[47] Bajaj Finsery Health, *B-Health*, available at https://www.bajajfinservhealth.in/ (Last visited on July 21, 2022).

[48] Lybrate, *Online Doctor*,available at https://www.lybrate.com/ (Last visited on July 21, 2022).

[49] PatientBond, *How Digital Health Platforms Increase Patient Payments*, June 24, 2020, available at https://www.patientbond.com/blog/how-digital-health-platforms-can-be-used-to-increase-patient-payments (Last visited on September 22, 2022); BusinessWorld, *Role Of Digital Payments In Transforming Healthcare Industry*, December 11, 2020, available at https://www.businessworld.in/article/Role-Of-Digital-Payments-In-Transforming-Healthcare-Industry/11-12-2020-352575/ (Last visited on September 22, 2022).

[50] Bajaj Finsery, *EMI Network Card*, available at https://www.bajajfinserv.in/emi-network-emi-card (Last visited on July 21, 2022).

collect the money and pass on a share to participating doctors. This system of operation can influence the analysis of whether the platform acts as an employer, but most importantly, it is essential to determine its status as an intermediary. The legal implication of these differences in the business model is discussed in the subsequent sections.

IV. TORT AND VICARIOUS LIABILITY

Medical negligence is usually based on the acts and omissions of a doctor.[51] However, a superior authority, i.e. hospitals, have always been held responsible for negligence.[52] This is because Courts have assumed that hospitals exercise control over their doctors in all cases and, therefore would be vicariously liable.[53] Applying these legal principles to medical platforms would result in disproportionately high and uncertain attribution of liability. Moreover, using the current legal test does not acknowledge the differences in business models of various platforms. Therefore, an alternative test is required to determine the liability of these platforms.

Classically, tort law states that a master can only be vicariously liable for the actions of their servant when they have an employer-employee relationship.[54] One cannot be vicariously liable for the actions of an independent contractor.[55] Traditionally, the test of 'control' was applied to determine whether the relationship was one of a masterservant or that of a master-independent contractor. This was assessed by a four-part test: "(1) Master's power of selection of his servant; (2) payment of wages or other remuneration; (3) Master's right to control the method of doing the work, and (4) Master's right of suspension or dismissal."[56]

However, this test has severe limitations when applied to professional jobs that require a high level of expertise. An employer cannot exercise significant control over employees under a contract of service (regular employment) in cases of highly technical jobs.[57] This doctrine also does not apply in modern industrial 'conditions' where there are various legal restrictions, trade union rules, etc.[58] As a result, the Supreme Court in *Dharangadhara Chemical Works Ltd.* v. *State of Saurashtra*has clarified that the test of control is *prima facie* and not the exclusive standard.[59] The assessment of the nature of the employment is usually holistic. This change has also carried over into the liability of hospitals: While hospitals

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[51] Laxman Balkrishna Joshi v. Trimbak Bapu Godbole, AIR 1969 SC 128.

[52] Arpana Dutta v. Apollo Hospitals Enterprises Ltd., 2000 SCC OnLine Mad 147, ¶25.

[53] *See infra* notes 62-73 and accompanying text.

[54] Ratanlal & Dhirajlal, The Law of Torts (Generic, 2020).

[55] *Id*.

[56] Short v.J. & W. Henderson Ltd., (1946) 62 TLR (HL) 427; State of U.P. v. Audh Narain Singh, 1964 SCC OnLine SC 12; State of Assam v. Kanak Chandra Dutta, 1966 SCC OnLine SC 9.

[57] Stevenson, Jordan and Harrison Ltd. v. Macdonald and Evans, (1952) 1 TLR 101, 111.

[58] Short v. J.&W. Henderson, Ltd., (1946) 62 TLR 427, 429.

[59] Dharangadhara Chemical Works Ltd. v. State of Saurashtra, AIR 1957 264, ¶¶9-15.

were earlier not held liable for the negligence of professional staff since they did not exercise a significant amount of control over the actions of skilled team,[60] it is now well-established that hospitals are liable for the negligence of their doctors.[61]

Savita Garg v.*National Heart Institute*[62] ('Savita Garg') is the foundational case for this proposition. In this case, Savita Garg filed a complaint against the National Heart Institute for their doctors' negligence that led to her husband's death.[63] The National Consumer Disputes Redressal Commission dismissed the complaint as the negligent doctors were never made a party to the proceedings, and ,the cause could not be sustained.[64] The Supreme Court reversed, holding that patients visit a hospital based on its reputation and expect a certain quality of service that hospitals have the duty to provide.[65] Moreover, patients are usually not aware of who the best doctor is and the hospital assigns a doctor from the list of available empanelled doctors.[66] The Court specifically rejected a contention that attempted to differentiate between a contract of service and a service contract, noting that courts have historically imputed liability for the actions of both temporary and permanent staff.[67] Therefore, it is of no consequence if the doctor is permanently employed, on a contract, or the nursing staff is temporary: the hospital is liable for negligence.

This decision has been affirmed in multiple subsequent cases.[68] In *Ashok Kumar Todani*v. *Rahul De,* the West Bengal State Consumer Redressal Commission relied on *Savita Garg* and held the hospital vicariously liable for the actions of the doctor.[69] The Maharashtra State Consumer Redressal Commission has also quashed a lower forum's decision on similar grounds.[70] In *Zarina*v. *State of M.P.,* the Madhya Pradesh HC reiterated the proposition that hospitals are responsible for the actions of their doctors.[71] The Supreme Court has also reiterated these principles multiple times, first in *V. Krishnakumar* v.*State of T.N.*[72] and then in *Maharaja Agrasen Hospital* v. *Rishabh Sharma*.[73] Since this test is premised on

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60 Hillyer v. St. Bartholomew's Hospital, (1909) 2 KB 820.

61 Meera Emmanuel, *Why Hospitals are Vicariously Responsible in Cases of Medical Negligence: What Supreme Court said*, December 18, 2009, available at https://www.barandbench.com/news/why-hospitals-are-vicariously-responsible-in-cases-of-medical-negligence-what-supreme-court-said (Last visited on August 27, 2022).

62 Savita Garg v.National Heart Institute, (2004) 8 SCC 56.

63 *Id.*,¶2.

64 *Id.*,¶3.

65 *Id.*,¶¶5,10.

66 *Id*.

67 *Id.*,¶¶11-16.

68 *See* Smt. Rekha Gupta v. Bombay Hospital Trust, 2003 (2) CPJ 160 (NCDRC); Joseph v. George Moonjely, 1994 SCC OnLine Ker 109; Krishna Mohan Bhattacharjee v. Bombay Hospital Medical Research Centre, 2015 SCC OnLine NCDRC 1422.

69 Ashok Kumar Todani v. Rahul De, Complaint Case No. CC/125/2011.

70 Ashu v. State of Maharashtra, (2006)2 CPR 347.

71 Zarina v. State of M.P., 2018 SCC OnLineMP 1727.

72 V. Krishnakumar v. State of T.N., (2015) 9 SCC 388.

73 Maharaja Agrasen Hospital v. Rishabh Sharma, (2020) 6 SCC 501, ¶11.4.17.

imputing liability based on the reputation of hospitals and the public perception of hospitals, the test in *Savita Garg* is referred to subsequently as the 'perception-based test'.

Applying these existing legal principles to medical platforms leads to the conclusion that platforms are liable for the negligence of their doctors. There are two reasons to believe that current legal principles establishing liability for the majority of medical platformsled to undesirable outcomes.

Firstly, courts are likely to find platforms liable based on the strong ethical and moral narrative permeating medical negligence jurisprudence. The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, notified by the erstwhile Medical Council of India, has several provisions on the ethical responsibility of doctors.[74] Several judgements have also traced the history of ethics in the medical profession, and emphasised their importance to the field.[75] In *P.B. Desai* v. *the State of Maharashtra,* the Supreme Court extensively discussed the relation between a doctor's moral or ethical and legal obligations.[76] While this has not been used as an independent ground to justify pushing liability, courts may leverage this existing discourse[77] to lean in favour of expanded liability for doctors in marginal cases. They may emphasise the ethical responsibility of digital medical platforms to provide quality services and hold them liable since they give access to the services of doctors, or they may reinforce the ethical obligations of doctors and attribute them to digital platforms, similar to the discourse relating to hospitals.[78]

Secondly, the perception-based test for pressing liability onto hospitals continues to apply to medical platforms. Medical platforms advertise themselves as providers of quality service, and many of them also assign doctors. Therefore, they squarely fall under the framework of *Savita Garg.* Even if the customers can choose their doctor, platforms are still likely to face tortious liability. Modern commercial hospitals allow patients to choose doctors, but still face vicarious liability. Similarly, medical platforms that play a significant role as an intermediary but permit a choice of doctors can be liable.

However, this is contingent on the assumption that courts will extend the perception-based test to medical platforms. It must be kept in mind that courts

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[74] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Rr. 1.2, 1.6, 1.7, 1.8, 6.5, 6.7, 7.22.

[75] Sagolsem Naran Singh v. RIMS, II (2018) CPJ 130, ¶¶24-25; Mohan Dai Oswal Cancer Treatment and Research Foundation v. Prashant Sareen, 2019 SCC OnLine NCDRC 75, ¶¶26-29; P.D. Hinduja National Hospital and Medical Research Centre v. Veera Rohinton Kotwal, 2018 (5) ALD 1, ¶¶49-50; Pankaj R. Toprani v. Bombay Hospital and Research & Medical Research Centre, 2020 SCC OnLine NCDRC105, ¶¶21-22; Pushpa Vyas v. Sajjan Daga, 2019 (2) ALD 18, ¶¶16-17.

[76] P.B. Desai v. State of Maharashtra, (2013) 15 SCC 481, ¶¶36-40.

[77] Muir Mills Unit of NTC (U.P.) Ltd. v. Swayam Prakash Srivastava, (2007) 1 SCC 491, ¶38; ESICorporation'sMedical Officer's Assn. v. ESICorpn., (2014) 16 SCC 162, ¶9.

[78] P.B. Desai, *supra* note 76.

may choose to evolve a distinct jurisprudence to assess the liability of these medical platforms. To understand why to let us refer to *Savita Garg* and the jurisprudence that has evolved. *Savita Garg* justified vicarious liability on the ground that patients visited the hospital due to 'reputation' and because the hospital usually assigned doctors.[79] While this has all the trappings of a two-part test that requires a factual inquiry, no case has ever engaged with the facts in this manner. In *Savita Garg*, the Court did not analyse whether the National Health Institute attracted customers because of its 'reputation' and whether the hospital assigned doctors or not. No subsequent case has done so either.[80]

Therefore, this leads to the conclusion that *Savita Garg's* analysis is a rhetorical justification to hold all commercial hospitals liable for the negligence of their doctors. This conclusion is bolstered by the *obiter* of the case, which generally talks about the asymmetric power of hospitals compared to patients.[81]

If this interpretation of jurisprudence is correct, then there is a real risk that courts will develop an alternative, rhetorical justification to hold all medical platforms liable. The court's rhetoric in *Savita Garg* was highly specific to a period that witnessed the rise of private hospitals.[82] In the case of digital platforms, the courts can develop a new justification for blanket liability similar to hospitals that will hold all medical platforms liable irrespective of differences in their business model.

This is an exceptionally dangerous possibility. The differences in business models logically require different levels of liability for platforms. Thus, an equitable legal framework would not hold appointment-based platforms liable for the negligence of doctors as these platforms only provide online appointment booking. It is excessive and disproportionate to hold them liable since they do not have any connection to the doctor and their negligence. On the other hand, comprehensive care platforms have packages for care and assign doctors of their own volition. Therefore, their engagement with doctors is more extensive and warrants an elevated level of liability.[83]

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79 Savita Garg, *supra* note 62.

80 *See* A. Padmavathi v. M. Vijayendra, 2016 SCC OnLine NCDRC 1760; Abhishek Ahluwalia v. Sanjay Saluja, 2014 SCC OnLine NCDRC 499; Acharya Vinoba Bhave Rural Hospital v. Samiksha, 2019 SCC OnLine NCDRC 343.

81 Savita Garg, *supra* note 62.

82 Anil Gumber, *Equity in Healthcare Utilisation and Cost of Treatment in Western India*, Vol.23, Journal of Social and Economic Development, 131 (2021); Farah Mohammed, *The Cautionary Tale of India's Private Hospitals*, January 26, 2018, available at https://daily.jstor.org/the-cautionary-tale-of-indias-private-hospitals/ (Last visited on September 23, 2022).

83 Himakini Mishra, *E – Healthcare Platforms – Navigating through Issues Sans a Proper Legal Framework,* April 4, 2022, available at https://knowlaw.in/index.php/2022/04/04/e-healthcare-platforms-navigating-through-issues-sans-a-proper-legal-framework/ (Last visited on August 27, 2022).

Given that there is variance among medical platforms, there is a need for a distinct liability framework for digital medical platforms. Part V discusses the contours of a probable new framework and argues that it is a more justified legal framework given the realities of these digital medical platforms.

V. A THREE-PART TEST FOR TORTIOUS LIABILITY OF DIGITAL MEDICAL PLATFORMS

Part IV has highlighted the inequity of applying the existing framework of tortious liability directly to digital medical platforms. Therefore, there is a need to assess liability through a new legal framework.

A. THE LEGAL BASIS FOR THE NEW FRAMEWORK

Preferably, a new framework should be proximate to existing legal principles to make a more straightforward case for its legitimacy. Therefore, the author's suggested framework is based on two existing legal principles. First, the existing legal framework for the liability of hospitals. If a medical platform's services are comparable to that provided by hospitals, they should be liable.

Second, the assessment should only consider aspects of the platform that are germane to the negligence in question. This involves distinguishing between 'pre-' consultation' and 'post-consultation' actions. Actions taken by the platform before the first consultation between the patient and doctor will be 'pre-consultation.' In contrast,any action taken afterward that directly furthers the doctor's negligent act will be considered 'post-consultation'. For example, a platform delivering medicine to the customer's doorstep in furtherance of a doctor's incorrect diagnosis would be considered a 'post-consultation' action.

This is an intelligible difference because we are attempting to hold platforms liable for the negligence of doctors. If a platform provides additional service 'post-consultation' to further the doctor's advice, the platform should be liable. By contrast, 'pre-consultation' actions that do not directly contribute to the furtherance of the negligent act should be exempt from liability analysis.

There are three possible challenges to this proposed framework. First, the platforms themselves onboard doctors,[84] and this act of onboarding itself means they enablefuture instances of negligence, which they should be liable for. Second, doctors take various actions before the consultation to ensure

[84] Entrepreneur India, *This Telemedicine Startup Will Help You Consult With Your Choice Of Doctors*, July 3, 2020, available at https://www.entrepreneur.com/en-in/news-and-trends/this-telemedicine-startup-will-help-you-consult-with-your/352787 (Last visited on October 4, 2022).

a more fruitful session.[85] Since these influence patient decisions,[86] the liability framework should account for these and the platforms that enable these actions. Third,whether negligence occurring during pre-consultation sessions is accounted for is contested, rendering the framework flawed and incomplete. Each of these three objections is addressed in turn.

The fact that platforms onboard doctors does not justify it being considered in the determination of liability for three reasons. First, this line of reasoning ultimately ends up in uniform liability for all platforms since all of them onboard doctors. This defeats the very purpose of creating a distinction between different kinds of platforms in the first place and ignores the key differences among platforms identified in Part III. Second, even if this is considered a relevant factor, this is unhelpful in determining liability. All platforms fulfil this condition, and as a result, it does not provide any intelligible condition to differentiate liability between different kinds of platforms.[87] Third, the act of onboarding doctors is not a direct contributor to the doctor behaving negligently. Merely onboarding several doctors do not constitute a sufficient connection to the negligent act of one specific doctor. On the other hand, the platform sending the negligently prescribed medicine to the patient is direct, proximate furtherance of the doctor's negligence.[88] This lack of direct connection means that a pre-consultation action like onboarding of doctors should be exempt from consideration.

The second challenge essentially states that doctors carry out various actions before a consultation. An example is when doctors require the patient to fill out a questionnaire asking questions regarding previous diagnoses, their expectations and feelings, and a record of their symptoms.[89] The patient's experience after filling up the form makes them more likely to attend a consultation,[90] making

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[85] Customers have various services available to them before their consultations in modern medicine. This may include public information about a doctor's qualifications and interpersonal skills or being asked to fill out a questionnaire before the consultation. *See* Kaya J. Peerdeman, *Pre-consultation Information About One's Physician Can Affect Trust and Treatment Outcome Expectations*, Vol. 104(2), Patient Education and Counselling, 427 (2021); Mark Richenback, *Enhancing the medical consultation with prior questions including ideas, concerns and expectations*, Vol. 6(1),Future Healthcare Journal, 181 (2019).

[86] Positive interactions before the consultation makes the patient more likely to participate in the consultation, *see*, Simon J. Attfield et. al., *Patient Information Needs: Pre and Post-consultation*, Vol. 12(2),Health Informatics Journal, 165 (2006).

[87] Entrepreneur India, *supra* note 84.

[88] An analogy in this regard can be drawn to tort law, where a doctor's act is only considered negligent if there is a proximity between the duty and the breach of duty. Similarly, the liability of platforms should only be established if there is a direct, proximate connection between the negligence and the duty not to further the negligence, *see* Amit Agarwal, *Medical Negligence: Indian Legal Perspective*, Vol. 19(1), Annals of Indian Academy of Neurology, 9 (2016).

[89] Intake Q, *Creating an Effective Pre-Appointment Questionnaire*,July 22, 2019, available at https://blog.intakeq.com/creating-an-effective-pre-appointment-questionnaire/ (Last visited on October 4, 2022).

[90] Richkenbach, *supra* note 85.

the chances of exposure to negligent conduct higher as a consequence. Thus, this should be accounted for in the liability framework.

This challenge appears significant, but it ignores the fundamental purpose of this distinction. The central concern while apportioning liability must be the negligent act of the doctor itself i.e., the negligence during the consultation. The liability of a platform should then be premised on the furtherance of the negligence itself since these post-consultation actions are the most direct enablers of the doctor's negligence. By contrast, pre-consultation sessions may be proximate to the negligent diagnosis or action, but it should not be a factor for platform liability since it is not direct furtherance of the negligent act. As they do not further the negligent act, it is unreasonable to apply them to platforms when determining their liability.

The final challenge raises concern about negligence occurring during pre-consultation actions and questions whether they are included under this framework. On cursory analysis, it is clear that this reasoning misunderstands the nature of these actions. Pre-consultation actions in such cases primarily entail requiring the patient to answer questions before the consultation,which the doctor then uses for better diagnosis, targeted questioning of the patient, etc.[91] Medical Negligence requires proving a duty of care, a breach of that duty, and harm accruing from the breach of said duty.[92] Neither of these conditions are met. First, the 'duty of care' in such a scenario is unclear. A duty usually involves the exercise of skill and care that a reasonable professional in the field would require.[93] Generally, this begins when the doctor is 'consulted' by the patient and the earliest duty is the duty to in deciding whether to undertake the case or not.[94] In this case, the setting of questions does not require any exercise of skill or care. Thus, there is no clear indication of what a 'duty of care' looks like. Second, even if there is a duty of care, there is no clarity on when there is a 'breach' of the duty. A 'breach' is usually whenever there is a violation of the current practice of the profession[95] or reasonable expectation.[96] This practice is extremely nascent and there is no existing, accepted practice under law.[97] Moreover, the 'reasonableness' of asking standard

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91 *Id*.

92 Rishab Sharma, *supra* note 73, ¶11.4.1.

93 Halsbury's Laws of England, 17-18 (Lord Hailsham of St. Marylebone, 4th ed.,1992).

94 Poonam Verma v. Ashwin Pate, (1996) 4 SCC 332, ¶19; Laxman Balkrishna Joshi v. Trimbak Bapu Godbole, AIR 1969 SC 128.

95 Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582; Crawford v. Board of Governors of Charing Cross Hospital, The Times, 1953, Dec. 8th; Daniele Bryden & Ian Storey, *Duty of Care and Medical Negligence*, Vol. 11(4),Continuing education in Anaesthesia Critical Care and Pain, 124 (2011).

96 Rishab Sharma, *supra* note 73, ¶¶11.4.8-11.4.12.

97 Mark Richenbach, *Enhancing the Medical Consultation with Prior Questions Including Ideas, Concerns and Expectations*, Vol. 6(1), Future Healthcare Journal, 181 (2019); Obioha C. Ukoumunne et. al., *A Preconsultation Web-Based Tool to Generate an Agenda for Discussion in Diabetes Outpatient Clinics to Improve Patient Outcomes (DIAT): A Feasibility Study*, Vol. 7, BMJ Open (2017).

questions cannot be clearly proven. The circumstances of a 'breach' are therefore unclear. Third, there is no 'harm' to the patient. Harm usually requires a tangible, physical impact.[98] It is a stretch to say that answering questions set for the purposes of better diagnosis can ever reach this high threshold. These questions usually ask for previous medical history and questions that require moderate self-reflection.[99] It is unforeseeable that these can ever rise to the standard of 'harm' laid down in medical negligence jurisprudence, as the exercise of filling out a questionnaire is not reasonably proximate to tangible harm.

Therefore, we can conclude that there is a reasonable ground to distinguish between pre-consultation actions and post-consultation actions and to use this to determine liability.

B. DEVELOPING A THREE-PART LIABILITY FRAMEWORK

Based on the above principles, the author proposes a holistic consideration of three factors to determine the liability of platforms. These factors are premised on the assumption that liability will vary for different platforms. If a platform furthers negligent conduct post-consultation to a larger extent, it should face greater liability.

First, the extent of services provided by the platform should be accounted for. Essentially, if a platform has additional services aside from consultation and appointment booking, it should be subjected to an elevated level of liability. For example, if a platform provides for the delivery of prescribed medicines and packages that promise a particular standard of care, then they should be liable. Such a relationship is analogous to the relationship between a doctor and a hospital, where the hospital often has pharmacies and infrastructure to supplement the doctor's prescription. This means delivery and consultation platforms and comprehensive care platforms will be more liable than appointment-based platforms and consultation-based platforms.

Additionally, it is important to scrutinise creative services on merits. For instance, Lybrate provides a forum where user queries can be answered on top of regular consultations. While it may be tempting to hold Lybrate to an elevated level of liability because of this innovation, this is unnecessary as the forum merely helps users make an informed choice and is not intended to serve as

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[98] Daya Shankar Tiwari, *Medical Negligence in India: A Critical Study*, SSRN, available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2354282 (2013); Arya Raj, *Critical Analysis of Legal Regimes for Medical Negligence in India: Need for a Comprehensive Legal Framework*,21 (LLM Dissertation, National University of Advanced Legal Studies Kochi) available at http://14.139.185.167:8080/jspui/bitstream/123456789/454/1/LM0320003-PHL.pdf (Last visited on September 12, 2022).

[99] IntakeQ, *Creating an Effective Pre-Appointment Questionnaire*,July 22, 2019, available at https://blog.intakeq.com/creating-an-effective-pre-appointment-questionnaire/ (Last visited on October 4, 2022).

medical advice. While such a mechanism may be a unique selling point, it does not that further the negligent act by the doctor. At best, it can be considered a pre-consultation reason for customers to buy in. As we have discussed previously, pre-consultation features do not contribute directly to negligence and therefore do not warrant scrutiny under liability analysis. As a result, courts should not consider pre-consultation innovative features that do not facilitate or amplify the negligence, as this can lead to the chilling and stifling of innovation. However, as explained earlier, if these innovative features happen to be post-consultation, then courts should consider it a factor for applying elevated liability. For instance, Lybrate's forum, where users can post queries, is a pre-consultation feature. Liability should only be determined on the basis of the contribution made by the platform in furtherance of the negligent diagnosis or action. In this case, a query answered before any consultation cannot reasonably be considered furtherance of any negligent diagnosis.[100]

Second, the Court should consider whether the customers are free to choose doctors. Some platforms allow customers to choose doctors, others assign doctors initially, and yet others assign different doctors if a customer is dissatisfied with the services of an ongoing one. The amount of agency provided to patients should be crucial in determining liability as it demonstrates the exercise of control. If a platform consistently chooses the doctors for the patient, then it should be held liable for the negligence of the doctor. On the flip side, if a patient has full autonomy in choosing a doctor, then the magnitude of liability should be lesser.

Finally, courts should keep one factor in mind when determining liability. Most medical platforms are start-ups that face considerably high risk. They generally run on thin margins and do not have established channels of cash flow.[101] This is exacerbated by the fact that they require high up front costs because of technological requirements.[102] The importance of these start-ups is underscored by the historical development of telemedicine discussed in Part II of this paper. Major hospital chains and the State have limited capacity to deal with novel and thorny issues cropping up in the field.[103] Therefore, it is important to promote start-up culture in the medical field and address emerging multifaceted issues.

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[100] Here, we are assuming that the advice on the forum would not be considered negligent if it led to harm on strength of the legal disclaimer provided. In case it were considered as such, the liability for that would be unrelated to our current enquiry and does not impact this analysis.

[101] FICCI HEAL, *Indian Healthcare Start-ups: An Inside look into Funding*,August 2016, available at https://smartnet.niua.org/sites/default/files/resources/ficci-heal.pdf (Last visited on July 21, 2022); EY, *Getting Future-Ready: Healthcare in India – 2022 and beyond*, February, 2022, available at https://assets.ey.com/content/dam/ey-sites/ey-com/en_in/topics/health/2022/ey-getting-future-ready-indian-life-sciences-industry-2022-and-beyond.pdf (Last visited on July 21, 2022).

[102] Dr Koppala Ravi Babu & Dr Amrutha Reddy, *Challenges Faced by Healthcare Start-Ups*, Vol. 9(8), ARCHIVES OF BUSINESS RESEARCH, 64 (2021); Debamita Chatterjee, *The Hidden Challenges for Health-Tech Startups*, July 20, 2020, available at https://www.fortuneindia.com/opinion/the-hidden-challenges-for-health-tech-startups/104659 (Last visited on August 27, 2022).

[103] Nikita Peer, *What's Tripping Healthcare in India and How Startups are Tackling It*, April 13, 2005, available at https://www.techinasia.com/whats-tripping-healthcare-india-startups-tacklin

To ensure that these start-ups are not excessively harmed by burdening costs, courts should exercise discretion in determining the existence or magnitude of liability. Such an exercise should not be arbitrary or capricious but should be reasonable. The Court can consider a several factors to determine whether leniency should be provided, including but not limited to whether the company has an otherwise unblemished record or that it has made a significant contribution to healthcare by virtue of its platforms. These factors are relevant to the determination of liability as they assist in assigning liability with greater precision.

It will be useful to elaborate on these two conditions in some detail. First, if the company has generally had a stellar record and has extensive operations, then the Court should reduce the magnitude of liability. The criteria for determining an 'unblemished record' should primarily be whether the platform has been held legally liable before. This can include previous instances of negligence by doctors or violations of platform obligations like privacy and or due diligence. Public perception of the platform should not be a consideration under this prong. The standard should be whether the company has previously violated any of its legal obligations. Companies that have generally operated in accordance with the law and have an unblemished record should be treated leniently because they are not 'repeat' violators of the law. Repeat offenders are uniformly punished more than first-time offenders in other areas of law, like criminal law.[104] The existence of liability itself serves as a deterrent for these platforms,[105] but since a distinction has to be made between different kinds of platforms, this factor can be considered relevant as it relies on a widespread canon of law.

Second, if the company's model is exceptionally innovative or it has otherwise made an immense contribution to healthcare, then the liability should be decreased to ensure that continued benefit of the same can generally accrue to users. Admittedly, whether development is 'innovative' or not will be dependent on public perception to some extent. However, it is possible to lay down clear conditions of what would constitute a valuable contribution to healthcare to reduce the possibility of wrongly crediting innovation. The Courts can rely on peer-reviewed reports and studies, case studies in which tangible benefit has accrued to customers, a new feature that has significantly expanded access to medical services, etc. to determine the importance of a contribution. It can rely on *amicus curiae* reports[106] and evidence from both sides to determine the importance of

(Last visited on August 27, 2022).

[104] C.Y. Cyrus Chu et. al., *Punishing Repeat Offenders More Severely*, Vol. 20,International Review of Law and Economics, 127 (2000).

[105] Organisation for Economic Cooperation and Development, *Best Practices for Consumer Policy: Report on the Effectiveness of Enforcement Regimes*,December 20, 2006, available at https://www.oecd.org/sti/consumer/37863861.doc (Last visited on September 23, 2022); Thomas J. Miceli &Catherine Bucci, *A Simple Theory of Increasing Penalties for Repeat Offenders* (University of Connecticut 2004, Economics Working Papers, Working Paper No. 39).

[106] Frank M. Covey Jr., *Amicus Curiae: Friend of the Court*, Vol. 9(1), De Paul Law Review, 30 (1959).

a contribution. The Court has also previously recognised the power asymmetry between parties in consumer disputes.[107] As a result, it should entertain reports from *amicus curiae* in favour of complaints who may not have the wherewithal to produce expert evidence and medical reports. The exact contours of such an assessment would be dependent on the facts of the case, but these are all factors that courts can reasonably assess.

A consideration of these factors is plainly in the public interest and the interest of justice since these start-ups help in democratising access to the market and provide a wider variety of services at a cheaper rate.[108] Several government schemes have recognised the importance of the start-up market. The Government generally promotes innovation and enforces start-up-friendly policies, and state officials generally praise the benefit of start-up culture and innovation.[109] Therefore, the Court can consider using its discretionary power when circumstances would warrant intervention.

This new alternate framework is not perfect and will lead to substantial litigation, especially in establishing crucial facts such as whether a feature is pre-consultation or post-consultation or to what extent start-up operation concerns should mitigate liability. However, it is superior at distributing liability in a fair and reasonable manner as opposed to the liability that would be enforced if the legal liability relating to hospitals was simply extended to medical platforms. Medical platforms show significantly more variance in their business models than hospitals, so applying different frameworks to assess liability is justified and reasonable. Otherwise, the liability of platforms would be far too broad and would create an unfair burden, leading to a large disincentive to innovate and legal uncertainty. This proposed framework is able to create a reasonable apportioning of liability. As noted in Part IV, there is a significant difference between different business models. By ensuring that only factors that are post-consultation are considered, this framework is able to rightly pin greater liability on comprehensive care platforms than appointment-based or delivery and consultation platforms. The liability is determined based on the extent to which the platform furthers the negligent conduct. To assess the magnitude thereafter, courts should analyse the discretion provided to customers to choose their doctors and other considerations, such as market risk, contribution to the field, etc.

[107] Balram Prasad v. Kunal Saha, (2014) 1 SCC 384.

[108] NITI Aayog, *Investment Opportunities in India's Healthcare Sector*, 2021, available at https://www.niti.gov.in/sites/default/files/2021-03/InvestmentOpportunities_HealthcareSector_0.pdf (Last visited on July 21, 2022).

[109] IANS, *Budget 2022: Indian Startups Seek Friendly Policies, Tax Incentives*, January 23, 2022, available at https://www.business-standard.com/budget/article/budget-2022-indian-startups-seek-friendly-policies-tax-incentives-122012300112_1.html (Last visited on July 21, 2022); Make in India, *Startup Ecosystem In India*,available at https://www.makeinindia.com/startup-ecosystem-india (Last visited on July 21, 2022).

VI. INTERMEDIARY LIABILITY

Other than playing the constructive role of an 'employer', these medical platforms also play the role of an intermediary. Any platform that acts as a link between two different parties is considered an intermediary. Generally, platforms are liable for the actions of their users unless it meets safe 'harbour' exemptions that are laid down in the law.[110] Therefore, an intermediary is held liable for the actions of its users if the conditions for claiming the safe harbour are not met. The Information Technology Act, 2000 '('IT Act') and the rules framed under it govern intermediary liability. §2(1)(w) of the IT Act, 2000 defines an intermediary as 'any person who on behalf of another person receives, stores or transmits that record or provides any service with respect to that record'.[111] Digital medical platforms can undoubtedly be considered intermediaries. Asintermediaries, medical platforms can be liable for the 'unlawful actions' of their users.[112] In this case, a user's actions will also include the actions of a negligent doctor. While intermediaries are usually used in the context of major e-commerce and social media platforms, the plain meaning of the term also encompasses medical platforms.

This leads to a catena of obligations. For example, the due diligence requirements under §3 of the Information Technology (Intermediary Guidelines and Digital Media Ethics Code) Rules, 2021('Digital Media Code') must be followed by digital medical platforms. Therefore, to publish a privacy policy prominently and end user agreement,[113] enforce compliance by terminating access whenever required,[114] preserve reportedly violative data for upto 180 days,[115] etc. The Consumer Protection (E-Commerce) Rules, 2020 require the appointment of a nodal officer,[116] procurement of undertakings from service providers,[117] and provide information in a clear and accessible manner.[118] In case of a violation of any of these obligations, platforms will be squarely liable as it is a violation of their obligations.

A more interesting analysis is when a platform can be held liable for the negligence of their doctors as an intermediary. Generally, §79 provides a 'safe harbour' exemption for intermediaries and exempts them from liability for 'information' that is made 'available' by them in case §§79(2) and 79(3) are adhered to. Section 79(2)(a) states that intermediaries are only exempt if the "function […] is limited to providing access to a communication system over which information

[110] The Information Technology Act, 2000, §79.

[111] *Id.*, §2(1)(w).

[112] The Information Technology (Intermediary Guidelines and Digital Media Ethics Code) Rules, 2021, R. 3(1)(d).

[113] *Id.*,R. 3(1)(a).

[114] *Id.*,R. 3(1)(c).

[115] *Id.*,R.3(1)(g).

[116] The Consumer Protection (E-Commerce) Rules, 2020, R. 4(1)(a).

[117] *Id.*,R. 5(2).

[118] *Id.*,R. 5(3)(a), 7.

made available by third parties is transmitted".[119] §79(2)(b) further states that such an exemption only applies if the intermediary does not initiate the transmission, select the receiver of said transmission or modify its content.[120]

A textual interpretation of these provisions leads to an inference of no liability in any case for medical platforms. The platform's role is limited to a communication system as the actual transmission of information occurs bilaterally between the patient and the doctor. Moreover, the customer initiates the transmission and the content of the advice is between the doctor and patient that is not modified by the platform.[121] The platform does not 'select' the receiver of the information since that decision is being made by the doctor while making their diagnosis.[122] Notably, all medical platforms, irrespective of the differences in their business model, fulfil all these conditions. This is even true for creative platforms like Lybrate, as a separate forum only provides a platform to enable interaction – it does not fulfil the conditions relating to intermediary liability as the doctor chooses the recipient and the forum is limited to behaving like a communication system, factors which are not sufficient to establish liability

Courts may be unwilling to apply a purely textual perspective since it provides an exemption to all medical platforms. The tendency of courts to inflate liability has been highlighted in Part IV, where hospitals were essentially held absolutely liable for medical negligence under *Savita Garg's* perception-based test. Courts may employ similar tactics in the case of digital medical platforms. It may opt to expansively interpret certain provisions in order to ensure that at least comprehensive care platforms face liability based on the lack of passivity of their operation. Specifically, §79(2)(b) can be widely interpreted to mean that by setting up the consultation or providing ancillary facilities like delivery of medicines, platforms initiate the 'transmission'. §79(2)(a) can be interpreted to mean that by providing a suite of services, platforms are going beyond providing access to a communication 'system' and therefore should not be able to claim the benefit of §79(1).

These arguments do not pass legal muster as it considers factors that are irrelevant to determining whether there is a liability. §79(2)(a) has to be read harmoniously with §79(2)(b) and the thrust of the provision has to be that medical platforms have a very limited role in the commissioning of the unlawful act. An isolated reading of §79(2)(a) would result in all activities of social media platforms being irrelevant since their purpose would no longer be "limited to providing access to a communication system".An analysis of whether §79(2) is violated should require a holistic assessment of the functioning of the platform and not an isolated

[119] The Information Technology Act, 2000, §79(2)(a).

[120] *Id*.,§79(2)(b).

[121] Amazon Seller Services (P) Ltd. v. Amway India Enterprises (P) Ltd., 2020 SCC OnLine Del 454, ¶¶121, 125-126.

[122] This is similar to the argument Amazon made in Amway India Enterprises (P) Ltd., see, *Id*.

consideration of additional services provided by the platform. This conclusion is bolstered by the Delhi High Court's judgement in *Amazon Seller Services (P) Ltd.* v. *Amway India Enterprises (P) Ltd.,* which noted that intermediaries that only provide access has to fulfil §79(2)(a), while those provide additional access have to comply §79(2)(b).[123] The Court further noted that §79 did not bar intermediaries from having value-added services.[124] Moreover, the Court specifically refuted the idea that Amazon was behaving as an 'active' seller,[125] ruling that §79 did not differentiate between 'passive' and 'active' sellers and that being an 'active' intermediary did not invite additional liability.[126] This is despite the fact that Amazon was considered a massive 'facilitator' that provides 'warehousing, logistical support, packaging, delivery services, payment services, collection gateways, etc'.[127] While this analysis was made in the context of e-commerce, it has application in the case of medical platforms. Medical platforms provide additional services outside of the consultation and can be considered a similar 'facilitator'. Since there is no difference between passive and active intermediaries per settled law, all medical platforms should be able to claim intermediary protection. This would circumvent the pre-consultation and post-consultation distinction proposed in Part V, as even comprehensive care platforms, analogous to active intermediaries, would be protected.

Another issue to consider is when intermediaries can be said to have 'actual knowledge' according to §79(3)(b). Generally, intermediaries have been granted exemptions with respect to content uploaded by users.[128] However, there are two different perspectives on when responsibility accrues. The first is embodied by the Supreme Court's decision in *Shreya Singhal* v. *Union of India* ('Shreya Singhal').[129] In reading down §79, the Court held that 'actual' knowledge only entails information received from the Government or the judiciary.[130] To require that platforms filter all requests is unrealistic considering the volume of transactions.[131] The contrary view believes that platforms have 'knowledge' if unlawful content has been reported. In *Myspace Inc.* v. *Super Cassettes India Ltd.* ('MySpace'), the Delhi High Court ruled that 'actual' knowledge means 'specific' knowledge – i.e. if the unlawful content is reported to the platform, then they should be presumed to have 'actual knowledge'.[132] This 'specific knowledge' was reiterated as an additional circumstance where knowledge is presumed in *Kent RO Ltd* v. *Amit Kotak* ('Kent').[133] The Court in MySpacedistinguished Shreya Singhalby stating

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[123] *Id.*, ¶121.
[124] *Id.*, ¶125.
[125] *Id.*, ¶18.
[126] *Id.*, ¶119.
[127] *Id.*, ¶53.
[128] Christian Louboutin Sas v. Nakul Bajaj, 2018 SCC OnLine Del 12215, ¶54.
[129] Shreya Singhal v. Union of India, (2015) 5 SCC 1.
[130] *Id.*, ¶119.
[131] *Id.*,¶17.
[132] Myspace Inc. v. Super Cassettes India Ltd.,2016 SCC OnLine Del 6382, ¶¶36-38.
[133] Kent RO Ltd.v. Amit Kotak, 2017 SCC OnLine Del 7201, ¶38.

that those observations were made in the context of Article 19(2) of the Indian Constitution.[134]

The author believes that the decisions in MySpaceand Kent are accurate from a legal perspective and also apply to medical platforms. Shreya Singhal was assessing the constitutionality of §79. While it did add two conditions and add the qualifier' only', the language of the Court did not foreclose further developments. This is especially considering that the Court would not have heard exhaustive arguments about the exact bounds of liability to be provided to intermediaries. Subsequent decisions of High Courts in MySpaceand *Kent* have been exposed to more complete argumentation that has allowed a more reasoned decision.

Irrespective of the merits of such a policy, it is established law and obligations will be assessed under the same. Additionally, these decisions should extend to medical platforms even though they were exclusively made in the context of e-commerce. This is because the textual legal requirements of the IT Act are similar and there has been no thorough discussion of intermediary liability in the context of medical platforms. In any case, these are more proximate to their obligations than the test of Shreya Singhal, which was dealing with a narrow constitutional challenge. In the absence of further clarity, the aforementioned principles should directly apply to medical platforms.

Under these principles, digital medical platforms are broadly exempt from intermediary liability. This is true even for the heightened 'specific knowledge' standard, where information does not need to be from the judiciary or Government but can also be user-reported. All cases unanimously agree that intermediaries should not develop mechanisms to filter content even if they are reported. In this case, medical platforms are not liable for the negligence of doctors in any case. Even the 36-hour requirement in the Digital Media Code does not apply to medical platforms since it only mandates take downs if the 'information is hosted, stored or published'.[135] There is no realistic situation where these platforms continue to host this information as typical social media or e-commerce platforms do. This is because social media platforms like Facebook and Twitter are liable only for posts by users that violate Indian law.[136] Digital medical platforms do not publicly reveal medical records that they are required to store by law and thus they are not liable under the Digital Media Code since something that is not publicly displayed cannot be subject to a takedown order.[137] The fact that these platforms do not face intermediary liability is a net positive outcome as it frees platforms from burdensome intermediary liability that often leads to significant legal uncer-

[134] Myspace Inc. v. Super Cassettes India Ltd., 2016 SCC OnLine Del 6382, ¶50.

[135] The Information Technology (Intermediary Guidelines and Digital Media Ethics Code) Rules, 2021, R. 3(1)(d).

[136] Law Commission of Ontario, *Internet Intermediary Liability in Defamation: Proposals For Statutory Reform*, July, 2017, available at http://www.lco-cdo.org/wp-content/uploads/2017/07/DIA-Commissioned-Paper-Laidlaw-and-Young.pdf (Last visited on 4 October, 2022).

[137] The Information Technology Act, 2000, §69A(1).

tainty. There is no justification for expanding intermediary liability in scope either since they will still be liable in tort. Tort can be considered a better alternative than intermediary liability for two reasons. First, both of these have provisions for damages and it is unclear why an additional area of law is required if the outcome is the same. Second, any intermediary rule is likely to come under constitutional challenge[138] which may make litigation under it cumbersome and uncertain.

However, there are doubts over whether the legal framework on intermediary liability will remain as accommodative towards digital medical platforms. Given the continuous public criticism of broad intermediary exemptions and the tightening of liability,[139] it is likely that a new framework to hold such platforms liable will be enacted in the future. However, speculating on the nature of such regulation is an exercise in futility due to the plurality of considerations[140] involved in determining the liability of intermediaries. What remains certain is that the current law of intermediary liability does not lead to any liability of these platforms and that such a framework is justified.

VII. CONCLUSION

An analysis of the existing law demonstrates that the current legal framework relating to emerging digital platforms is fairly underdeveloped and shrouded with legal uncertainty. This is a state of affairs that should be swiftly addressed and clarified since these platforms already make a considerable contribution to the provision of medical services globally.

The TPG already delineates the liability of these platforms with respect to obligations like privacy and due diligence with precision. One of the major remaining avenues of litigation is likely to be cases regarding the negligence of doctors on a particular platform. Currently, there is a variance in the liability that digital medical platforms are exposed to. Under tort law, these platforms are likely to be absolutely liable for the negligence of their doctors. On the other hand, these platforms are likely to face little to no liability in the capacity of an intermediary.

This paper suggests an alternative to the current liability under tort law by proposing a three-part framework to assess the liability of these platforms.

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[138] The current Digital Media Code is under challenge in multiple forums, *see* Mehal Jain, *IT Rules 2021: Supreme Court To Hear Centre's Challenge Against Interim Orders Of High Courts On July 19*,May 19, 2022, available at https://www.livelaw.in/top-stories/supreme-court-it-rules-cable-tv-rules-hate-speech-hate-crimes-199585 (Last visited on September 12, 2022).

[139] Christoph Schman and Haley Pedersen, *Platform Liability Trends Around the Globe: From Safe Harbors to Increased Responsibility*,May 19, 2022, available at https://www.eff.org/deeplinks/2022/05/platform-liability-trends-around-globe-safe-harbors-increased-responsibility (Last visited on September 12, 2022).

[140] Vasudev Devadasan, *Intermediary Guidelines and the Digital Public Sphere: Balancing the Scales*,June 4, 2021, available at https://indconlawphil.wordpress.com/2021/06/04/intermediary-guidelines-and-the-digital-public-sphere-balancing-the-scales/ (Last visited on September 12, 2022).

First, the features of the platform should be considered. If there are post-consultation features, then only these should be considered in the determination of liability. Creative services should not be penalised if they are not post-consultation, as this may unjustly prevent innovation and development in the sector. Second, whether customers can choose their doctor should be considered in determining liability. Assigning a doctor means greater facilitation of negligent conduct than permitting customers to choose. Finally, the fact that these firms are overwhelmingly start-ups means that courts should carefully assess the extent of liability and limit the liability whenever appropriate. This framework is a comprehensive, functional alternative to the absolute liability currently attributed under the perception-based test.

In the field of intermediary liability, the current framework leads to no liability. While this is a fair outcome for digital medical platforms and should be preserved, there is no certainty about what future regulation will entail. In order to ensure confidence in the market and greater certainty, there is an urgency to clarify the applicable legal standards.