Aamir Hussain, *Standard Form Contracts in the Health Sector: The Plague of Exclusion Clauses and Unconscionability*, 9(1) NLUJ L. REV. 154 (2022).

STANDARD FORM CONTRACTS IN THE HEALTH SECTOR: THE PLAGUE OF EXCLUSION CLAUSES AND UNCONSCIONABILITY

*~Aamir Hussain**

ABSTRACT

The health sector is conventionally regarded as an important facet of human development and every person's life is invariably linked to it. In the performance of its services, hospitals usually require the patients or their kin to sign an undertaking, usually in the form of a 'Standard Form Contract'. Such contracts are unilaterally set by the hospitals wherein the patient has no bargaining power vis-à-vis the substance of the contract, regardless of how unfair the terms might be. Albeit such unfair terms are usually considered within the domain of consumer law in India, this paper tries to approach this issue through a contractual lens. Such hospitals often incorporate sweeping exclusion clauses in their contracts which exclude them from all liability. This paper problematises the issue with such unilaterally set contracts while bearing in mind the nature of the medical practice. It borrows from the jurisprudence of the United States, in terms of how they have dealt with such broad exclusion clauses, and submits remedies in contract law to tackle this issue.

* Aamir Hussain is a second-year student at the National Law School of India University, Bengaluru. He may be contacted at aamir.hussain@nls.ac.in.

TABLE OF CONTENTS

I. INTRODUCTION 156
II. THE EXISTENCE AND NATURE OF A CONTRACTUAL RELATIONSHIP? 157
III. HURDLES AND EXCEPTION CLAUSES 160
A. COMPLICATED TERMS AND UNEQUAL BARGAINING POWER 160
B. EXCLUSION CLAUSES IN MEDICAL CONTRACTS 164
C. PUBLIC POLICY 168
IV. UNITED STATES' JURISPRUDENCE 170
V. CONCLUSION AND WAY FORWARD 172

I. INTRODUCTION

A 'standard form contract' contains a uniform set of conditions that have been prefixed by one of the parties in a contractual agreement.[1] Such contracts can be used for contracting with numerous persons as it provides a general template that is open to acceptance by anybody who wishes to enter into such a contract.[2] This significantly reduces the amount of money and time spent on drafting a separate contract for every new transaction, thereby making the whole process more feasible.[3] Hence, such types of contracts have gained traction in modern times.[4]

Standard form contracts are essentially "take it or leave it" contracts, which implies that there is no room for negotiation *vis-à-vis* the terms of the contract.[5] The terms of the agreement are pre-determined and there is no scope to change the same.[6] The contract that arises out of this is binding on both the parties even if they have not read the terms of the contract, or are unaware of its legal implications.[7] Such contracts are also called "contracts of adhesion" as the individual has no other choice but to adhere to the terms of the contract.[8] The entire jurisprudence of Indian law

---

1 M.P. Ram Mohan et. al., *Indian Law on Standard Form Contracts,* 62(4) J. INDIAN L. INSTITUTE 2, 2 (2020) (*hereinafter* "**Mohan**").
2 *Id.*
3 JACK BEATSON, ANDREW BURROWS, JOHN CARTWRIGHT, ANSON'S LAW OF CONTRACT 171 (Oxford University Press 6th ed. 2020).
4 *Id.* at 171-172.
5 Sachin Kumar Sharma, *Standard Form Contracts- A Comprehensive Analysis,* 2(6) IJARIIE 1159, 1159 (2016) (*hereinafter* "**Sharma**").
6 *Id.*
7 Mohan, *supra* note 1, at 3.
8 Sharma, *supra* note 5, at 1159.

on the subject of standard form contracts has evolved through judicial pronouncements over the years.[9]

In this paper, the author contends that hospitals should not have an unfettered right to exclude liability through exclusionary clauses in hospital contracts. *Firstly,* the paper delves into the question of whether the relationship between a hospital and a patient or a doctor and a patient is subject to the provisions of the Indian Contract Act, 1872 ("**ICA**") and what is the nature of this relationship. *Secondly*, the paper deals with the problems associated with adhesive contracts in the medical sector – unfair terms, inequality of bargaining power and exclusion clauses. *Thirdly*, the paper looks into the jurisprudence of the United States of America to see how they have dealt with the question of the enforceability of exclusion clauses through their judicial pronouncements. *Lastly*, the author concludes the paper and submits remedies that can be incorporated to counter the problem posed by unfair terms and sweeping exclusion clauses in hospital contracts.

II. THE EXISTENCE AND NATURE OF A CONTRACTUAL RELATIONSHIP?

It was held by the Hon'ble Supreme Court in *Indian Medical Association v. V.P. Shantha* ("**V.P. Shantha**") that the relationship between a medical practitioner and a patient is a "*contract for personal service.*"[10] Therefore, the relationship between a doctor and a patient is contractual in nature. Similarly, hospitals are also liable for the negligence of doctors

[9] Mohan, *supra* note 1, at 3.
[10] Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651 (India), ¶ 56.

working under them as per the doctrine of *respondeat superior,* which holds the hospital vicariously liable for its employee's negligent acts.[11] Furthermore, the hospital can also be held liable under the doctrine of *ostensible agency,* even if there is no employer-employee relationship between the hospital and the doctor, i.e., when the doctor is an independent contractor.[12]

A contract for medical treatment could either be expressed or implied. Most contracts between a doctor and a patient are implied contracts, except for consent forms.[13] It has also been held by the Supreme Court that by offering medical treatment, a doctor "*impliedly undertakes that he is possessed of skill and knowledge*" necessary for such treatment.[14] Similarly, hospital contracts, more specifically the consent forms signed by patients, are a form of an express contract between the hospital and the patient. The terms of such a contract are unilaterally dictated by the hospital, which makes it a standard form contract.

As per the ICA, a contract will be valid only if there is free consent of both parties while entering into said contract. For any service discharged by a medical practitioner, he has to obtain consent from the patient. Section 13 of the ICA defines "consent" as when "*two or more persons agree on the same thing in the same sense.*"[15] Additionally, the significance of consent is also highlighted under the Code of Medical Ethics, which are guidelines laid

[11] GANEEV KAUR DHILLON, ET. AL., LAW OF BUSINESS CONTRACTS IN INDIA, 218 (SAGE Publications 2009).
[12] *Id.*
[13] *Id.* at 217.
[14] Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651 (India), ¶ 32.
[15] Indian Contract Act, 1872, §13. No. 9, Acts of Parliament, 1872 (India).

down by the Medical Council of India ("**MCI**").[16] Regulation 7.16 necessitates that consent should be acquired from the "*husband or wife, parent or guardian in the case of minor, or the patient himself*" in written form prior to the operation.[17] Obtaining such consent is a standard practice in the Indian medical sector.[18] However, the Supreme Court has recognised an exception to this in the case of an emergency, wherein it is the mandatory obligation of a doctor to discharge medical aid owing to the patient being incapable of giving consent.[19]

This paper, however, shall focus on written consent forms in the health sector concerning non-emergency procedures wherein the patients (or their authorised agents) have to sign the contract to receive medical treatment. Patients who enter into such contracts usually have the mental faculty to read, understand and negotiate (albeit theoretically) an agreement with the hospital.[20] However, the problem here is that the patients face an adhesive contract that contains a myriad of perplexing terms and the patients do not have any power to negotiate the terms of such a contract.[21] In such a case, the patient has no other alternative than to sign on the dotted line.

---

[16] Indian Medical Council (Profession Conduct, Etiquette and Ethics) Regulations, 2002, Gazette of lndia, pt. lll sec. 4 (Apr. 6, 2002).
[17] See *id.,* Reg. 7.16.
[18] Omprakash V. Nandimath, *Consent and medical treatment: The legal paradigm in India,* 25(3) INDIAN J. UROLOGY 343, 344-345 (2009).
[19] Pt. Parmananda Katara v. Union of India, (1995) 3 SCC 248 (India), ¶ 3.
[20] George A. Nation III, *Contracting for Healthcare: Price Terms in Hospital Admission Agreements,* 124(1) DICKINSON L. REV. 91, 136 (2019).
[21] *Id.*

III. HURDLES AND EXCEPTION CLAUSES

A. COMPLICATED TERMS AND UNEQUAL BARGAINING POWER

The central problem that arises in such hospital-contracts is that due to unequal bargaining power, it is the hospital that determines the terms of the contracts, no matter how unreasonable or unconscionable these might be. The problem with such a contractual relationship is that because one party has weaker bargaining power, its consent cannot be considered unequivocal, even if it is genuine.[22] In fact, in such a scenario, the patient has no bargaining power. They either have to accept the terms of the contract, or they will be denied health services. Therefore, the scales tilt in favour of the stronger party, i.e., the hospitals. This ultimately becomes a lose-lose scenario for the patient since they would either have to accept a contract wherein, they have no bargaining power, or, if they refuse to adhere to the contractual terms, then it would lead to them not receiving medical treatment.

Another issue that is associated with these contracts is that the terms of the contract might use lots of complicated legal and/or medical jargon that could render the contract unintelligible for a layperson. Furthermore, the terms and conditions of such contracts are often lengthy and the common masses are not in a habit to read such terms. Therefore, even if a person accepts the terms, he might not be aware of the terms, or the legal implications of what he is consenting to.[23] Such problems are

---

[22] Tasveera Ramkaran, A Critical Analysis of Exclusionary Clauses in Medical Contracts (Dec. 2013) (Unpublished LL.M. thesis, University of KwaZulu Natal) (on file with author) (*hereinafter* "**Ramakaran**").

[23] Sharma, *supra* note 5, at 1163.

further compounded by the use of fine print and exclusionary clauses.[24] It might be argued that a summary can be attached to the front of the document which the people can read and understand before entering into the contract.[25] Although this might solve the problem of legal literacy while contracting, the problem that lingers is that the patients, albeit informed, are still the weaker party and do not have the power to change or negotiate the terms of the contract.

The ICA has remedies to protect the weaker party from components of procedural unconscionability such as protection against undue influence and coercion. This essentially refers to unconscionability that results from improprieties in the formation of a contract.[26] Section 16 of the ICA read with Section 19A renders the contract entered into under undue influence voidable on the option of the influenced party.[27] However, there is no provision to hold the terms of a contract void owing to its unfairness or unconscionability.[28]

The Privy Council and some High Courts in India have warned that inequality in bargaining power cannot be considered a general doctrine for setting a contract as void unless there is a violation of procedural elements such as undue influence.[29] This has been supplemented by the Supreme Court by noting that, if the parties in a commercial contract have entered

24 LAW COMMISSION OF INDIA REPORT NO. 199: UNFAIR (PROCEDURAL AND SUBSTANTIVE) TERMS IN CONTRACTS, at 54 (2006) (*hereinafter* "**Law Commission of India Report**").
25 Sharma, *supra* note 5, at 1163.
26 LAW COMMISSION OF INDIA REPORT, *supra* note 24, at 188.
27 Indian Contract Act, 1872, § 16, 19A, No. 9, Acts of Parliament, 1872 (India).
28 LAW COMMISSION OF INDIA REPORT, *supra* note 24, at 16.
29 Mohan, *supra* note 1, at 11.

into an unconscionable bargain wilfully, they cannot seek any remedy for the same.[30] The Court went on to affirm that a contract will be interpreted based on its wording, and that it is not for the court to make a new contract, no matter how reasonable.[31] The term *caveat subscriptor* – "let the signer beware" – applies and it is assumed that the signatory has read the terms and is hence bound by them.[32]

The author will not get into the debate of whether this position of the Court is justified or not, however, it would not apply to a contractual relationship between a hospital or doctor and a patient. This can be better understood by undertaking a textual analysis of Section 16, which defines "undue influence".[33] Section 16(2) states the condition where a party can be in a position to dominate the will of the other; here clause (a) states that such a position can exist in the case of a fiduciary relationship between the parties.[34] A doctor, by virtue of their qualification, possesses special knowledge in the area of medicine, which puts them above patients who are largely unaware of various illnesses and their ramifications.[35] Since the relationship between a doctor and a patient is based on trust, therefore, there exists a fiduciary relationship between them.

Additionally, clause (b) of Section 16(2) avers that such a position can also exist when the mental capacity of the consenting party is affected

---

30 S.K. Jain v. State of Haryana, (2009) 4 SCC 357 (India), ¶ 8.
31 General Assurance Society Ltd. v. Chandmull Jain, AIR 1966 SC 1644 (India), ¶ 11; S.K. Jain v. State of Haryana, (2009) 4 SCC 357 (India), ¶ 10.
32 Ramkaran, *supra* note 22, at 15.
33 Indian Contract Act, 1872, § 16, No. 9, Acts of Parliament, 1872 (India).
34 Indian Contract Act, 1872, § 16(2)(a), No. 9, Acts of Parliament, 1872 (India).
35 Cameron Stewart, Andrew Lynch, *Undue influence, consent and medical treatment,* 96 J. ROYAL SOCIETY OF MEDICINE 598, 598 (2003) (*hereinafter* "**Stewart and Lynch**").

because of "*illness, or mental or bodily distress*."[36] More often than not, a patient would fall under this category as it could be the very reason, they might seek medical treatment; with the exception of cosmetic procedures. This can be better understood by considering Lord Donaldson's judgement in the English case of *Re T (Adult: Refusal of Treatment)*.[37] Herein, he noted that the capacity of an individual to enter into a contract could be impeded owing to temporary factors such as confusion, pain, severe fatigue, or drugs being used to treat them which could make the patient susceptible to influence.[38]

Therefore, by virtue of the relationship that exists between a hospital or doctor and a patient, they are not only in a position of higher bargaining power but can also exercise undue influence on the weaker party. However, as per Justice Shaw's judgement in the case of *Raghunath Prasad v. Sarju Prasad*, the presumption of unconscionability is also contingent on whether undue influence has been exercised by the dominating party or not.[39] After the determination of this issue, a third point of "*onus probandi*" emerges.[40] Accordingly, the burden of proof is upon the dominating party to show that the contract was not induced by undue influence, and is also given under Section 16(3) of the ICA.[41] Therefore, the burden of proving that a *prima facie* unconscionable contract signed by a patient has not been induced by undue influence ought to lie upon the doctor or the hospital.

---

[36] Indian Contract Act, 1872, § 16(2)(b), No. 9, Acts of Parliament, 1872 (India).
[37] Re T (Adult: Refusal of Treatment), [1992] 4 All ER 649 (India).
[38] *Id.* at 662.
[39] Raghunath Prasad v. Sarju Prasad, (1924) 26 BOMLR 595 (India), ¶ 11.
[40] *Id.*
[41] *Id.*; Indian Contract Act, 1872, § 16(3), No. 9, Acts of Parliament, 1872 (India).

B. EXCLUSION CLAUSES IN MEDICAL CONTRACTS

Exception clauses are beneficial contractual arrangements drafted by either of the parties in anticipation of contingencies that could arise in the future preventing or hindering performance or consequences stemming from "non-performance, part performance or negligent performance" of a contract.[42] One of the primary reasons for the widespread use of such clauses is that organisations can use them to protect themselves from any prospective liability. Within the medical contract, such clauses can be incorporated by hospitals to completely absolve themselves from any liability that might arise. Exclusionary clauses can either exclude partial or complete liability; however, the author shall primarily focus on sweeping clauses that are intended to completely exclude all liability.

Such exclusionary clauses are of the nature that favours one of the parties to a contract, in the present context, the hospitals.[43] Exclusion clauses are recognised by the ICA based on the idea of "freedom of contract."[44] However, the traditional characteristics of freedom to contract and *consensus ad idem* are often absent in such contracts.[45] However, owing to the difference in bargaining power between the hospitals and the patients, these clauses are often misused by the former.[46] The participation of the patient in such cases is therefore limited to mere adherence to the

---

[42] M.P. Ram Mohan & Anmol Jain, *Exclusion Clauses Under the Indian Contract Law: A Need to Account for Unreasonableness,* 13(4) NUJS L. REV. 1, 2 (2020) (*hereinafter* "**Mohan and Jain**").
[43] Ramkaran, *supra* note 22, at 15.
[44] Mohan and Jain, *supra* note 42, at 5.
[45] LAW COMMISSION OF INDIA REPORT, *supra* note 24, at 54.
[46] Mohan and Jain, *supra* note 42, at 7.

unilaterally drafted contract and the exclusion clause precludes the possibility of the hospital being held liable for its actions.

The admission forms of St. George's Hospital in Port Elizabeth and the Sandton Medi-Clinic illustrate the general form such exclusion clauses can take in medical contracts. The exclusion clause states: "*Therefore, by signing this consent to operation form, a patient and any person who signs this form on behalf of such patient, indemnify the Medi-Clinic Group of Companies, as well as their employees, officials and agents against all liability to such patient and to the person.*"[47] Such sweeping exclusion clauses put the already weaker party, i.e., the patient in a rather precarious position. They are at a disadvantage from the very outset, even before the contract is concluded with the hospital.[48] The institutional nature of hospitals enables them to adopt the requisite legal infrastructure to draft such clauses whereas the individual patients agreeing to this have no knowledge of its implications and are left with no recourse.

The author submits that such sweeping exclusion clauses in medical contracts should be considered unlawful and legally unenforceable. The *V.P. Shantha* case talks about the duty of care that needs to be taken by a doctor and the possession of the required "*skill and knowledge*" to discharge medical service.[49] Therefore, it does not follow that exception clauses could be drafted that can render the contravention of this standard to be non-

---

[47] Henry Lerm, *A Critical Analysis of Exclusionary Clauses in Medical Contracts* (July 2008) (Unpublished LL.D. thesis, University of Pretoria) (On file with Author) 1085-1086.
[48] Darragh Douglas Meaker, *Standard Form Contracts and Exemption Clauses for Medical Procedures in South Africa: A Consumer's Narrative,* 23 (LL.M. thesis, University of Pretoria, 2018), https://repository.up.ac.za/bitstream/handle/2263/69917/Meaker_Standard_2018.pdf?sequence=1&isAllowed=y.
[49] Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651 (India), ¶ 31; Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole (1969) 1 SCR 206 (India), ¶ 11.

justiciable. Such exclusion of liability will not withstand the scrutiny of the 'theory of fundamental breach'. This doctrine provides that a party cannot exclude themselves from the liability of a "fundamental" breach, wherein they have failed in performing the 'core' or fundamental obligation in the contract.[50] Since a patient's consent to the overbroad possibility of harm is antithetical to the object of entering into a medical contract, therefore, such clauses shall fail the scrutiny of the aforementioned doctrine.

Regulation 1.1.2 and Regulation 1.2.1 state that the object of the medical profession is to render "*service to humanity*" and the financial aspect is a secondary consideration.[51] Furthermore, the act of advertising by a medical practitioner or a hospital is considered unethical under Regulation 6.1.[52] These regulations indicate that the nature of the contractual relationship in the medical sector is different from commercial contracts undertaken by other institutions.

Two additional factors are relevant here to support the above submission. *Firstly*, as highlighted above, the doctor-patient relationship is of a *fiduciary* nature. This has relevance to the nature and interpretation of a contract, holding the person receiving a service at the end of an informational asymmetry at a higher standard. This is most commonly seen in insurance agreements, where by virtue of the fiduciary relationship and the information asymmetry, the client is held to a higher scrutiny because of the *uberrima fides* obligations arising out of a fiduciary relationship.[53] This

[50] Sharma, *supra* note 5, at 1160.
[51] Indian Medical Council (Profession Conduct, Etiquette and Ethics) Regulations, 2002, Gazette of lndia, pt. lll sec. 4 (Apr. 6, 2002), *supra* note 16, Reg. 1.1.2, 1.2.1.
[52] See *id.,* Reg. 6.1.
[53] Life Insurance Corporation of India v. Asha Goel (Smt.), (2001) 2 SCC 160 (India), ¶¶ 12, 14.

is evidently applicable here, where the medical practitioner has the benefit of the information asymmetry in the fiduciary relationship as discussed earlier. Therefore, contested interpretations in such cases must favour the patient.

Secondly, there is an inherent disparity between the position of a patient, as against a doctor or a hospital. As the author has indicated above, this exists due to the special knowledge that a doctor possesses and the coercive institutional power of hospitals as opposed to an individual patient, leading to disparity in bargaining power.[54] This is different from the first rationale offered in the sense that here the focus is on the differential bargaining power arising out of institutional and knowledge-differential conditions, while the first point is specifically about the special duty arising in a fiduciary relationship.

Lastly, the object of a medical contract also merits a look. Barring cosmetic procedures, patients mostly visit doctors for the treatment of their ailments.[55] As discussed earlier, this could lead to a greater risk of undue influence being exercised over patients while entering into medical contracts. Furthermore, in the case of commercial contracts, a party could decide not to avail of a particular service altogether if the terms of the contract are not amenable to them. However, a patient does not have the same choice since a refusal of treatment could lead to serious ramifications on their health or even death. Therefore, it follows that exception clauses

[54] Mohan, *supra* note 1, at 3.
[55] Stewart and Lynch, *supra* note 35, at 598.

in medical contracts should be subject to a higher test of scrutiny and cannot be granted the same leeway as in the case of commercial contracts.

C. PUBLIC POLICY

Unlike commercial contracts, medical contracts are mostly centred around health. The Supreme Court has held the right to health as an important facet of the right to life under Article 21 of the Indian Constitution.[56] Additionally, under Article 47, one of the duties of the State is to "improve public health".[57] This highlights that health is an important element of public policy and therefore, medical contracts cannot be seen as comparable to those in the commercial sphere.

Additionally, the author contends that medical contracts with sweeping exclusion clauses should be held void to the extent of such clauses, as they are contrary to public policy under Section 23 of the ICA.[58] Section 23 of the ICA states that a contract that is immoral and contrary to public policy shall be held void. In the case of *Central Inland Water Transportation Corporation Ltd. v. Brojo Nath Ganguly* ("**Brojo Nath**"), the Supreme Court held that in standard form contracts wherein a party with superior bargaining power contracts with those with inferior or no bargaining power, then any "unconscionable, unfair, and unreasonable" terms in the contract will be considered against public policy.[59] The court

---

[56] Consumer Education and Research Center v. Union of India, AIR 1995 SC 636 (India).
[57] INDIA CONST., art. 47.
[58] Indian Contract Act, 1872, § 23, No. 9, Acts of Parliament, 1872 (India).
[59] Central Inland Water Transport Corporation Ltd. v. Brojo Nath Ganguly, (1986) 3 SCC 156 (India), ¶ 91; *see also* Lilly White v. R. Munuswami, (1965) 1 MLJ 7 (India).

goes on to say that public policy is not limited to a matter of policy decisions taken by the government, but also matters that are of public interest.[60]

By virtue of the public policy element of healthcare and the implied duties of a medical practitioner as laid down in *V.P. Shantha*,[61] sweeping exclusion clauses will be unreasonable and considered antithetical to public policy under Section 23 of the ICA. A counter to this contention could be that doing so would impinge on the right of freedom of contract of the parties. There have been several cases where the Supreme Court has upheld the validity of 'limitation of liability' clauses.[62] However, the principle of freedom of contract is a "*reasonable social ideal*" insofar as equality of bargaining power can be assumed between the contracting parties.[63] This essentially means that carefully drafted exclusion clauses in case of commercial contracts among equal parties will not attract Section 23 of the ICA.[64] In the ace of standard form contracts though, the party opposing the exclusion clause could argue on the unconscionability of the clause owing to unequal bargaining power among the parties.[65] Therefore, the hospitals should not have an unfettered right to exclude liability and any contractual term that seeks to exonerate the hospital and its staff from such

---

[60] *Id.* ¶ 92.
[61] Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651 (India), ¶ 56.
[62] Bharathi Kinitting Company v. DHL Worldwide Express Courier Division of Airfreight Ltd., (1996) 4 SCC 704 (India), ¶ 6-7.
[63] Delhi Transport Corporation v. D.T.C. Mazdoor Congress, 1991 Supp (1) SCC 600 (India), ¶ 279.
[64] Aditya Mehta, et. al., *Do parties have an unfettered right to exclude or limit their liability for breach of contract? – Part II*, INDIA CORPORATE LAW: CYRIL AMARCHAND BLOGS (Jan. 6, 2023), https://corporate.cyrilamarchandblogs.com/2020/06/do-parties-have-an-unfettered-right-to-exclude-or-limit-their-liability-for-breach-of-contract-part-ii/.
[65] *Id.*

liability will be substantively unfair, i.e., when the terms are in themselves unfair.[66]

IV. United States' Jurisprudence

Exclusion clauses (or exculpatory agreements) in the United States of America are largely considered to be invalid in hospital contracts.[67] The courts employ the common law where they find that public interest has been undermined, and the medical profession and practices fall largely within the domain of public interest.[68] Additionally, unconscionability in contracts is also subject to a test of unenforceability under the Uniform Commercial Code of 1977 ("**UCC**").[69] Section 2-302 of the UCC states that the court may refuse to enforce a contract with an unconscionable clause or enforce the remainder of the contract without the unconscionable clause.[70]

One of the leading cases American on the matter of exclusion clauses is *Tunkl v. Regents of University of California* ("**Tunkl**") wherein the plaintiff brought a suit challenging a clause that absolved all liability of the hospital for any future acts of negligence while treating patients.[71] The clause read that "*the patient or his legal representative agrees to and hereby releases The Regents of the University of California, and the hospital from any and all liability for the negligent or wrongful acts or omissions of its employees, if the hospital has used*

---

66 LAW COMMISSION OF INDIA REPORT, *supra* note 24.
67 Ramkaran, *supra* note 22, at 24.
68 *Id.*
69 LAW COMMISSION OF INDIA REPORT, *supra* note 24, at 77.
70 The Uniform Commercial Code, U.C.C § 2-302 (Am. Law Inst. & Unif. Law Comm'n 1977).
71 Tunkl v. Regents of University of California*,* 60 Cal.2d 92 (Cal. 1963).

due care in selecting its employees."[72] The Supreme Court of California held this clause to be legally unenforceable and stated that such clauses exculpating the hospitals from negligent acts are contrary to public interest.[73] In coming to its decision, the court propounded six criteria for the validity of such a clause that has been explained in the following paragraph.

The court held that such contracts should pertain to a business that merits public regulation and that is engaged in providing a service of great salience to the public, having an element of practical necessity attached to it for the public.[74] The court also held that such a party holds themselves out as willing to perform the aforementioned service to almost any member of the public.[75] Owing to the essentiality of the service and the economic context of the transaction, the party with the greater bargaining power has an undue advantage that it exercises to preclude protection of the purchaser from the party's negligence.[76] This essentially puts the purchaser in a precarious position wherein they are subject to the carelessness of the seller or their agents.[77]

These six criteria were reaffirmed and heavily relied on by the Supreme Court of Tennessee in the case of *Olson v. Molzen*.[78] The court, in coming to its decision, considered the inequality of bargaining power

---

[72] *Id.*
[73] Kevin F. Harrison, *Taking the Tort out with a Contract: Liability Release Contracts in California*, 15(2) WESTERN STATE UNIVERSITY L. REV. 785 (1988).
[74] Tunkl v. Regents of University of California, 60 Cal.2d 92 (Cal. 1963), ¶ 1.
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] Olson v. Molzen, 558 S.W.2d 429 (Tenn. 1977).

between the hospital and the patient while rejecting the exculpatory clause.[79] However, this test of enforceability of exculpatory clauses was extended only to contracts of professional services.[80] Medical practice, by virtue of being a professional service, therefore falls under this category. Subsequently, this question of the validity of exclusion clauses also arose in *Copeland v. HealthSouth/Methodist Rehabilitation Hospital* wherein an elderly man entered into a contract with a medical transportation company with a clause excluding the company from liability in case of negligence on its part.[81] The Supreme Court of Tennessee held that such a clause is unenforceable and that the validity of exculpatory clauses in professional or non-professional service contracts will be contingent on the relative weight given to the following factors — relative bargaining power of the parties, comprehensibility of language in exculpatory clauses, and public policy implications.[82]

V. CONCLUSION AND WAY FORWARD

Through this paper, the author has highlighted that the contractual relationship between a doctor or hospital and a patient is innately different from the one which exists in other commercial contracts. As held in the *V.P. Shantha* case, doctors have an implied responsibility to employ a reasonable duty of care and to apply the requisite "*skill and knowledge*"

---

[79] Daniel J. Adomitis, *Torts - Medical Malpractice - Limitation of Liability,* 45 TENNESSEE L. REV. 791, 793 (1977-1978).

[80] Holden Branscum, *Enforceability of Exculpatory Clauses: Judicial Declarations of Public Policy as a Means to Promote Freedom of Contract in Tennessee,* 51 UNIVERSITY OF MEMPHIS L. REV. 811, 813 (2021) (*hereinafter* "**Branscum**").

[81] Fredrick Copeland v. HealthSouth/Methodist Rehabilitation Hospital, 565 S.W.3d (Tenn. 2018).

[82] Branscum, *supra* note 80, at 818.

required while discharging any medical service.[83] Furthermore, there exists an inherent inequality of bargaining power between the hospital, which is an institution, and the patient who is an individual.

Additionally, the healthcare sector is intrinsically tied to public policy by virtue of being a matter of public interest as has been argued in this paper. Therefore, sweeping exclusion clauses in hospital contracts that give a free rein to hospitals to exonerate themselves of all liability seem to be grossly repugnant. Hospitals should not have unfettered freedom to contract out of the "duty of care" that they owe to patients and to exclude liability for negligence on their part. Hence, it follows that such sweeping clauses should be held void under Section 23 of the ICA as being opposed to public policy.

This intrinsic connection between the field of medical practice and public policy is equally visible in the United States, as it is in India. Therefore, the author submits that exclusionary clauses in hospital contracts in India should be subject to a similar test as laid down by the Supreme Court of California in the *Tunkl* case. As highlighted earlier, one limitation of the statutory framework in India is that it does not deal with the question of unfair terms in contracts, i.e., substantive unfairness. Certain other countries, for instance, the United Kingdom have tackled this issue by enacting a separate statute. Under the UK Unfair Contract Terms Act, 1977 ("**UCTA**") exclusions clauses are subjected to a 'test of reasonability' under Section 11, and the matters with regards to the requirement of reasonableness have been stated in Schedule 2 of the Act.[84]

---

[83] Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651 (India), ¶ 56.
[84] Unfair Contract Terms Act, 1977, § 11, sch. 2 (Eng.).

Similarly, the UCC in the United States prescribes that unconscionable clauses in contracts should be subject to a test of enforceability and shall be held invalid to the extent of such a clause.[85]

Although, sweeping exclusion clauses might be opposed to public policy, however, there might be other unconscionable clauses in hospital contracts that are *prima* facie unfair. The ICA does not propose any provision proscribing substantive unconscionability, save for a public policy exception under Section 23.[86] Therefore, the author contends that India should have a crystallised statutory position that deals with the enforceability of exception clauses, subjecting it to a test of reasonability. This can be achieved by adopting the recommendation of the 103rd Law Commission Report given under Chapter 6. The insertion of a new chapter and section has been proposed, combining the elements of the UCTA and the UCC:[87]

"Section 67A : (1) Where the Court, on the terms of the Contract or on the evidence adduced by the parties, comes to the conclusion that the contract or any part of it is unconscionable, it may refuse to enforce the contract or the part that it holds to be unconscionable.

(2) Without prejudice to the generality of the provisions of this section, a contract or part of it is deemed to be unconscionable if it exempts

---

[85] The Uniform Commercial Code, U.C.C § 2-302 (Am. Law Inst. & Unif. Law Comm'n 1977).

[86] Mohan, *supra* note 42, at 10.

[87] LAW COMMISSION OF INDIA REPORT NO. 103, UNFAIR TERMS IN CONTRACT, at 9 (1984).

any party thereto from—(a) the liability for wilful breach of the contract, or (b) the consequences of negligence."[88]

Another problem that could foreseeably arise is that despite such remedies being incorporated into the Indian jurisprudence, they would only serve as curative remedies as they would come into force only after the breach of duty has taken place. It is submitted that there should also exist a preventive remedy to protect the interests of the patients even before they enter into the contract. Here, the author submits that the role of a regulatory authority can be instrumental in the medical sector to oversee hospital contracts.

Several regulatory authorities, such as the Insurance Regulatory Development Authority ("**IRDA**") and the Telecom Regulatory Authority of India ("**TRAI**") regulate contracts between companies and individuals.[89] They have numerous clauses in their statutes ensuring that no company in these sectors can benefit unreasonably at the cost of the consumers.[90] As per the author, similar regulatory authorities should also be set up by the States since health falls under the "State List" as per the Constitution.[91] These regulatory authorities could lay down the broad stipulations that ought to be adhered to by hospitals while drafting their standard form contracts for the patients.

---

[88] *Id.* at 9.
[89] ARIJEET SHUKLA & PRAKHAR AGARWAL, CONTRACTS, AGREEMENTS AND PUBLIC POLICY IN INDIA 186 (National Law School of India University 2015).
[90] *Id.* at 186.
[91] INDIA CONST, art. 246, sch. VII.

Additionally, regional authorities can be set up within this framework in order to regulate the "terms and conditions" offered to the patients, akin to what is provided by Section 14(2)(i) of the IRDAI Act for the insurance sector.[92] This would enable and empower these regulatory bodies to strike down any unfair or unconscionable terms that exist in such hospital contracts. These bodies can undertake periodical assessments, similar to what has been envisaged under the Clinical Establishments (Registration and Regulation) Act, 2010,[93] in order to ensure that any unconscionable term or a sweeping exclusion clause is vitiated and retracted. This would protect the patients from being on the end of an unfair bargain and ensure that hospitals cannot preclude liability by incorporating overbroad exclusion clauses in their contracts.

---

92 Insurance Regulatory & Development Authority Act, 1999, § 14(2)(i), No. 41, Acts of Parliament, 1999 (India).

93 Clinical Establishments (Registration and Regulation) Act, 2010, § 5(c), No. 23, Acts of Parliament, 2010 (India).