2025:KER:90417

"C.R."

IN THE HIGH COURT OF KERALA AT ERNAKULAM

PRESENT

THE HONOURABLE MR. JUSTICE SUSHRUT ARVIND DHARMADHIKARI

&

THE HONOURABLE MR. JUSTICE SYAM KUMAR V.M.

WEDNESDAY, THE 26TH DAY OF NOVEMBER 2025 / 5TH AGRAHAYANA, 1947

WA NO. 1621 OF 2025

AGAINST THE JUDGMENT DATED 23.06.2025 IN WP(C) NO.1365 OF 2019 OF HIGH COURT OF KERALA

APPELLANT/S:

1 KERALA PRIVATE HOSPITALS ASSOCIATION HAVING ITS REGISTERED OFFICE AT KPHA HEAD QUARTERS,
ASHIR BHAVAN ROAD, KACHERIPPADY, ERNAKULAM, KOCHI-682018, REPRESENTED BY ITS PRESIDENT, HUSSAIN KOYA THANGAL.

2 HUSSAIN KOYA THANGAL,
AGED 54 YEARS
CHAIRMAN, NIMS HOSPITAL, WANDOOR, PB NO.17, P.O., VANIYAMBALAM, MALAPPURAM DISTRICT, KERALA-679339.

BY ADV SRI V.V. ASOKAN (SR); SRI.K. ANAND

RESPONDENT/S:

1 STATE OF KERALA,
REPRESENTED BY THE PRINCIPAL SECRETARY TO GOVERNMENT, HEALTH AND FAMILY WELFARE DEPT. GOVERNMENT SECRETARIAT, TRIVANDRUM-695001.

2 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), KASARGOD-671121.

3 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), KANNUR-670002.

4 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), KOZHIKODE-673020.

5 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), KALPETTA, WAYANAD-673121.

6 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), PALAKKAD-678001.

7 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), MALAPPURAM-676505.

8 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), TRICHUR-680003.

9 THE DISTRICT REGISTERING AUTHORITY
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), ERNAKULAM-682030.

10 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), ALLEPPEY-688001.

11 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), KOTTAYAM-686002.

12 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), IDUKKI-685603.

13 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), PATHANAMTHITTA-689645.

14 THE DISTRICT REGISTERING AUTHORITY,
(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), KOLLAM-691013.

15 THE DISTRICT REGISTERING AUTHORITY,

(REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.(HEALTH), TRIVANDRUM-995013., PIN - 695013

16 ADDL.R16. P.C. RAMACHANDRAN NAIR,
AGED 64, S/O.CHANDRASEKHARAN PILLAI, LEGAL CELL PRESIDENT, HUMAN RIGHTS PROTECTION MISSION MAJOR ROAD VYITTILA, COCHIN. IS IMPLEADED AS PER ORDER DATED 25/6/19 IN I.A.NO.1/2019 IN WPC NO.1365/19., PIN - 682019

17 ADDL.R17 SASIKUMAR PALAKALAM,
AGED 66 YEARS, PALAKALAM HOUSE, ITHITHANAM P.O., CHANGANACHERRY, KOTTAYAM. PIN -686535

18 ADDL.R18 JALY MALOOR,
AGED 61 YEARS, MALOOR HOUSE, PULLAD. P.O., PIN -689548

19 ADDL.R19 AL SHABEER RAHMAN,
AGED 49 YEARS, TC48/217, BILAL NAGAR, AMBALATHARA, POONTHURA P.O., MUTTATHARA, PIN -695026

20 ADDL.R20 SEBASTIAN K.V.,
AGED 54 YEARS, KUNNINE HOUSE, NATIONAL NAGAR, SHIRIBAGILU PO/ VILLAGE, ULIYATHADUKA, PIN - 671124

21 ADDL.R21 SINU L.R.,
AGED 45, SANTHI NAGAR 219 A, KUZHIVILA PUTHAN VEEDU, AYATHIL, PATTATHANAM P.O., KOLLAM, PIN - 691021. [ADDL.R17 TO R21 ARE IMPLEADED AS PER ORDER DATED 30.01.2024 IN I.A-1/2024 IN WP(C) 1365/2019]

BY ADVS. GOVERNMENT PLEADER SHRI.N. MANOJ KUMAR, STATE ATTORNEY SHRI.S.KANNAN, SENIOR G.P.; SRI AJITH JOY

THIS WRIT APPEAL HAVING RESERVED ON 25.10.2025, ALONG WITH WA.1806/2025, THE COURT ON 26.11.2025 DELIVERED THE FOLLOWING:

IN THE HIGH COURT OF KERALA AT ERNAKULAM

PRESENT

THE HONOURABLE MR. JUSTICE SUSHRUT ARVIND DHARMADHIKARI

&

THE HONOURABLE MR. JUSTICE SYAM KUMAR V.M.

WEDNESDAY, THE 26TH DAY OF NOVEMBER 2025 / 5TH AGRAHAYANA, 1947

WA NO. 1806 OF 2025

AGAINST THE JUDGMENT DATED 23.06.2025 IN WP(C) NO.29353 OF 2019 OF HIGH COURT OF KERALA

APPELLANT/S:

1 INDIAN MEDICAL ASSOCIATION
KERALA STATE BRANCH, INDIAN MEDICAL ASSOCIATION STATE HEADQUARTERS, ANAYARA P.O., THIRUVANANTHAPURAM - 695 029, REPRESENTED BY ITS SECRETARY - DR. SULPHI N.

2 HOSPITAL BOARD OF INDIA,
KERALA CHAPTER, INDIA MEDICAL ASSOCIATION STATE HEADQUARTERS, ANAYARA P.O., THIRUVANANTHAPURAM - 695 029 REPRESENTED BY ITS SECRETARY - DR. DEEPAK JOSEPH CHAZHIKKADAN

BY ADVS. SMT.T.K.SREEKALA
SMT.S.PARVATHI
SMT.NIKITHA SUSAN PAULSON
SMT.UTHARA ASOKAN
SHRI.K.I. MAYANKUTTY MATHER (SR.)

RESPONDENT/S:

1 STATE OF KERALA, REPRESENTED BY PRINCIPAL SECRETARY TO GOVERNMENT, HEALTH AND FAMILY WELFARE DEPARTMENT, THIRUVANANTHAPURAM G.P.O., THIRUVANANTHAPURAM - 695 001

2 SECRETARY TO GOVERNMENT
DEPARTMENT OF HOME AFFAIRS, SECRETARIAT, THIRUVANANTHAPURAM G.P.O., THIRUVANANTHAPURAM - 695 001

3 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), KASARGODE P.O., KASARGOD - 671 121

4 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), KANNUR P.O., KANNUR - 670 002

5 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), KOZHIKODE P.O., KOZHIKODE - 673 020

6 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), KALPETTA P.O., WAYANAD - 673 121

7 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), PALAKKAD P.O., PALAKKAD - 678 001

8 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), MALAPPURAM.P.O., MALAPPURAM - 676 505

9 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), TRICHUR P.O., TRICHUR - 680 003

10 THE DISTRICT REGISTERINT AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), ERNAKULAM P.O., ERNAKULAM - 682 030

11 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), ALLEPPEY P.O., ALLEPPEY - 688 001

12 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), KOTTAYAM P.O., KOTTAYAM - 686 002

13 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O.

(HEALTH), IDUKKI P.O., IDUKKI - 685 603

14 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), PATHANAMTHITTA P.O., PATHANAMTHITTA - 689 645

15 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), CHADAYAMANGALAM P.O., CHATHAYAMANGALAM - 691 013

16 THE DISTRICT REGISTERING AUTHORITY
REPRESENTED BY THE DISTRICT MEDICAL OFFICER (HEALTH), OFFICE OF THE D.M.O. (HEALTH), THIRUVANANTHAPURAM G.P.O., TRIVANDRUM - 695 013

BY ADVS. GOVERNMENT PLEADER SHRI.N. MANOJ KUMAR, STATE ATTORNEY SHRI.S.KANNAN, SENIOR G.P.

THIS WRIT APPEAL RESERVED ON 25.10.2025, ALONG WITH WA.1621/2025, THE COURT ON 26.11.2025 DELIVERED THE FOLLOWING:

JUDGMENT

"C.R."

[WA Nos.1621/2025, 1806/2025]

Sushrut Arvind Dharmadhikari, J.

The aforementioned two intra-Court appeals challenge the final judgment dated 23.06.2025, passed in W.P.(C) No.1365/2019 and W.P.(C) No.29353/2019. In the impugned judgment, the learned Single Judge, after a reasoned analysis, rejected the appellants' challenge to various provisions of the Kerala Clinical Establishments (Registration and Regulation) Act, 2018 (hereinafter referred to as the "Act") and the Kerala Clinical Establishments (Registration and Regulation) Rules, 2018 made thereunder (hereinafter referred to as the "Rules") as neither unconstitutional nor arbitrary on multiple grounds, and ultimately dismissed the writ petitions by a common judgment.

Facts:

2. The facts adumbrated herein have been briefly borrowed from W.A. No.1621/2025 and W.P.(C) No.1365/2019.

3. The first appellant is the registered association of the managements of private hospitals in the State of Kerala. The second appellant is one of the members of the first appellant. The writ petition challenges certain provisions of the Act and the Rules framed thereunder. The principal grounds of challenge raised by the appellants in the writ petition are:

(i) the mandatory requirement to furnish exhaustive details of all employees, including doctors and paramedical staff; and

(ii) the obligation to publish the list of fees to be charged for each item of treatment and for "*packages*".

Appellants' contentions:

4. The appellants contended that these provisions and requirements are arbitrary, vague, impractical, and *ultra vires* the parent legislation, lacking adequate statutory safeguards or definitions.

5. It was argued that Sections 39(2) and 39(3), which mandate clinical establishments to display "*fee rates*" and "*package rates*" for various services, are inherently vague and undefined. The lack of clarity

regarding what constitutes a "*type of service*" or a "*package*" makes compliance practically impossible and invites arbitrary enforcement, thereby violating the fundamental rights guaranteed under Articles 14 and 19(1)(g) of the Constitution of India.

5.1 For every "*type of service*", the components involved vary from patient to patient and from doctor to doctor. The management of each patient may follow different approaches as treatment progresses. Nothing can be predicted with certainty, especially in critical cases. Therefore, it is impossible to notify rates in advance for the various types of services. Further, it is argued that what is intended by "*packages*" is not clear. Treatments often involve a combination of various procedures and services, which further complicates compliance with the requirement to publish uniform "*package*" rates. These issues were not addressed by the learned Single Judge in the impugned judgment.

5.2 It is the argument of the learned Counsel for the appellants that, so far as Section 47 of the Act is concerned, it deals with the treatment of victims in emergencies and uses the expression "***shall***."

This provision imposes an important obligation on clinical establishments. However, its blanket application is impractical, as many smaller institutions lack the requisite staff, infrastructure, and logistical capacity to arrange such safe transport. The requirement for "safe transport" must be interpreted contextually, taking into account the limitations of smaller clinical establishments. The learned Single Judge failed to consider this legitimate operational concern raised by the appellants. The Schedule itself categorizes hospitals (which are also clinical establishments) based on their bed strength, for the purpose of determining application fees. However, as per Section 13 of the Act, such categorization is impermissible. Therefore, the Government must prescribe the categories and the standards required for each category; this cannot be done through a Schedule in the Rules.

5.3 So far as the exhibition of exhaustive rate lists is concerned, it is not feasible in the case of MEDISEP and CGHS package rate lists, which include more than 1,920 and 1,859 treatment and surgical procedures, particularly given the dynamic nature of medical care and

the variability in patient-specific treatment protocols. Therefore, the requirement to publish such lists under Sections 39(2) and 39(3) of the Act is arbitrary and impractical. As for Clause 11 of Form 2A, it pertains to physical facilities, while Clause 12 requires disclosure of employee details. There is no provision in the Act or the Rules that empowers the Government, the Council, or the District Authorities to request such details. Large hospitals employ over 2,000 individuals, including floating staff and temporary personnel, whose roles and presence may fluctuate frequently, making accurate and continuous disclosure not only burdensome but also impracticable.

5.4 Furthermore, the details pertaining to doctors and other staff are confidential and form part of the internal administrative framework of the institution. Publishing such sensitive information on a public platform could lead to its misuse by competing institutions, which might exploit the data for poaching or other unfair practices, thereby adversely affecting the operational integrity and competitive standing of the hospital. Further, it is argued that the pro forma prescribed for

provisional registration requires information not contemplated under the Act or the Rules. Section 16(3) of the Act clearly stipulates that all establishments in existence as of 01.01.2019 shall be granted provisional registration. This mandate cannot be diluted through administrative formats imposing additional requirements. Therefore, imposing preconditions for provisional registration exceeds the scope of statutory authority and is contrary to the express provisions of the Act. Consequently, the entire exercise carried out for the purpose of provisional registration is invalid in the eyes of law.

5.5 The learned Single Judge did not address the issue of temporary or open registration for existing institutions. This critical matter directly affects institutions that were operational as of 01.01.2019. The appellants had raised their grievances with the Government regarding the registration process, but no effective action was taken. With no alternative remedy available, the appellants approached this Court; however, the learned Single Judge failed to adjudicate on this aspect. Section 16(2) of the Act, which contemplates

penalties for operating without registration, is arbitrary and unworkable in the absence of any prescribed timeline under the Act or the Rules for submitting an application for provisional registration. This ambiguity allows for arbitrary enforcement and the imposition of penal consequences without clear legal standards.

5.6 The final submission made by the learned Counsel for the appellants is that the learned Single Judge failed to substantively address the constitutional and legal issues raised, particularly the vagueness and arbitrariness of Sections 16(2), 39(2), and 39(3) of the Act. By merely granting the appellants liberty to raise practical difficulties before the Government for consideration and adoption of remedial measures, the Court refused to adjudicate the validity of the impugned provisions. This approach left it to the Government's discretion to address the difficulties faced by hospitals, despite the lack of enforceable timelines or standards, thereby undermining the appellants' fundamental rights under Articles 14, 19(1)(g), and 21 of the Constitution of India. Being aggrieved, the present writ appeal has been filed.

Government's submission:

6. *Per contra*, the learned State Attorney vehemently opposed the prayer and submitted that the learned Single Judge had rightly dismissed the writ petition, as the issue involved in this case concerns the public at large.

7. The Act is intended to provide for the registration and regulation of clinical establishments rendering services in recognized systems of medicine in the State, and for matters connected therewith or incidental thereto, with a view to prescribing standards of facilities and services that may be provided by them for the improvement of public health.

1. *Public Health and Safety*:

The primary objective of the Clinical Establishments Act is to safeguard public health and ensure patient safety. The regulation of clinical establishments aims to minimize medical errors, enforce minimum standards, and ensure that healthcare facilities are equipped to manage emergencies effectively. High standards of care protect not only

individual patients but also the community at large.

2. *Rights of Patients*:

A strong regulatory framework safeguards the rights of patients by ensuring they receive adequate information about their care, treatment options, potential risks, and the approximate costs of their treatment. The Act empowers patients to make informed choices while holding healthcare providers accountable for their practices.

3. *Ethical Standards*:

The Act is intended to promote ethical standards in clinical practice, ensuring that patient rights are protected and that treatments are carried out based on informed consent and clinical necessity.

4. *Transparency and Accountability*:

Establishing a regulatory framework promotes transparency within clinical establishments. It holds these institutions accountable for their practices and outcomes, thereby fostering trust between patients and healthcare providers.

5. *Monitoring and Compliance*:

Regulation allows for the regular monitoring and evaluation of clinical establishments. Compliance with these regulations can be assessed through inspections, ensuring that facilities adhere to the required health and safety standards.

6. *Crisis Preparedness*:

The Act ensures that clinical establishments are better prepared and equipped for public health emergencies and disasters by mandating specific protocols and preparedness plans. The Regulations ensure that hospitals are equipped, both physically and operationally, to manage emergency situations

7. *Patient Safety*:

Proper regulation can reduce the occurrence of medical errors, improve overall health outcomes, and protect patients from malpractice. Regulations can establish protocols for emergency procedures and patient management.

8. *Quality Assurance*:

Regulation ensures that clinical establishments maintain a consistent

and high standard of care.

9. *Consistency Across the Sector*:

Regulation creates a level playing field within the healthcare sector, ensuring that all clinical establishments operate under the same standards and guidelines. Such consistency helps patients make informed decisions regarding their treatment.

7.1 The legislation is founded on the necessity of ensuring public health, safety, and quality of care. Balancing the autonomy of hospital management with necessary regulations is essential for an effective healthcare system that prioritizes the well-being of patients and the integrity of medical practice. This legislation is enacted in the larger public interest, ultimately serving to protect and empower patients without affecting the legal rights of clinical establishments.

8. The learned State Attorney further contended that the Act is referable to Entry 6 of List II of the Seventh Schedule read with Article 246 of the Constitution of India, which provides for the legislative competency of the State. Article 47 of Part IV of the Constitution of India

(Directive Principles of State Policy) casts a duty on the State to raise the standard of living of the people and to improve public health. The Act has been promulgated to provide for the registration and regulation of all public and private clinical establishments. It is a social welfare legislation aimed at prescribing minimum standards of facilities and services rendered by clinical establishments, so as to maintain a minimum standard of medical care. By invoking Section 52 of the Act, the Rules have been framed as per the Government Order dated 26.12.2018, which was published in the Gazette on 26.12.2018.

Provisions of Act and Government Orders:

9. The Act was initially implemented in the State with effect from 01.01.2019 with respect to recognized systems of modern medicine. The Act, with respect to other systems of medicine, was implemented with effect from 13.06.2019 [Exhibit R1(a)]. Therefore, the provisions of the Act were implemented in a phased manner. By virtue of Section 3 of the Act, the State Council was established as per the Government Order dated 31.12.2018. The role of the Council is to compile, maintain, and

publish a State Register for Clinical Establishments, as provided under Section 12 of the Act.

9.1 The State Government, by invoking Section 13(1) read with Section 52 of the Act, through Government Order dated 11.03.2023, duly published in the Official Gazette on 20.04.2023, drafted the Kerala Clinical Establishments (Minimum Standards for Modern Medicines, Diagnostic Centers, Medical Laboratories, Dental) Rules of 2023 [Exhibit R1(b)]. The Rules of 2023 prescribe the minimum standards to be maintained by clinical establishments in the State. To maintain clinical standards, hospitals are classified as follows:

(a) Primary Health Care Institutions, which have been further classified as clinics, polyclinics, day surgery centers, and hospitals;

(b) Secondary Health Care Institutions;

(c) Tertiary Health Care Institutions.

9.2 As per Section 16 of the Act, no person shall run a clinical establishment without registration. Section 17 provides for registration, which is valid for four years and six months, as per the Government

Order dated 14.11.2021. Section 19 of the Act provides for permanent registration, which is valid for three years.

9.3 As per Section 34 of the Act, the Appellate Authority has been constituted by Government Order dated 16.01.2019 [Exhibit R1(c)]. As per the Order dated 08.07.2022 [Exhibit R1(d)], a subcommittee was constituted by the Council for formulating lifesaving services, with the office-bearers of IMA and KPHA included as subject experts.

9.4 Invoking the powers conferred on the Secretary of the Council under Section 47(2) of the Act, the lifesaving services to be provided by each category of clinical establishment have been notified. A notification dated 02.05.2023 [Exhibit R1(e)] was issued by the Secretary of the Kerala State Council for Clinical Establishments, Thiruvananthapuram, wherein healthcare institutions are categorized as primary healthcare institutions, secondary healthcare institutions, and tertiary healthcare institutions.

9.5 As seen in the notification, clinics are required only to provide the contact details of an ambulance and the nearest taxi stand.

In the case of polyclinics, day surgery centers, and hospitals, ambulance services must be made available, which may also be outsourced. In tertiary healthcare institutions, critical patients are to be transported under the supervision of trained and qualified staff using appropriate ICU ambulance services.

9.6 By invoking Section 19(12) of the Act, Independent Assessors have been appointed as per the notification dated 10.05.2023 [Exhibit R1(f)], who shall inspect and examine whether the registered clinical establishments adhere to the prescribed standards as notified. A Grievance Redressal Committee has been constituted as per Government Order dated 15.03.2023 [Exhibit R1(g)], as contemplated under Section 36 of the Act.

9.7 Section 39(2) contemplates that the various services provided by clinical establishments and their fee rates must be published. The Act and the Rules do not prescribe any uniform standard rates for specific treatments or services. Clinical establishments are required to display the rates/fees charged by them, which is necessary in public interest, so

that patients can make informed decisions when availing services or treatments from a clinical establishment. This requirement ensures transparency and fairness.

Presumption of Constitutionality:

10. The learned State Attorney submitted that there is always a presumption in favour of the constitutionality of a statute. The presumption in favour of the validity of the statute has not been rebutted by the appellants. For this purpose, the learned State Attorney places reliance on:

(i) ***Nagaland Senior Government Employees Welfare Association v. State of Nagaland***[1], paragraphs 41 and 42.

> "41. We find ourselves in agreement with the aforesaid view of the High Court. It cannot be overlooked that the whole idea behind the impugned provision is to create opportunities for employment and check unemployment. The impugned provision is aimed to combat unrest amongst educated unemployed youth and to ensure that they do not join underground movement. As observed by this Court in *State of Maharashtra v. Chandrabhan AIR 1983 SC 803*, public employment opportunity is national

[1] (2010) 7 SCC 643

wealth in which all citizens are equally entitled to share. In our opinion the legislation of the kind we are concerned with must be regarded as establishing the government policy for retirement from public employment based on age or length of service to achieve a legitimate aim in public interest to permit better access to employment to large number of educated youth in the State and for the purpose of curbing the unemployment. The legitimacy of such an aim of public interest cannot be reasonably called into question. In any case, the impugned provision founded on peculiar considerations of the State does not appear to be unreasonable nor it smacks of any arbitrariness. Moreover, the impugned provision is in consonance with the legal position highlighted by this Court in *Yeshwant Singh Kothari* and *Nagaraj* and as stated in *Nagaraj*, that while testing the validity of policy issues like the age of retirement, it is not proper to put the conflicting claims in a sensitive judicial scale and decide the issue by finding out which way the balance tilts. Such an exercise is within the domain of the Legislature. By the impugned provision, the Legislature, after balancing the competing interest of different groups, has sought to open avenues of employment for a large number of educated youth in the State. From the material placed on record it cannot be said that impugned provision has been enacted without any data and consideration of broad aspects of the question.

42. We are not impressed by the argument of the appellants that impugned provision is arbitrary not only from the point of view of the employees as a whole but also from the point of view of public interest since the public at large shall be deprived of the benefit of the mature

experience of the senior government employees. If the State Government felt that it was not fair to deny the large number of educated youth in the State an opportunity of public employment because of existing provisions of retirement from public employment and accordingly decided to have the impugned provision enacted through the legislative process, we are afraid, in the guise of mature experience, such provision may not be held to against public interest and arbitrary."

(ii) ***R. K. Garg v. Union of India***[2], paragraphs 7 and 8:

"7. Now once it is accepted that the President has legislative power under Article 123 to promulgate an ordinance and this legislative power is co-extensive with the power of the Parliament to make laws, it is difficult to see how any limitation can be read into this legislative power of the President so as to make it ineffective to alter or amend tax laws. If Parliament can by enacting legislation alter or amend tax laws, equally can the President do so by issuing an Ordinance under Article 123. There have been, in fact, numerous instances where the President has issued an Ordinance replacing with retrospective effect a tax law declared void by the High Court or this Court. Even offences have been created by Ordinance issued by the President under Article 123 and such offences committed during the life of the Ordinance have been held to be punishable despite the expiry of the Ordinance. Vide: State of Punjab v. Mohar Singh. It may also be noted that Clause (2) of Article 123 provides in terms clear and explicit that an Ordinance promulgated under that

[2] (1981) (4) SCC 675

Article shall have the same force and effect as an Act of Parliament. That there is no qualitative difference between an ordinance issued by the President and an Act passed by Parliament is also emphasized by Clause (2) of Article 123 which provides that any reference in the Constitution to Acts or laws made by Parliament shall be construed as including a reference to an Ordinance made by the President. We do not therefore think there is any substance in the contention of the petitioner that the President has no power under Article 123 to issue an Ordinance amending or altering the tax laws and that the Ordinance was therefore outside the legislative power of the President under that Article.

8. That takes us to the principal question arising in the writ petitions namely, whether the provisions of the Act are violative of Article 14 of the Constitution. The true scope and ambit of Article 14 has been the subject matter of discussion in numerous decisions of this Court and the propositions applicable to cases arising under that Article have been repeated so many times during the last thirty years that they now sound platitudinous. The latest and most complete exposition of the propositions relating to the applicability of Article 14 as emerging from "the avalanche of cases which have flooded this Court" since the commencement of the Constitution is to be found in the Judgment of one of us (Chandrachud, J. as he then was) in Re: Special Courts Bill It not only contains a lucid statement of the propositions arising under Article 14, but being a decision given by a Bench of seven Judges of this Court, it is binding upon us. That decision sets out several propositions delineating the true scope and ambit of Article 14 but not all of them are relevant for our purpose and hence we shall refer only to those which have a direct

bearing on the issue before us. They clearly recognise that classification can be made for the purpose of legislation but lay down that:

> 1. The classification must not be arbitrary but must be rational, that is to say, it must not only be based on some qualities or characteristics which are to be found in all the persons grouped together and not in others who are left out but those qualities or characteristics must have a reasonable relation to the object of the legislation. In order to pass the test, two conditions must be fulfilled, namely,(1) that the classification must be founded on an intelligible differentia which distinguishes those that are grouped together from others and (2) that differentia must have a rational relation to the object sought to be achieved by the Act.
>
> 2. The differentia which is the basis of the classification and the object of the Act are distinct things and what is necessary is that there must be a nexus between them. In short, while Article 14 forbids class discrimination by conferring privileges or imposing liabilities upon persons arbitrarily selected out of a large number of other persons similarly situated in relation to the privileges sought to be conferred or the liabilities proposed to be imposed, it does not forbid classification for the purpose of legislation, provided such classification is not arbitrary in the sense above mentioned.

It is clear that Article 14 does not forbid reasonable classification of persons, objects and transactions by the legislature for the purpose of attaining specific ends. What is necessary in order to pass the test of permissible classification under Article 14 is that the classification must not be "arbitrary, artificial or evasive" but must be based on some real

and substantial distinction bearing a just and reasonable relation to the object sought to be achieved by the legislature. The question to which we must therefore address ourselves is whether the classification made by the Act in the present case satisfies the aforesaid test or it is arbitrary and irrational and hence violative of the equal protection clause in Article 14."

(iii) ***PUCL v. Union of India***[3], paragraphs 36, 37, 42 and 43

"36. The question as to whether a statute is ultra vires the Constitution of India having conferred unguided, uncanalised or wide power cannot be determined in vacuum. It has to be considered having regard to the text and context of the statute as also the character thereof. It deals with a sensitive subject.

37. Section 18 has been enacted for the purposes specified therein. It is well settled that guidelines for enacting the said provision must be found out from the subject-matter covering the field. For the said purpose, even the preamble of the Act may be looked into.

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42. The statutory scheme contained in the provisions of the Act, the Rules framed thereunder, composition of the Atomic Energy Commission and AERB leave no manner of doubt that the effective functions of the nuclear power plants are sensitive in nature. The functions of the Board are varied and wide. Only out of certain functions of the Board, some have

[3] (2004) 2 SCC 476

been marked as "secret" which fulfilled the statutory criteria laid down under Section 18 of the Act. A statute carries with it a presumption of constitutionality. Such a presumption extends also in relation to a law which has been enacted for imposing reasonable restrictions in the fundamental right.

43. A further presumption may also be drawn that the statutory authority would not exercise the power arbitrarily."

(iv) ***K. B. Nagur, MD (Ayurvedic) v. Union of India***[4], paragraphs 17, 18, 20 and 21

"17. Still another aspect is that presumption of constitutionality is always in favour of a legislation, unless the contrary is shown. Furthermore, a legislature, in enacting a law, operates on a presumption, in law and practice, both, that all other forums and entities constituted under one or other Act would, in their functioning, act in accordance with law and expeditiously. As it is a settled precept in the application of economic principles, that all other things will remain the same i.e. ceteris paribus, similarly, for the proper interpretation and examination of a provision of a statute, all bodies must be presumed to act effectively and in accordance with law.

18. A statute is construed so as to make it effective and operative as per the principle expressed in *ut res valeat potius quam pereat*. There is, therefore, a presumption that the legislature does not exceed its jurisdiction and the burden of establishing that the Act is not within the

[4] (2012) 4 SCC 483

competence of legislature or that it has transgressed other constitutional mandates, such as those relating to fundamental rights, is always on the person who challenges its vagaries.

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20. It is also a settled and deeply-rooted canon of constitutional jurisprudence, that in the process of constitutional adjudication, the courts ought not to pass decisions on questions of constitutionality unless such adjudication is unavoidable. In this sense, the courts have followed a policy of strict necessity in disposing of a constitutional issue. In dealing with the issues of constitutionality, the courts are slow to embark upon an unnecessary, wide or general enquiry and should confine their decision as far as may be reasonably practicable, within the narrow limits required on the facts of a case.

21. From the above discussion, it is clear that question of constitutionality of a provision is a matter which the courts would venture to examine only for valid, proper and sustainable grounds. We do not see that the provisions of Section 7 of the Act, or any part thereof, suffer from any legal infirmity, excessive legislative power or violate any legal right of any person, including the petitioner, much less a constitutional right. Keeping the principle of strict necessity in mind, the courts do not venture to examine the constitutional validity of a provision and even strike down such provisions, if they are constitutional and a court does so only if the situation created by such legislation is irremediable or unredeemable. None of these circumstances exist in the present case."

(v) ***Dr. Jaya Thakur Vs. Union of India***[5], paragraphs 66 to 68:

> "66. For considering the issue with regard to validity of the amendments, it will be apposite to refer to some of the judgments of this Court delineating the scope of the judicial review in examining the legislative functions of the legislature.
>
> 67. A Bench of three learned Judges of this Court in Asif Hameed v. State of J&K observed thus: (SCC pp. 373-74, paras 17-19)
>
> > "17. Before adverting to the controversy directly involved in these appeals we may have a fresh look on the inter se functioning of the three organs of democracy under our Constitution. Although the doctrine of separation of powers has not been recognised under the Constitution in its absolute rigidity but the Constitution makers have meticulously defined the functions of various organs of the State. The legislature, executive and judiciary have to function within their own spheres demarcated under the Constitution. No organ can usurp the functions assigned to another. The Constitution trusts to the judgment of these organs to function and exercise their discretion by strictly following the procedure prescribed therein. The functioning of democracy depends upon the strength and independence of each of its organs. The legislature and executive, the two facets of people's will, they have all the powers including that of finance. Judiciary has no power over sword or the purse nonetheless it has power to ensure that the aforesaid two main

[5] (2023) 10 SCC 276

organs of State function within the constitutional limits. It is the sentinel of democracy. Judicial review is a powerful weapon to restrain unconstitutional exercise of power by the legislature and executive. The expanding horizon of judicial review has taken in its fold the concept of social and economic justice. While exercise of powers by the legislature and executive is subject to judicial restraint, the only check on our own exercise of power is the self-imposed discipline of judicial restraint.

18. Frankfurter, J. of the US Supreme Court dissenting in the controversial expatriation case of Trop v. Dulles21 observed as under: (SCC OnLine US SC paras 57-58)

> “57. All power is, in Madison's phrase, "of an encroaching nature". Judicial power is not immune against this human weakness. It also must be on guard against encroaching beyond its proper bounds, and not the less so since the only restraint upon it is self-restraint.
>
> 58. Rigorous observance of the difference between limits of power and wise exercise of power between questions of authority and questions of prudence requires the most alert appreciation of this decisive but subtle relationship of two concepts that too easily coalesce. No less does it require a disciplined will to adhere to the difference. It is not easy to stand aloof and allow want of wisdom to prevail to disregard one's own strongly held view of what is wise in the conduct of affairs. But it is not the business of this Court to pronounce policy. It must observe a fastidious regard for limitations on its

> own power, and this precludes the Court's giving effect to its own notions of what is wise or politic. That self-restraint is of the essence in the observance of the judicial oath, for the Constitution has not authorized the judges to sit in judgment on the wisdom of what Congress and the Executive Branch do.'
>
> 19. When a State action is challenged, the function of the court is to examine the action in accordance with law and to determine whether the legislature or the executive has acted within the powers and functions assigned under the Constitution and if not, the court must strike down the action. While doing so the court must remain within its self-imposed limits. The court sits in judgment on the action of a coordinate branch of the Government. While exercising power of judicial review of administrative action, the court is not an appellate authority. The Constitution does not permit the court to direct or advise the executive in matters of policy or to sermonize qua any matter which under the Constitution lies within the sphere of legislature or executive, provided these authorities do not transgress their constitutional limits or statutory powers."

68. It could thus be seen that the role of the judiciary is to ensure that the aforesaid two organs of the State i.e. the legislature and the executive function within the constitutional limits. Judicial review is a powerful weapon to restrain unconstitutional exercise of power by the legislature and executive. The role of this Court is limited to examine as to whether the legislature or the Executive has acted within the powers and functions assigned under the Constitution. However, while doing so, the Court must remain within its self-imposed limits."

10.1 The Apex Court, in ***Rajbala v. State of Haryana***[6], held that a statute cannot be held unconstitutional on the ground that it is arbitrary, since such an exercise involves a value judgment. It was also held therein that the courts do not examine the wisdom of the Legislature, unless the statute violates any specific provisions of the Constitution of India.

10.2 On the possibility of abuse of the provisions of the Act, as alleged by the appellants, the learned State Attorney contended that while there is a theoretical possibility of abuse of the provisions of the Act and the Rules made thereunder, this arises from the appellants' misconception of the scope of the authority's powers. The provisions of the Act and the Rules do not confer un-canalized or unguided powers on the statutory authorities. The alleged chance of misuse is therefore imaginary. The possibility or chance of abuse or misuse of a statutory provision should not be a guiding factor when considering the constitutionality or validity of a statute. Accordingly, no penal action

[6] (2016) 2 SCC 445

can be initiated without first affording the party concerned an opportunity to show cause. An Appellate Authority has also been constituted, as well as a Grievance Redressal Committee. From the original order, an appeal is contemplated, and revision is also provided before the High Court.

10.3 Furthermore, on the allegations regarding the difficulty in implementing the provisions of the Act, the learned State Attorney submitted that such difficulties are imaginary, misconceived, and misplaced. It is trite law that hardship, by itself, in implementing the provisions of an Act does not constitute grounds for declaring the said provision unconstitutional. If a Parliamentary Act is valid and constitutional, it cannot be held ultra vires merely because a party faces some difficulty in implementing the same. The learned State Attorney relies on the case of ***Seema Silk and Sarees v. Directorate of Enforcement***[7], paragraph 18, for the above proposition, which reads thus:

"18. Commercial expediency or auditing of books of accounts cannot be

[7] (2008) 5 SCC 580

> a ground for questioning the constitutional validity of a Parliamentary Act. If the Parliamentary Act is valid and constitutional, the same cannot be declared ultra vires only because the appellant faces some difficulty in writing off the bad debts in his books of accounts. He may do so. But that does not mean the statute is unconstitutional or the criminal prosecution becomes vitiated in law."

Dura Lex Sed Lex

11. The legal maxim ***Dura Lex Sed Lex*** means "**the law is harsh, but it is the law.**" It is trite law that even if a statutory provision causes hardship to some persons, the Court is bound to enforce it. Similarly, the hardship or inconvenience faced by a group of persons cannot, by itself, be a ground for declaring the law to be invalid.

Cause of action

12. The learned State Attorney further submitted that the Writ Petitions are highly premature, as the appellants have no cause of action to maintain them. The Writ Petitions have been filed based on misplaced and misconceived apprehensions.

12.1 In ***Kusum Ingots and Alloys Ltd. v. Union of India***[8], the

[8] (2004) 6 SCC 254

Supreme Court, held that the mere passing of legislation does not confer any right on a party to file a Writ Petition challenging its validity, unless a cause of action arises therefor. A cause of action with respect to legislation arises only when the provisions thereof, or some of them, are implemented and give rise to civil consequences for the appellants. A Writ Court cannot determine a constitutional question in a vacuum.

The display of rates

13. The learned State Attorney contended that there is no insistence on the clinical establishments to display a uniform rate for the services rendered by them. By virtue of Section 39 of the Act, clinical establishments are required to display the actual rates charged for the services or treatment provided. The publication of such rates enables patients to make an informed decision regarding the cost of the treatment or service they intend to avail themselves of from the concerned clinical establishment. This requirement is necessary to ensure transparency and fairness. Section 39(4) of the Act provides that

no clinical establishment shall charge fees or package rates exceeding those displayed on the notice board.

13.1 There may be certain advantages to some and disadvantages to others; however, this cannot be a ground to challenge the vires of a statute, as held by the Apex Court in ***State of Bihar v. Sachchidanand Kishore Prasad Sinha***[9], in paragraph 14, which reads as follows:

> "14. It is one thing to suggest that the rule-making authority may consider making a further distinction on the lines suggested and an altogether different thing to strike down the rule itself on the ground of inadequate classification. It is true that the rental value of building falling in any of the three categories will not be uniform. There would be any number of distinguishing features even among, say, pucca buildings with RCC roof depending upon the quality of finish, the nature of fittings, the dimensions of rooms, the type of material used in construction and so on and so forth. It would be an endless quest. It would not be easy to draw the lines of distinction. It may not be possible to evolve a classification to cater to all these several distinctions. Even if it is so evolved, not only would it be too complex and elaborate, it would leave too much discretion to assessing authorities, the elimination of which is one of the main objects of the new Rules. The low rates of tax specified in

[9] (1995) 3 SCC 86

Rule 6 of the Assessment Rules (2 1/2% of the annual rental value in the case of tax on holdings, 2% of annual rental value in the case of water tax as well as latrine tax) ensures that even a building with an inferior quality of furnish is not subjected to an undue burden of tax. Treating all pucca buildings with RCC roof as one class and subjecting them to uniform rate of tax subject, of course, to the location and nature of user cannot be said to amount to hostile discrimination so as to offend Article 14. A mere possibility of a better classification is no ground to strike down the classification made by the statutory authority more particularly in the case of a taxing enactment. Saying so would be to deny the "range of selection and freedom in appraisal not only in the objects of taxation and the manner of taxation but also in the determination of the rate or rates applicable". It would also run counter to the entire reasoning of this Court in R.K. Garg2 in the passages quoted above. Similarly, the other objection that the Municipal Corporation area ought to have been divided on the basis of zones and not on the basis of the roads is also not a ground upon which the Court could have invalidated the rule. It is not pointed out that the division with reference to roads amounts to hostile treatment. In case of such classification, there will always be some instances where one gets an advantage and the other suffers a disadvantage but that is no ground, as has been repeatedly emphasised by this Court in the decisions referred to above for invalidating a statute and more particularly a taxing statute. The merit of the Assessment Rules, 1993 as emphasised by the High Court at more than one place, is that they rid the houseowners of the harassment and the constant threats of revision of annual rental value by the officials concerned of the

Corporation. The earlier system of taxation left too much discretion in their hands. Now, the only thing that has to be ascertained is the carpet area of the house, the rest is determined by the rules and the notifications. There is no question of revision of annual rental value periodically on the ground that the rental value has gone up. A new system, with all good intentions is being tried out a system designed in the interest of the body of houseowners/tax-payers as well as the Corporation. May be, this is the trial and error method spoken of in R.K. Garg2. Unless found to be offending the constitutional or statutory provisions, it must be allowed to be worked out. One should start with the presumption that the Corporation knows what is the better method of classification. It has chosen to divide it with reference to roads. It is difficult for the Court to substitute its opinion for that of the Corporation nor can anyone guarantee that if the Municipal Corporation area is divided on the basis of zones it will be a perfect classification and would eliminate all complaints and grievances of differential treatment. It is because of the inherent complex nature of taxation that a greater latitude and a larger elbow room is conceded to the legislature or its delegate, as the case may be in such matters. Dealing with a similar objection, this Court said in *Khandige Sham Bhat v. Agrl. I.T. Officers*: (SCR pp. 822-23)

> "It is suggested that a more reasonable course would have been to tax the assessees in the Madras area for the income that accrued to them during the 5 months by treating the said income as the income for the entire year commencing from 1-4-1956 and ending on 31-3-1957 and that in that event not only their income for the said period

> could not have escaped taxation but it would have also avoided the unjust treatment meted out to them in the rate of tax. Prima facie there appears to be some plausibility in this argument; but a closer examination discloses that though the method suggested may have been better than the method actually adopted, the hardship in individual cases cannot in any event be avoided. It is true taxation law cannot claim immunity from the equality clause of the Constitution. The taxation clause shall also not be arbitrary and oppressive, but at the same time the court cannot, for obvious reasons, meticulously scrutinise the impact of its burden on different persons or interests. Where there is more than one method of assessing tax and the legislature selects one out of them, the court will not be justified to strike down the law on the ground that the legislature should have adopted another method which, in the opinion of the court, is more reasonable, unless it is convinced that the method adopted is capricious, fanciful, arbitrary or clearly unjust."

Right to privacy in the context of information sought for under Form II

14. Under Clause 12 of Form II of the Rules of 2018, among other requirements, the respective clinical establishments are required to provide details of their doctors, nursing staff, technical staff, paramedical staff, administrative staff, and supporting staff, including their names, qualifications, registration numbers, the council under

which the doctors, nurses, and technical staff are registered or certified, and the nature of the services rendered. The details sought with respect to medical practitioners are already available in the *Indian Medical Registry*. To facilitate easier public access to these details, the Central Government has made it mandatory for all registered medical practitioners to obtain a *Unique Identification Number* from the *National Medical Commission*. This enables the public to access information about a registered medical practitioner, such as their registration number, date of birth, and date of registration.

14.1 As of now, the *National Medical Registry* contains, among other information, all entries of registered medical practitioners from the State Registers maintained by the respective State Medical Councils. The register has been made publicly accessible on the official website of the *National Medical Commission* and includes relevant information regarding a medical practitioner, such as their registration number, name, father's name, date of registration, place of work (name of the hospital or institute), medical qualifications (including additional qualifications),

field of specialty, year of passing, and the name of the university or institute from which the qualifications were obtained. Therefore, the details and data sought do not violate Article 14 or Article 19(1)(g) of the Constitution of India.

14.2 Furthermore, the websites of almost all major hospitals in the State, such as Lakeshore Hospital, Amrita Institute of Medical Sciences, KIMS Health, etc., provide information about the medical practitioners associated with them, including their qualifications, experience, and photographs. Section 15(b) of the Act prescribes the minimum qualifications required for medical and paramedical staff, which have been fixed and published by the Council. Enquiring about the qualifications of employees is intended to ascertain whether they possess the required qualifications and is in consonance with the avowed objectives of the Act. Moreover, clinical establishments are otherwise statutorily bound to maintain details of their employees under the applicable Labour laws.

14.3 The website and portal of the Kerala State Council for Clinical Establishments are hosted by the National Informatics Center. The details and data collected by the Council as part of registration are stored in the State Data Center and managed by the Government of Kerala. The information entered by a clinical establishment can only be accessed by the State Administrator, the District Registering Authority concerned, and the clinical establishment itself. No one else can access the data collected and entered therein. Moreover, the details and data entered by the respective clinical establishments in the official portal are secure and shall remain confidential-an affidavit to this effect was placed on record on 06.02.2024. The mode of inspection, as contemplated under Rule 26 of the Rules of 2018, must be carried out without affecting the privacy of the patients as per Rule 26(4)(iii) and Rule 26(9) of the Rules.

Violation of Article 19 (1) (g) of the Constitution of India

15. Article 19(1)(g) of the Constitution of India is subject to reasonable restrictions imposed by the State in the interest of the general public, including the prescription of professional or technical

qualifications necessary for practicing any profession or carrying on any occupation, trade, or business. There is no absolute prohibition. Through the Act, the State is merely seeking to regulate these activities in the larger interest of the public.

Statistics

16. As of 01.09.2024, 13,208 clinical establishments have been registered provisionally, while 573 clinical establishments have been registered permanently. Out of the total members of KPHA, only 108 have obtained registration. Of the approximately 4,500 dental clinics and hospitals, 3,807 have obtained registration.

Cancellation of Registration – the modalities and impact thereof -

17. Section 16 (6) of the Act reads as thus:

> 'Where a clinical establishment is offering services in different medical category, such clinical establishment shall apply for separate provisional or permanent registration for each category under this Act:
> Provided that a laboratory a diagnostic centre which is a part of clinical establishment need not be registered separately."

Therefore, every clinical establishment offering services in different medical categories shall apply for provisional or permanent registration

for each category, as the case may be. Consequently, any cancellation, if at all, shall not be carried out *en bloc*.

17.1 Furthermore, as provided under Section 19(14) of the Act, the cancellation of provisional or permanent registration shall be carried out in the manner prescribed. Prior to such cancellation, the clinical establishment shall be granted sufficient opportunity, including the opportunity to show cause, as per Section 25 of the Act. From every decision of the authority issued under Sections 27, 28, and 29 of the Act, an appeal may be made to the appellate authority in the manner prescribed, within 45 days of the decision. A revision of such decisions is also contemplated under Section 35 of the Act. Additionally, a grievance redressal mechanism is provided under Section 36 of the Act.

17.2 By Exhibit R1(b), the minimum standards to be maintained by a clinical establishment have been prescribed. Sufficient time should be granted to a clinical establishment to comply with these prescribed minimum standards. According to Rule 26(1) of the Rules of 2018, if there is any reason to suspect that a clinical establishment is functioning

without registration, the council, the authority, or any other officer authorized in this regard may conduct an inspection, after giving due notice to the clinical establishment and providing it the right to be represented.

Legal pronouncements where vires of similar enactment was under challenge

18. Lastly, the learned State Attorney submitted that, in identical circumstances, where the vires of similar enactments was under challenge, various High Courts have upheld the constitutional validity of the Act and its provisions.

Md. Rezaul Karim v. State of West Bengal[10]

18.1 The vires of the West Bengal Clinical Establishments (Registration, Regulation, and Transparency) Act of 2017 were under challenge. The challenge was dismissed, and it was held that the Act is constitutional.

[10] 2018 KHC 2011 (Calcutta High Court)

Madhukar Dwivedi v. State of Chhattisgarh[11]

18.2 A Public Interest Litigation was filed seeking directions to close down all illegal nursing homes, clinics, and pathology laboratories, and to prevent illegal medical practice in Chhattisgarh. In that case, it was held that the provisions of the *Chhattisgarh Rajya Upcharyagriha Tatha Rogopchar Sambandhi Sthapanaye Anugyapan Adhiniyam, 2010* are valid and must be scrupulously followed within the State.

Dr. Ashwani Goyal v. Union of India[12]

18.3 A Public Interest Litigation was filed in which the provisions of the Clinical Establishments (Registration and Regulation) Act of 2010 were under challenge. The challenge was dismissed, and it was held that the Act is constitutional.

D. Dharmabalan v. The Secretary, Department of Health and Family Welfare, Government of Tamil Nadu[13]

18.4 The Writ Petition was filed challenging the vires of the

[11] 2018 KHC 2483 (Chhattisgarh High Court)
[12] 2012 Supreme (OnLine)(Del) 4751
[13] 2019 SCC OnLine Mad 39250

provisions of the Tamil Nadu Private Clinical Establishments (Regulation) Act of 1997. The challenge was dismissed, and it was held that the Act is constitutional.

Dr. Ramneek Singh Bedi v. Union of India[14]

18.5 The petitioners sought a declaration that the Clinical Establishments (Registration and Regulation) Act of 2010 is ultra vires the Constitution. The challenge was dismissed, and it was held that the Act is constitutional.

Dr. Yashbir Singh Tomar v. State of Uttarakhand[15]

18.6 The provisions of the Clinical Establishments (Registration and Regulation) Act of 2010 were under challenge. The challenge was dismissed, and it was held that the Act is constitutional.

Therefore, the learned Attorney General summed up his arguments, stating that welfare legislation introduced by the Government should not be interfered with.

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[14] 2011 SCC OnLine P&H 9634
[15] 2017 Supreme (UK) 302 (Uttarakhand High Court))

Discussion and Analysis:

19. Heard Mr V.V. Asokan learned Senior Counsel for the appellants, Mr N Manoj Kumar, learned State Attorney, assisted by Mr S. Kannan, learned Senior Government Pleader for respondent nos.1 to 15 and Mr Ajit Joy, learned Counsel for respondent nos.16 to 21.

20. Having briefly enumerated the facts above, the following issues arise for our consideration in the appeals:

(i) Whether the Act (particularly Sections 16(2), 39(2), and 39(3), along with the allied rules and forms) is unconstitutional, ultra vires, arbitrary, or illegal?

(ii) Whether the impugned Rules and Schedules are ultra vires the Constitution as well as the Act?

(iii) Whether the learned Single Judge erred in sustaining the framework and in applying comparative and constitutional standards as provided under the Act?

Provisions of the Act under challenge:

21. Section 16 of the Act

"16. Registration of clinical establishments.

(1) All clinical establishments in Kerala shall be registered with the Authority concerned under the provisions of this Act and the rules made thereunder.

(2) No person shall run a clinical establishment unless it has been duly registered in accordance with the provisions of this Act and the rules made thereunder.

(3) All clinical establishments functioning at the commencement of this Act shall be granted provisional registration by the Authority concerned.

(4) All clinical establishments having provisional registration shall acquire the standards for permanent registration in the category within such period as may be prescribed.

(5) All clinical establishments which come into existence after the commencement of this Act shall apply for permanent registration with the Authority within such period as may be prescribed.

(6) Where a clinical establishment is offering services in different medical category, such clinical establishment shall apply for separate provisional or permanent registration for each category under this Act:

Provided that a laboratory or a diagnostic centre which is a part of a clinical establishment need not be registered separately.

21.1 Section 39 of the Act

"39. Display of the certificate of registration and other information by the clinical establishment.

(1) Every clinical establishment shall display, in a conspicuous place in the clinical establishment its certificate of registration, provisional or

permanent.

(2) Every clinical establishment shall display, in a conspicuous place in the clinical establishment in Malayalam as well as in English the fee rate and package rate charged for each type of service provided and facilities available, for the information of the patients.

(3) All clinical establishments in the State shall display package rates for specific procedures.

(4) No clinical establishment shall charge fees or package rates more than what is displayed."

21.2 Section 47 of the Act

"47. Treatment of victims in emergencies.-

(1) The clinical establishment shall provide, such medical examination and treatment as may be required and can be provided with the staff and facilities available in the establishment, to save the life of the patient and make the safe transport of the patient to any other hospital.

(2) The Council shall notify the life saving services to be provided by each category of clinical establishments."

22. The doctrine of ***presumption of constitutionality*** holds that a law passed by a competent legislature is presumed to be constitutional unless proven otherwise. The burden of proof lies with the party challenging the law to clearly demonstrate that it violates a constitutional provision. Courts operate on the following assumptions

when reviewing a statute:

(i) The legislature understands and appreciates the needs of the people.

(ii) The laws enacted are designed to address manifest problems.

(iii) The legislature has acted in good faith.

23. To understand the purpose of the enactment of the Act and the Rules thereunder, it is necessary to examine the statutory scheme and the rationale for enacting such an Act in the larger public interest.

I. Legislative Competence & Constitutional Architecture

23.1 So far as competence is concerned, the regulation of public health, hospitals, and dispensaries falls within Entry 6 of List II (State List) in the Seventh Schedule. The Kerala Legislature therefore had plenary competence to enact the Act. The existence of the Central Clinical Establishments Act, 2010, which is traceable to Article 252, does not divest the State Government of its legislative competence.

23.2 The constitutional bedrock of the Article 21 of the Constitution of India, as judicially expanded, subsumes the right to

health and emergency medical care. In ***Parmanand Katara v. Union of India***[16], the Supreme Court held that every doctor, whether in a public or private hospital, is under a professional obligation to extend medical aid to protect life and no procedural impediment can obstruct this. In ***Paschim Banga Khet Mazdoor Samity v. State of West Bengal***[17], the Court declared that the State is obliged to ensure adequate emergency medical facilities and cannot plead financial constraints. The Directive Principle in Article 47 fortifies the State's duty to improve public health.

23.3 The Act does not create new constraints; rather, it operationalizes these constitutional duties through a registration-cum-standards regime, a transparency mandate, and enforceable minimum requirements for emergency care and stabilization.

II. Statutory Scheme:

24. ***Registration & Standards (Secs. 12-16)***: All clinical establishments must obtain and maintain registration, subject to compliance with notified standards. The Act authorizes classification by

[16] (1989) 4 SCC 286
[17] (1996) 4 SCC 37

category, size, and capacity; empowers the prescription of infrastructure, staffing, equipment, infection control, and safety norms; and provides for inspections and audits.

24.1 ***Transparency (Sec. 39)***: Establishments must publicly display the types of services and their rates, including packages where applicable, and provide itemized bills - ensuring that patients can compare, choose, and contest charges.

24.2 ***Emergency Care & Stabilization (Sec. 47)***: Every establishment must screen and stabilize patients, and where required, ensure their safe transfer to higher-level care, without refusing treatment due to immediate inability to pay or incomplete documentation.

24.3 ***Enforcement & Penalties***: Non-compliance may result in suspension or cancellation of registration and the imposition of monetary penalties. Administrative and appellate remedies are provided, and due process safeguards apply to any adverse action.

III. Scope of the Patients' Right to Emergency/Critical Care

25. From the statute and binding precedents, the scope is settled:

- **Universal applicability:** The duty applies to all establishments - government, private, trust-run, or charitable.
- **Immediate obligation:** No refusal or delay is permitted due to inability to pay, lack of documents, or pending insurance/jurisdictional formalities.
- **Stabilization first:** The minimum obligation is to provide lifesaving first aid and stabilization before referral or transfer.
- **Non-discrimination:** No discrimination is allowed based on caste, creed, gender, religion, language, sexual orientation, class, or financial status.
- **Enforcement:** Non-compliance may result in regulatory action (suspension/cancellation, penalties), civil liability, and constitutional remedies under Article 226."

IV. International & Comparative Standards

A. UN/WHO Framework

26. The WHO Emergency Care System Framework (2019) defines emergency care as care for acute illness and injury across all ages,

including conditions that may cause death or disability without rapid intervention. The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 (Art. 12), obliges States to secure the highest attainable standard of health, including timely emergency services. WHO defines 'stabilization' as essential initial interventions - airway, breathing, and circulation; hemorrhage control; trauma and obstetric stabilization; pain relief; psychological support - and safe transfer without deterioration. WHO minimum standards address core infrastructure, essential equipment (oxygen, ventilators, monitors, defibrillators), essential medicines (Model List), and adherence to Standard Treatment Guidelines.

B. United States: EMTALA (1986)

26.1 The Emergency Medical Treatment and Active Labor Act (EMTALA) is a United States federal law enacted in 1986 to ensure public access to emergency services regardless of a person’s ability to pay. EMTALA (42 U.S.C. § 1395dd) imposes strict statutory duties on hospitals participating in Medicare: conducting a Medical Screening Examination

for anyone presenting to the ER; stabilizing patients with an emergency medical condition; prohibiting patient dumping before stabilization; and forbidding refusal of care based on ability to pay. Enforcement mechanisms include civil penalties (up to $50,000 per violation), exclusion from Medicare, and private patient lawsuits. The statutory definition, including life or organ-threatening conditions, serious impairment of bodily functions, severe pain, or risk to an unborn child - has become a global template.

C. Europe: EU/ECHR

26.2 The European Convention on Human Rights (ECHR) is an international treaty safeguarding human rights and fundamental freedoms for individuals in the 46 Council of Europe member states. The European Union Charter of Fundamental Rights (Art. 35) guarantees access to healthcare, while ECHR Article 2 jurisprudence (e.g., *Nitecki v. Poland*, 2002) holds that denial of life-saving care may violate the right to life. EU Directives promote transparency (cross-border care reimbursements), radiation safety (2013/59/Euratom), and infection-

control standards (2010/32/EU). EUSEM issues professional triage and resuscitation protocols, and EMA/CEN harmonize medicines and medical device standards.

26.3 Thus, in the United States, the legal framework is very stringent, imposing hospital-facing statutory liabilities with penalties and patient remedies. In Europe, a rights-based architecture is complemented by harmonized safety and quality standards. In the State of Kerala, EMTALA-style definitions are embedded, with enforcement currently through registration control, penalties, and constitutional remedies, while granular standards are to be progressively notified.

V. The Patients' Rights Charter

27. The Patients' Rights Charter was drafted by the National Human Rights Commission (NHRC) in 2018 and later endorsed by India's Ministry of Health and Family Welfare (MoHFW). Although it is not legally binding, the Ministry has encouraged state governments and union territories to adopt and implement its principles. The Charter (2018) enumerates a rights matrix, including access to information;

medical records within 72 hours; emergency treatment irrespective of payment; informed consent; privacy and dignity; the right to a second opinion; transparency in rates and itemized bills; non-discrimination; safety and quality; free choice of laboratories and pharmacies; safe discharge or transfer; and grievance redress. The 2018 Act substantially overlaps with, and gives regulatory teeth to, these entitlements, particularly regarding emergency care, transparency, and grievance mechanisms.

VI. The Doctrinal Distinction of Hospital vs Practitioner Liability:

28. The Kerala Act is institution-based and regulates clinical establishments; a practitioner is exposed under it either as the proprietor or if their conduct triggers institutional action. The National Medical Commission (NMC) regulates the professional conduct of Registered Medical Practitioners (RMPs) in India. Its regulations include specific provisions concerning a doctor's duty not to refuse emergency treatment, to maintain confidentiality, and to exercise due care. While the NMC has issued several regulations and guidelines, including the

2002 Code of Medical Ethics, its most recent iteration is the 2023 Registered Medical Practitioner (Professional Conduct) Regulations.

28.1 The regulations also mandate that a Registered Medical Practitioner (RMP) must not willfully neglect a patient or withdraw from a case without providing adequate notice to the patient and their family. Doctors are required to act in the best interests of the patient, delivering compassionate and respectful care. RMPs should, as far as possible, prescribe drugs using generic names and ensure rational prescription practices. They must maintain proper medical records, with the 2023 regulations emphasizing digitization. Patients have a right to access their medical records upon request. The regulations also require RMPs to report any professional incapacity that could harm patients, including incapacity caused by substance use, which is considered professional misconduct.

28.2 Individual practitioners may face civil liability under the **Consumer Protection Act, 2019** (***Indian Medical Association v. V.P.***

Shantha[18]***)***, and criminal liability under **IPC Sections 304A, 336-338**, subject to the gross negligence threshold established in ***Jacob Mathew v. State of Punjab***[19], which requires prior expert opinion. Professional discipline under NMC regulations also applies. Registered Medical Practitioners are bound by duties not to refuse emergency treatment, to maintain confidentiality, and to exercise due care. Constitutional liability arises under Article 21, and denial of emergency aid may be challenged through writ jurisdiction.

VII. Standard of Review: Constitutionality & Proportionality:

29. A statute is not to be invalidated for mere 'arbitrariness' in the loose sense (***State of A.P. v. McDowell***[20]); yet manifest arbitrariness is a recognized ground under Article 14, as reaffirmed in ***Shayara Bano v. Union of India***[21], and ***Navtej Singh Johar v. Union of India***[22]. Economic and social regulation warrants judicial deference (***R.K. Garg v. Union of***

[18] (1995) 6 SCC 651
[19] (2005) 6 SCC 1
[20] (1996) 3 SCC 709
[21] (2017) 9 SCC 1
[22] (2018) 10 SCC 1

India[23]; ***Swiss Ribbons Pvt. Ltd. v. Union of India***[24]). When privacy is implicated, the ***Puttaswamy*** test-legality, legitimate aim, proportionality, and procedural safeguards-applies. ***Modern Dental College v. State of M.P.***[25] articulates the proportionality test in professional regulation: the measure must pursue a legitimate aim, be suitable to achieve it, be the least restrictive among effective alternatives, and strike a fair balance between individual rights and the public interest.

Analysis of the Appellants' Challenges:

30. On the challenge to **Section 39** - "***Types of Service***" and "***Package Rates***" - on the grounds of vagueness or overbreadth, we reject the plea of vagueness. The terms "***types of service***" and "***package rates***" are well-understood in Indian healthcare administration: CGHS, ESI, State Health Insurance schemes such as KASP, third-party payor packages, and MEDISEP, schedules widely employ baseline packages for

[23] (1981) 4 SCC 675
[24] (2019) 4 SCC 17
[25] (2016) 7 SCC 353

common procedures with defined inclusions and exclusions. The Act does not require clairvoyant pre-pricing of every possible clinical contingency; it mandates good faith baseline tariffs for identifiable services and packages, with itemized billing for add-ons, complications, and extended stays.

30.1 **Suitability and Legitimate Aim:** Transparency combats information asymmetry and guards against exploitative charging, serving a quintessential public interest.

Necessity and Minimal Impairment: A disclosure mandate is less intrusive than direct price-fixation; it preserves professional autonomy while providing consumers with necessary information.

Fair Balance: Patients gain clarity, while providers retain clinical freedom and may recover documented add-ons.

30.2 The Centers for Medicare and Medicaid Services (CMS) is a U.S. federal agency and does not have international equivalents that serve as true comparators, due to the unique structure of the American healthcare system. Unlike countries where a single national health

service or ministry provides both health insurance and healthcare delivery, CMS primarily administers health insurance programs, such as Medicare and Medicaid, and regulates certain healthcare standards. Cross-border transparency norms are therefore not directly comparable. Consequently, Section 39 of the Act can withstand stringent scrutiny under Articles 14 and 19 of the Constitution of India.

31. On the challenge to **Form 2A /Rule 24**-relating to staff particulars and privacy-the regulator's need to verify minimum staffing, competence, and 24x7 coverage is axiomatic in a standards-based regime. The data is furnished to the registering authority for oversight; it is not a mandate to publish personal information publicly. Applying ***Puttaswamy***, the measure: (i) has legality, as it is grounded in a statutory source; (ii) pursues a legitimate aim, namely patient safety and quality of care; (iii) is proportionate, being limited to role-appropriate particulars and enabling audit or inspection; and (iv) carries procedural safeguards, including use limitation and the possibility of review or appeal of adverse actions. Concerns regarding "poaching" or RTI

disclosure cannot override patient safety. Nothing prevents the State from issuing clarificatory guidelines on purpose limitation, data minimisation, confidentiality, retention, and access control, consistent with general data protection principles.

32. **Section 47:** On the emergency Stabilization and Safe Transfer, while compliance may be challenging for small clinics, Section 47 mirrors WHO stabilization guidelines and EMTALA duties: screen, stabilize within capacity, and ensure safe transfer. The obligation is graded according to capacity - a primary clinic is not required to perform neurosurgery; it must provide first aid, haemodynamic support, and airway/breathing management as feasible, and arrange safe transport with appropriate documentation and communication. The prohibition against refusal due to inability to make immediate payment vindicates Article 21 of the Constitution of India.

32.1 **Proportionality is satisfied**: The aim is lifesaving; suitability for immediate stabilization prevents death or disability; necessity is met, as no equally effective but less burdensome alternative exists; and

balance is maintained, as the requirement is limited to feasible interventions with referral. Comparative law - EMTALA and EUSR/EUSEM - confirms that this represents a customary regulatory minimum.

33. On the challenge to ***Ultra Vires*** - Categorisation by Bed Strength; Scope of Rulemaking, Section 13 empowers the prescription of standards and categories. Differentiation by bed strength is a rational proxy for capacity and risk profile, as it informs fees, inspection frequency, staffing minima, and equipment requirements. Form 2A's particulars are ancillary to registration and standards verification. The Rules and Schedules do not supplant the Act; they implement it. Accordingly, the challenge fails.

33.1 On the issue of **Arbitrariness/Manifest Arbitrariness**, the impugned provisions address recognised harms restrictive and unfair trade practice of billing, understaffing, denial of emergency care, are tailored to the aim, and afford procedural safeguards. They are neither capricious nor excessive. Even tested against the manifest arbitrariness

doctrine, they pass muster.

Clarificatory Construction & Administrative Directions:

34. To obviate practical ambiguity while preserving constitutionality, we clarify:

(1) "***Package rates***" **(Section 39)** refer to baseline tariffs for commonly performed procedures with standard inclusions. Unforeseen complications, management of co-morbidities, extended ICU stays, and high-end consumables may be billed separately, provided there is disclosure and clinical justification.

(2) ***Staff data (Form 2A)*** shall be collected and used solely for regulatory purposes. The authority shall frame guidelines on confidentiality, purpose limitation, access control, and retention. Publication to the general public is not required unless specifically authorised by law.

(3) ***Section 47*** compliance is capacity-graded*:* all establishments must provide first aid and stabilization to the extent feasible and ensure safe transfer, including communication, documentation, and transport. No establishment shall deny initial lifesaving aid on account of non-

payment or lapses in documentation.

Coordination with Parallel Regimes:

35. This regulatory framework aligns with the **Consumer Protection Act, 2019** (providing civil compensation for deficiency in medical services), the **IPC** (criminal liability for negligence subject to ***Jacob Mathew*** (supra) safeguards), and **NMC** professional disciplinary mechanisms. The Act's institutional enforcement complements, rather than supplants, these remedies.

Grievance Redress, Transparency & Oversight on Good Governance Measures

36. Consistent with the Single Judge's approach and past pandemic-era directions, we underscore the following:

- **Visible rate display** at admissions, billing counters, and on websites; itemised bills available on request.
- **District-level grievance cells** under the DMO/Registering Authority, with a time-bound complaints process; periodic compliance audits focusing on emergency care denials, exorbitant

add-ons, and staffing minima.

- **Digital registers/portals** for registration status, inspection notes (appropriately redacted), and speaking orders in penalty actions.
- **Training and drills** on triage/stabilization, infection control, and safe transfer protocols, drawing on WHO/EUSEM materials.

These are matters of administrative implementation. The State is at liberty to refine them through executive instructions consistent with the Act and Rules.

***Conclusion and Directions*:**

37. For all the reasons stated above, we hold that the validity of the impugned Sections 16, 39, and 47 of the Kerala Clinical Establishments (Registration and Regulation) Act, 2018, along with the allied Rules and Schedules, is ***intra vires*** and requires no interference. The provisions are neither vague nor disproportionate and are in conformity with global standards, as discussed in the preceding paragraphs.

37.1 Accordingly, we uphold the decision of the learned Single Judge. The writ appeals are dismissed. Normally, we would have imposed heavy cost on the appellants for not taking any steps to implement or comply with the provisions of the Act, which is a welfare legislation, for more than 7–8 years after it came into force, thereby depriving the citizens of the State of their fundamental rights and the benefits contemplated under the Act. However, we refrain from doing so in view of the interim relief granted by the learned Single Judge as well as by this Court during the pendency of the proceedings. Accordingly, there shall be no order as to costs. All interlocutory applications relating to interim matters stand closed. Interim order granted on 03.07.2025 stands vacated.

***Guidelines*:**

38. Before parting with the appeal, we consider it appropriate to issue the following guidelines to ensure the effective implementation of the Act, consistent with its objects and the spirit of its Preamble:

i. *Capacity-Graded Emergency Care*

Every clinical establishment shall, at a minimum:

(a) screen and stabilize emergency patients within its capacity; and

(b) ensure safe transfer, with proper documentation and communication, to a higher centre when indicated. No establishment shall deny initial life-saving aid on the ground of non-payment of advance or lack of documents.

(c) At the time of discharge of a patient from the hospital, the hospital authorities shall ensure that, along with the discharge summary, all investigation reports pertaining to the treatment, such as ECG, X-ray, CT scan, and other test reports, are also handed over to enable the patient to maintain proper records.

ii. ***Transparency and Public Display (Reception/Admission Areas and Website)***

Each clinical establishment shall prominently display, in Malayalam and English, at the Reception/Admission desk and on its official website:

(a) the list of services offered.

(b) baseline and package rates for commonly performed procedures,

with a note that unforeseen complications or additional procedures shall be itemised.

(c) key facility information, including bed categories, availability of ICU/OT, imaging and laboratory facilities, and ambulance/contact details.

(d) a summary of Patients' Rights, including emergency care, informed consent, confidentiality, non-discrimination, access to medical records within 72 hours, itemised bills, and grievance redressal pathway; and

(e) the name, phone number, and email ID of the Grievance Officer, along with contact details of the District Registering Authority/DMO helpline and other escalation contacts.

iii. *Patient Information Brochure*

At the time of admission, and as a downloadable document from the establishment's website, every hospital shall provide a brochure or leaflet in Malayalam and English containing information on:

- services offered.

- baseline and package rates with inclusions.

- deposit and refund policy.

- insurance/TPA empanelment and claim procedures.

- estimate and billing policy.

- discharge procedures.

- ambulance and transport charges.

- 24×7 emergency care protocol; and

- grievance redressal and escalation mechanism.

iv. *Grievance Redress Mechanism*

(a) Every clinical establishment shall maintain a Grievance Desk/Helpline and register every complaint with a unique reference number, issuing an acknowledgement immediately through SMS, WhatsApp, or in physical form.

(b) The establishment shall endeavour to resolve all complaints within seven (7) working days. Unresolved or serious matters shall be escalated to the District Registering Authority/DMO without delay.

(c) Each establishment shall maintain a Complaint Register, in physical or electronic form, available for inspection. A summary of grievances

and actions taken shall form part of the monthly compliance reports submitted to the competent authority.

v. ***Updates and Accuracy***

All displayed rate lists, brochures, and website information shall be kept current. Any change in services, rates, or grievance contact details shall be promptly updated, with the date of revision clearly indicated.

vi. ***Compliance with the Kerala Clinical Establishments (Registration and Regulation) Act, 2018***

(a) Every clinical establishment shall file an undertaking of compliance with Sections 39 and 47 of the Act and the above directions within thirty (30) days from the date of this judgment before the District Registering Authority.

(b) The said Authority shall conduct verification audits within sixty (60) days from the date of this judgment and thereafter periodically, taking appropriate action for any deficiencies detected, in accordance with the Act and Rules.

vii. ***Patient Remedies (Without Prejudice to Other Rights)***

Patients shall remain at liberty to:

(a) pursue remedies for deficiency of service before the competent Consumer Disputes Redressal Commission.

(b) lodge complaints with the local police where appropriate, including cases involving alleged fraud or cheating.

(c) escalate grave or systemic grievances to the Chief Secretary and the State Police Chief; and

(d) seek assistance from the District or State Legal Services Authorities for advice and facilitation.

All establishments shall cooperate fully and issue receipts for all payments and complaints received.

viii. ***Language and Accessibility***

All mandatory displays, notices, and brochures shall be provided in Malayalam and English, and shall be clear, legible, and prominently accessible at the Reception/Admission areas and other conspicuous locations within each establishment, as well as on the homepage of its official website.

ix. *Non-Compliance*

Non-compliance with these guidelines shall attract regulatory action under the Kerala Clinical Establishments (Registration and Regulation) Act, 2018, including suspension or cancellation of registration and imposition of penalties, in addition to any civil, criminal, or constitutional remedies available to patients.

***Compliance Direction*:**

39. The Registrar of this Court shall forthwith forward an authenticated copy of this judgment to the Chief Secretary, Government of Kerala, and to the State Police Chief. They shall issue appropriate notifications/orders and ensure strict compliance with the procedures and directions contained herein, as well as with the provisions of the Act. Apart from the above, the State Government shall publicise the effective contents/directions issued in this judgment through visual media and print media, for a period of one month, in Malayalam and English daily, having wide circulation, so as to ensure broad public and to enable citizens to understand their rights regarding medical treatment. A

detailed compliance report shall be filed before this Court within thirty (30) days from the date of receipt of a certified copy of this judgment.

Let this judgment serve not merely as a declaration of law but as a reaffirmation of the right to dignified, ethical, and equitable medical care.

Sd/-
SUSHRUT ARVIND DHARMADHIKARI
JUDGE

Sd/-
SYAM KUMAR V.M.
JUDGE

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