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# CROSS-STATE TELEMEDICINE LICENSING AND DATA PRIVACY IN INDIA

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Ashmit Chauhan, National Law Institute University

Aryan Pundir, National Law Institute University

Vismaya Tulsian, National Law Institute University

## ABSTRACT

Telemedicine has moved from the periphery of healthcare delivery in India to its institutional core. What began as an emergency response during the COVID-19 pandemic has now crystallised into a routine mode of medical consultation, diagnosis, and follow-up care, particularly for populations located far from tertiary healthcare facilities. Yet, the legal framework governing telemedicine remains tethered to territorially bounded regulatory paradigms that were designed for a pre-digital era. This paper examines the constitutional, regulatory, and data protection challenges posed by cross-state telemedicine in India. It argues that the existing framework the Telemedicine Practice Guidelines, 2020 and the Digital Personal Data Protection Act, 2023 fail to adequately resolve jurisdictional uncertainty, professional accountability, and health data governance in interstate teleconsultations. Drawing upon Indian Supreme Court jurisprudence on proportionality, professional regulation, privacy, and cooperative federalism, alongside comparative federal models from the United States, European Union, Canada, and China, the paper proposes an integrated institutional reform framework. This framework comprises a National Telemedicine Registry under the National Medical Commission, sector-specific health data governance rules under the DPDP Act, and specialised adjudicatory mechanisms for interstate telemedicine disputes. The paper contends that such coordinated institutional reform is essential to realise telemedicine's constitutional promise under Articles 14 and 21 of the Constitution of India.

## I. Introduction

Telemedicine unsettles one of the most deeply embedded assumptions of modern medical regulation that the practice of medicine is territorially fixed<sup>1</sup>. For much of the twentieth century, professional licensing regimes across jurisdictions operated on the premise that medical practice occurred at a physical site, typically where a physician and patient were co-present. This assumption shaped not only licensing requirements but also disciplinary jurisdiction, standards of care, and liability frameworks. Digital medical practice disrupts this logic in fundamental ways. When a physician located in Chennai conducts a video consultation with a patient in rural Ladakh, geography ceases to offer a stable anchor for legal authority. The law is forced to confront questions it was not designed to answer: where does medical practice occur, which regulator exercises disciplinary control, and which legal regime governs the data generated in the course of treatment?

India's engagement with telemedicine predates the pandemic, but it was COVID-19 that transformed telemedicine from a marginal innovation into a central pillar of healthcare delivery. The nationwide lockdowns of 2020 rendered physical consultations difficult or impossible, compelling regulators to legitimise remote care at unprecedented speed. The issuance of the *Telemedicine Practice Guidelines* in March 2020 marked a critical moment in this regulatory shift<sup>2</sup>. For the first time, teleconsultation was formally recognised as lawful medical practice rather than an emergency exception. What was initially conceived as a temporary accommodation, however, has since hardened into routine reliance. Telemedicine is no longer exceptional. It is ordinary.

Despite this transformation, the legal architecture governing telemedicine remains procedurally permissive but institutionally incomplete. The Guidelines provide granular instructions on how teleconsultations may be conducted which are by addressing consent, documentation, and prescription protocols but they remain conspicuously silent on questions of interstate practice. Physicians remain uncertain whether a registration with one State Medical Council suffices for nationwide tele practice. Patients are often unclear about the appropriate forum for redress when harm arises from an interstate teleconsultation. Telemedicine platforms, meanwhile, operate in a compliance grey zone under data protection law, unsure whether they function as

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<sup>1</sup> Ministry of Health & Family Welfare, *Telemedicine Practice Guidelines* (Mar. 25, 2020) (India).

<sup>2</sup> Board of Governors, *Telemedicine Practice Guidelines* (2020) (India) (in supersession of the Med. Council of India).

data fiduciaries or mere processors. These uncertainties are not merely administrative inconveniences<sup>3</sup>. They generate a chilling effect that discourages interstate specialist consultations, exacerbates access disparities, and undermines the transformative potential of telemedicine.

This paper advances the central claim that India's telemedicine governance suffers less from a lack of rules than from a lack of institutional coordination. The problem is not doctrinal absence but regulatory fragmentation. Telemedicine sits at the intersection of constitutional federalism, professional regulation, tort law, and data protection. Each of these domains is governed by distinct institutional actors operating with limited coordination. The result is a patchwork framework that places disproportionate compliance burdens on practitioners while offering limited clarity to patients. Addressing this fragmentation requires moving beyond guideline-based regulation towards integrated institutional solutions capable of reconciling state autonomy with national healthcare objectives.

The paper proceeds in eight parts. Part II situates telemedicine within India's constitutional structure, examining how federalism and professional regulation doctrine respond to borderless medical practice. Part III analyses the *Telemedicine Practice Guidelines* as a form of delegated legislation, highlighting their jurisdictional silences and doctrinal vulnerabilities. Part IV examines medical negligence and interstate liability, focusing on forum selection and standards of care. Part V analyses health data governance under the *Digital Personal Data Protection Act, 2023*, with particular attention to consent, fiduciary responsibility, and continuity of care. Part VI offers a comparative analysis of federal approaches to telemedicine regulation. Part VII proposes an integrated reform framework tailored to India's constitutional and institutional context. Part VIII concludes by situating telemedicine governance within the broader constitutional commitments to equality and access to healthcare.

## II. Constitutional Foundations: Health, Federalism, and Professional Regulation

Healthcare regulation in India is constitutionally located within *Entry 25 of List III of the Seventh Schedule*, placing it within the Concurrent List<sup>4</sup>. This allocation reflects a deliberate constitutional choice that healthcare is both a matter of national concern and one that requires localised administration sensitive to regional needs. This balance manifested through state-

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<sup>3</sup> World Health Organization, *Global Strategy on Digital Health 2020–2025* (2021).

<sup>4</sup> INDIA CONST. sched. VII, list III, entry 25.

centric medical licensing regimes enforced by State Medical Councils, with the Union playing a coordinating role through central regulatory bodies such as the Medical Council of India and, subsequently, the National Medical Commission. The constitutional design presupposed that medical practice was territorially anchored, making state-level control both administratively efficient and normatively defensible.

Telemedicine fundamentally unsettles this settlement. When medical consultations occur through digital interfaces, the assumption that professional practice is geographically fixed becomes increasingly artificial. The constitutional question is not whether states possess the power to regulate medical practice but whether territorially rigid licensing requirements remain constitutionally reasonable when applied to borderless medical services. This question must be analysed through the Supreme Court's jurisprudence on professional regulation, proportionality, and federal coordination.

In the case of *Modern Dental College v State of Madhya Pradesh*<sup>5</sup> the Supreme Court upheld extensive regulatory control over professional education, but with an important caveat. The Court emphasised that regulatory intervention must satisfy the test of proportionality and cannot impose excessive or arbitrary barriers to professional practice. The Court observed, that the regulation must be facilitative rather than obstructive. This principle acquires renewed significance in the telemedicine context. A regulatory requirement that compels physicians to obtain multiple state registrations merely to offer teleconsultations across state boundaries risks transforming regulatory supervision into a structural barrier to practice.

The proportionality framework articulated in *Modern Dental College* was later defined in *Internet and Mobile Association of India v RBI*<sup>6</sup>, where the Court invalidated the Reserve Bank of India's prohibition on banking services for cryptocurrency exchanges. The Court did not question the regulator's authority to address systemic risks. Instead, it held that regulatory action must be calibrated to demonstrable harm and must adopt the least restrictive means available. This reasoning suggests that speculative concerns regarding patient safety or regulatory oversight cannot justify blanket territorial licensing restrictions that effectively foreclose interstate teleconsultation.

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<sup>5</sup> *Modern Dental Coll. & Rsch. Ctr. v. State of M.P.*, (2016) 7 SCC 353.

<sup>6</sup> *Internet & Mobile Ass'n of India v. Reserve Bank of India*, (2020) 10 SCC 274.

Federalism jurisprudence further supports a coordinated regulatory approach. In the case of *State of Rajasthan v Union of India*<sup>7</sup>, the Supreme Court articulated a vision of cooperative federalism in which state and Union powers are exercised in harmony to advance national objectives. Access to healthcare particularly in geographically remote or underserved regions constitutes such a national objective. Fragmented licensing regimes that impede interstate telemedicine risk undermining this constitutional commitment by privileging territorial control over substantive access.

The constitutional analysis thus points towards a regulatory model that preserves state oversight of professional standards while enabling nationally coordinated practice rights. Telemedicine does not require the erosion of state authority, but it does require its reconfiguration. Cooperative federal mechanisms rather than rigid territorial exclusivity are better suited to reconcile professional regulation with the constitutional imperatives of equality and access under *Articles 14 and 21*.

### **III. The Telemedicine Practice Guidelines and the Limits of Delegated Regulation**

The Telemedicine Practice *Guidelines*, notified in March 2020 by the Board of Governors in supersession of the Medical Council of India, constitute the principal regulatory instrument governing telemedicine in India. Their issuance was widely perceived as a pragmatic and timely response to the exigencies of the COVID-19 pandemic. For the first time, teleconsultation was formally recognised as lawful medical practice rather than an informal or emergency deviation from standard care. The Guidelines prescribe detailed procedural safeguards relating to patient identification, informed consent, record-keeping, and prescription of medicines, thereby seeking to normalise telemedicine within the ethical framework of the medical profession.

As telemedicine evolved from an emergency accommodation into a routine mode of healthcare delivery, the structural limitations of the Guidelines have become increasingly evident. Most critically, the Guidelines are conspicuously silent on questions of interstate practice and jurisdictional competence<sup>8</sup>. They do not clarify whether registration with a single State Medical Council authorises a physician to provide teleconsultations to patients located in other states. Nor do they specify which regulatory authority is competent to investigate professional

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<sup>7</sup> *State of Rajasthan v Union of India* (1977) 3 SCC 592.

<sup>8</sup> *Medical Council of India Act*, No. 102 of 1956; *National Medical Commission Act*, No. 30 of 2019.

misconduct arising from cross-state teleconsultations. This silence has produced a fragmented regulatory landscape in which State Medical Councils retain broad discretion to assert jurisdiction on an ad hoc basis.

The legal significance of this omission becomes apparent when the Guidelines are examined through the lens of Indian administrative law. As a form of delegated legislation, the Telemedicine Practice Guidelines derive their authority from the statutory framework governing medical regulation. Subordinate legislation, is subject to well-established doctrinal constraints. The Supreme Court has consistently held that delegated legislation may be invalidated where it is arbitrary, unreasonable, or fails to address essential aspects of the parent statute<sup>9</sup>. Crucially, subordinate legislation cannot avoid foundational regulatory questions by deferring them indefinitely to executive discretion.

When applied to telemedicine, this doctrine exposes a core vulnerability in the Guidelines. The parent statutory framework governing medical practice is not confined to procedural ethics alone; it is centrally concerned with licensing, discipline, and professional accountability. Declining to address jurisdictional competence in interstate teleconsultations, the Guidelines leave unresolved a question that lies at the heart of professional regulation. This omission is not merely technical. It has tangible consequences for practitioners who may face overlapping or inconsistent regulatory demands, and for patients who may struggle to identify appropriate forums for grievance redressal.

The problem is further compounded by the structure of State Medical Councils themselves. In the absence of clear national rules, councils may interpret their jurisdiction expansively, asserting disciplinary authority over physicians registered in other states on the basis that harm occurred within their territorial boundaries. Such assertions risk creating a chilling effect on interstate telemedicine, particularly for specialists who provide consultations across multiple jurisdictions. From an administrative law perspective, this outcome is difficult to justify. Regulatory discretion, while necessary, must operate within clearly defined boundaries to prevent arbitrariness and unequal treatment.<sup>10</sup>

More broadly, the Guidelines exemplify a recurring pattern in Indian digital regulation: the privileging of procedural compliance over institutional design. While safeguards such as

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<sup>9</sup> *State of T. N. v P Krishnamurthy* (2006) 4 SCC 517 (India).

<sup>10</sup> *Indian Express Newspapers (Bombay) Pvt Ltd v Union of India* (1985) 1 SCC 641 (India).

consent and documentation are essential, they cannot substitute for a coherent allocation of regulatory authority. Telemedicine implicates questions of federal competence that delegated legislation is structurally ill-equipped to resolve. As telemedicine becomes an ordinary mode of care, reliance on provisional guideline-based regulation risks producing systemic instability.

In this sense, the limitations of the Telemedicine Practice Guidelines are not accidental but structural. They reflect the constraints of emergency rule-making in a domain that now demands durable institutional solutions. Without statutory clarification or coordinating mechanisms capable of mediating between state and Union authorities, telemedicine regulation will remain perpetually incomplete.

#### **IV. Medical Negligence, Jurisdiction, and Interstate Liability in Telemedicine**

Indian medical negligence jurisprudence has evolved through a combination of tort principles, consumer protection mechanisms, and professional disciplinary norms. These doctrines have been applied within a territorially bounded framework in which the location of treatment, the physician's place of practice, and the forum of adjudication largely coincided. Telemedicine disrupts this alignment. When medical advice is rendered across state boundaries through digital interfaces, the determination of jurisdiction, applicable standards of care, and appropriate forums for redress becomes significantly more complex.

The Supreme Court's foundational articulation of medical negligence is found in *Spring Meadows Hospital v Harjol Ahluwalia*<sup>11</sup>, where the Court affirmed that medical professionals owe a duty of reasonable care and competence to patients. This duty is not absolute; it is assessed with reference to the standards prevailing within the medical profession. The Court subsequently refined this approach in *Jacob Mathew v State of Punjab*, emphasising that negligence must be evaluated against accepted medical practice and cautioning against criminalising mere errors of judgment. Importantly, *Jacob Mathew* also recognised the need to protect medical professionals from frivolous or excessive litigation, noting that over-deterrence may ultimately harm patient care.<sup>12</sup>

These principles, however, were articulated in the context of physically co-located medical practice. Telemedicine introduces a jurisdictional discontinuity that existing doctrine does not

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<sup>11</sup> *Spring Meadows Hosp. v Harjol Ahluwalia* (1998) 4 SCC 39 (India).

<sup>12</sup> *Jacob Mathew v State of Punjab* (2005) 6 SCC 1 (India).

adequately address. When an adverse outcome arises from an interstate teleconsultation, multiple jurisdictional claims become plausible. The patient may seek to invoke the jurisdiction of courts or consumer fora in the state where harm was suffered, while the physician may argue that professional regulation and liability should be governed by the law of the state in which she is registered and practises. In the absence of statutory guidance, courts may adopt divergent approaches, undermining predictability and legal certainty.

Consumer protection jurisprudence exacerbates this uncertainty. The Consumer Protection Act, 2019 permits consumers to institute complaints in forums where the cause of action arises, wholly or in part<sup>13</sup>. Applied to telemedicine, this provision potentially enables patients to institute proceedings in their home states against physicians located elsewhere. While such access-enhancing provisions are normatively attractive from the patient's perspective, they risk imposing disproportionate burdens on medical practitioners, particularly specialists who provide teleconsultations across multiple states. The prospect of being hailed before multiple consumer fora across the country may discourage physicians from engaging in interstate telemedicine altogether.

Comparative experience illustrates the stakes of this choice. In the United States, courts have often adopted a "*patient-location doctrine*", treating medical practice as occurring where the patient receives care. While this approach prioritises patient protection, it has also necessitated the creation of interstate licensure compacts to mitigate compliance burdens. Wholesale adoption of a patient-location doctrine in India, without corresponding institutional safeguards, would likely exacerbate regulatory fragmentation rather than resolve it.

The absence of specialised adjudicatory mechanisms further compounds the problem. Ordinary consumer fora are ill-suited to adjudicate complex questions involving interstate jurisdiction, professional standards, and digital evidence. The result is a liability regime that is simultaneously over-inclusive and under-coordinated: expansive in forum availability, yet deficient in doctrinal coherence<sup>14</sup>. A telemedicine-specific liability framework must therefore reconcile two competing imperatives, ensuring accessible remedies for patients while providing physicians with predictable and proportionate regulatory exposure.

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<sup>13</sup> *Consumer Protection Act*, No. 35 of 2019, §§ 34, 47, 58 (2019).

<sup>14</sup> Organisation for Economic Co-operation & Development, *Addressing the Liability Challenges of Telemedicine* (OECD Health Pol'y Stud., 2020).

## V. Health Data Governance and Telemedicine under the DPDP Act, 2023

Health data constitutes the informational backbone of telemedicine. Every teleconsultation generates, processes, and transmits sensitive personal data, including medical histories, diagnostic information, prescriptions, and follow-up records. The enactment of the *Digital Personal Data Protection Act, 2023* marks a significant shift in India's data governance landscape, introducing a comprehensive statutory framework for the protection of personal data. Its relevance to telemedicine is therefore both immediate and profound.

The normative foundation of the DPDP Act lies in the Supreme Court's decision in *Justice K.S. Puttaswamy v Union of India*<sup>15</sup>, which recognised informational privacy as an intrinsic component of the right to life and personal liberty under Article 21. The Court emphasised individual autonomy, consent, and purpose limitation as central to any legitimate data processing regime. The DPDP Act operationalises these principles through a consent-centric framework, requiring data fiduciaries to process personal data only for lawful purposes and with the informed consent of data principals.

While this framework strengthens individual autonomy, its application to healthcare raises distinctive challenges. Medical treatment often requires continuous and iterative data processing over extended periods. The *DPDP Act's* emphasis on freely revocable consent creates tension with professional obligations of continuity of care<sup>16</sup>. A patient's withdrawal of consent midway through treatment may place physicians in an ethical dilemma: compliance with data protection law may conflict with the duty to provide ongoing medical care. Unlike the *European Union's General Data Protection Regulation*, which explicitly permits health data processing for medical treatment without repeated consent, the Indian framework lacks a comparable sector-specific carve-out.

The position of telemedicine platforms further complicates the data governance landscape. Platforms increasingly play an active role in structuring consultations, storing medical records, deploying algorithms, and facilitating follow-up care<sup>17</sup>. Yet the *DPDP Act* does not clearly delineate whether such platforms function as data fiduciaries, joint fiduciaries, or mere data processors. This ambiguity has significant compliance implications. If platforms are treated as

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<sup>15</sup> *Justice K S Puttaswamy (Retd) v. Union of India*, (2017) 10 SCC 1 (India).

<sup>16</sup> *Digital Personal Data Protection Act*, No. 22 of 2023, §§ 4–7 (2023).

<sup>17</sup> Regulation (EU) 2016/679 of the European Parliament and of the Council, art. 9(2)(h), 2016 O.J. (L 119) 1.

independent fiduciaries, they bear primary obligations relating to consent management, breach notification, and grievance redressal. If they are treated as processors, responsibility shifts towards physicians or healthcare institutions.

This uncertainty risks producing perverse outcomes. Smaller practitioners and start-up platforms may adopt excessively conservative compliance strategies, limit data collection or withdrawing services altogether. Larger platforms, by contrast, may leverage superior compliance infrastructure to consolidate market power. In this sense, the absence of sector-specific data protection rules threatens not only privacy but also competition and access within the telemedicine ecosystem.<sup>18</sup>

From a constitutional perspective, these concerns implicate both *Articles 14* and *21*. Uneven compliance burdens may produce arbitrary differentiation between similarly situated practitioners, while inadequate data governance undermines the informational autonomy recognised in *Puttaswamy*. A calibrated regulatory response must therefore balance individual privacy with the functional realities of healthcare delivery. Sector-specific rules clarifying consent exceptions for treatment, delineating fiduciary responsibilities, and standardising health data practices are essential to achieving this balance.

## **VI. Comparative Federal Models of Telemedicine Regulation**

Comparative federal experience underscores a central insight; sustainable telemedicine governance is less a function of substantive medical standards than of institutional coordination. Jurisdictions that have successfully scaled cross-border telemedicine have done so by recalibrating licensing, liability, and data governance through cooperative mechanisms rather than by insisting on territorially exclusive control. While no foreign model can be transplanted wholesale into the Indian constitutional context, the institutional logics animating these systems are instructive.

### **A. United States: Interstate Medical Licensure and Coordinated Federalism**

The United States offers a paradigmatic example of coordination without centralisation. Medical licensing remains a state function, yet interstate telemedicine is facilitated through the *Interstate Medical Licensure Compact (IMLC)*. The Compact does not create a national licence;

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<sup>18</sup> NITI Aayog, *Health Data Management Policy* (2020).

instead, it streamlines verification and enables expedited multi-state licensure for eligible physicians. This model preserves state authority over professional discipline while reducing compliance friction for interstate practice.<sup>19</sup>

The normative strength of the *IMLC* lies in its recognition that territorial sovereignty and professional mobility need not be antagonistic. States retain disciplinary power, but they cede exclusivity in verification. The Compact emerged not through federal pre-emption but through inter-state agreement, reflecting a cooperative federalism ethos. The Indian analogue would not be an identical compact, but a nationally coordinated credentialing mechanism that respects state oversight while enabling borderless practice.

### **B. Canada: Bilateral Reciprocity and Incremental Harmonisation**

Canada's federal structure assigns healthcare regulation primarily to provinces. In response to pandemic-era constraints, several provinces adopted bilateral reciprocity arrangements permitting physicians licensed in one province to practise telemedicine in another. This incremental approach prioritised access while avoiding sweeping structural reform<sup>20</sup>.

Yet the Canadian experience also reveals the limits of bilateralism. Reciprocity agreements remain uneven across provinces, producing patchwork access and legal uncertainty. The lesson for India is cautionary that bilateralism without central coordination risks reproducing fragmentation, particularly in a country with far greater inter-state diversity and scale.

### **C. European Union: Country-of-Origin Regulation**

Within the European Union, cross-border healthcare operates under a country-of-origin principle, whereby service providers are regulated primarily by their home states<sup>21</sup>. This approach presupposes a baseline equivalence of regulatory standards across Member States, reinforced by supranational oversight and judicial harmonisation.

India lacks the structural conditions that make this model viable. Variations in state-level regulatory capacity, disciplinary enforcement, and institutional resources render a pure

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<sup>19</sup> Interstate Medical Licensure Compact (2017).

<sup>20</sup> Canadian Medical Association, *Virtual Care in Canada: Progress and Barriers* (2021).

<sup>21</sup> Directive 2011/24/EU of the European Parliament and of the Council on the Application of Patients' Rights in Cross-Border Healthcare, 2011 O.J. (L 88) 45.

country-of-origin approach normatively fragile. Nonetheless, the EU model highlights the importance of regulatory trust and mutual recognition which are elements that any Indian reform must consciously cultivate.

#### **D. China: Centralised Registries and Administrative Control**

China's telemedicine framework relies heavily on centralised registries and administrative oversight. Physicians registered on national platforms may offer teleconsultations across provinces under uniform standards<sup>22</sup>. While this model enables scale and clarity, it does so at the cost of transparency, professional autonomy, and procedural safeguards.

For India's constitutional democracy, the Chinese approach functions more as a cautionary contrast than a template. Centralisation without accountability risks eroding professional independence and patient trust.

#### **E. Comparative Synthesis**

Across jurisdictions, a common thread emerges; telemedicine governance succeeds where institutions mediate territorial authority rather than entrench it. Whether through compacts, reciprocity, or registries, effective systems recognise that borderless care demands coordinated oversight. India's challenge is to design institutions that enable such coordination while respecting constitutional federalism and professional autonomy.

### **VII. Towards an Integrated Indian Framework for Telemedicine Governance**

India's telemedicine challenges cannot be resolved through marginal adjustments to existing guidelines. What is required is an integrated institutional framework capable of reconciling state authority with national healthcare objectives, professional accountability with practitioner mobility, and data protection with clinical continuity. This section proposes three mutually reinforcing reforms.

#### **A. National Telemedicine Registry under the National Medical Commission**

First, India should establish a *National Telemedicine Registry (NTR)* under the *National*

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<sup>22</sup> National Health Commission of the People's Republic of China, *Internet Diagnosis and Treatment Measures* (2018).

*Medical Commission (NMC)*. The Registry would not replace state medical registers; rather, it would function as a coordinating credential enabling registered physicians to engage in interstate telemedicine.<sup>23</sup>

Eligibility for the Registry could be conditioned on verification of state registration, compliance history, and completion of telemedicine-specific training modules. Once registered, physicians would be authorised to provide teleconsultations nationwide, subject to uniform professional standards. State Medical Councils would retain disciplinary authority over their registrants, but complaints arising from interstate telemedicine would be channelled through coordinated procedures. This model preserves state oversight while eliminating duplicative licensing. It aligns with the Supreme Court's insistence that professional regulation be facilitative rather than obstructive, and it operationalises cooperative federalism in a concrete institutional form.

## **B. Sector-Specific Health Data Rules under the DPDP Act**

Second, the Data Protection Board should promulgate sector-specific rules for health data processing under the *Digital Personal Data Protection Act, 2023*. Generic consent frameworks are ill-suited to the clinical realities of telemedicine. Health data governance requires calibrated exceptions that recognise the ethical imperatives of treatment continuity.<sup>24</sup>

Such rules should:

- (i) Clarify consent exceptions for medical treatment and follow-up care;
- (ii) Delineate fiduciary responsibilities among physicians, hospitals, and platforms; and
- (iii) standardise data retention, breach notification, and grievance redressal mechanisms in healthcare contexts.

By providing clarity, sector-specific rules would reduce compliance anxiety, prevent market concentration driven by regulatory asymmetries, and strengthen the informational autonomy recognised under *Article 21*.

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<sup>23</sup> *National Medical Commission Act*, No. 30 of 2019, §§ 10, 24 (2019).

<sup>24</sup> *Digital Personal Data Protection Act*, No. 22 of 2023, § 40 (2019).

### C. Specialised Adjudicatory Mechanisms for Interstate Telemedicine Disputes

Third, India should establish specialised adjudicatory mechanisms either dedicated telemedicine benches within existing tribunals or a standalone Telemedicine Disputes Tribunal with jurisdiction over interstate telemedicine disputes<sup>25</sup>. Ordinary consumer fora lack the technical expertise and jurisdictional coherence necessary to adjudicate complex questions involving digital evidence, professional standards, and cross-border liability. Specialised adjudication would enhance consistency, reduce forum shopping, and provide both patients and practitioners with predictable remedies. Crucially, it would allow liability standards to evolve in dialogue with professional norms rather than in isolation from them.

### D. Normative Justification

Taken together, these reforms advance three constitutional objectives. First, they promote equality by enabling uniform access to medical expertise irrespective of geography. Second, they safeguard personal liberty and dignity by ensuring continuity of care and data protection. Third, they respect federal structure by coordinating state authority.

Telemedicine governance, in this sense, becomes not a threat to federalism but an opportunity to reimagine it.

## VIII. Conclusion

Telemedicine forces Indian public law to confront a foundational misalignment between inherited regulatory structures and contemporary modes of service delivery. The territorial assumptions that historically underpinned medical licensing, professional discipline, and liability adjudication were premised on a world in which medical practice occurred through physical co-presence. Telemedicine dissolves this spatial coincidence. In doing so, it exposes the limits of regulatory frameworks that continue to treat geography as the primary determinant of legal authority.

This paper has argued that the central challenge confronting telemedicine governance in India is not one of regulatory absence, but of institutional fragmentation. The Telemedicine Practice Guidelines, while normatively significant, operate as provisional instruments that legitimise

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<sup>25</sup> Law Commission of India, *Consumer Protection and Medical Services*, Rep. No. 242 (2012).

teleconsultation without resolving the deeper questions of jurisdiction, accountability, and interstate practice. Medical negligence doctrine, developed within territorially bounded settings, struggles to accommodate cross-state digital care without producing uncertainty for both patients and practitioners. The *Digital Personal Data Protection Act*, grounded in a robust privacy jurisprudence, risks imposing compliance structures that insufficiently account for the ethical and functional realities of healthcare delivery. Each regime, considered independently, is defensible; taken together, they reveal a governance architecture that lacks internal coherence.

The constitutional implications of this fragmentation are substantial. *Article 21* of the Constitution, as interpreted by the Supreme Court, has long encompassed access to healthcare as an element of dignity and personal liberty. When regulatory uncertainty deters physicians from offering interstate teleconsultations, access to medical expertise becomes contingent on geography rather than need. *Article 14's* guarantee of equality is similarly implicated when patients in peripheral or underserved regions are structurally disadvantaged by regulatory architectures designed around territorial exclusivity. Telemedicine thus emerges not merely as a technological innovation, but as a constitutional stress test revealing how far legal institutions have adapted to the realities of a digitally mediated society.<sup>26</sup>

At the same time, the challenges posed by telemedicine do not justify the erosion of federalism or professional autonomy. The answer is not centralisation for its own sake, nor the displacement of state authority in favour of uniform national control. Rather, as the comparative analysis demonstrates, effective telemedicine governance depends upon coordination rather than consolidation. Jurisdictions that have successfully scaled cross-border telemedicine have done so by designing institutions that mediate between levels of authority, enable mutual recognition, and preserve professional accountability without imposing duplicative barriers.

The integrated reform framework proposed in this paper seeks to operationalise these insights within India's constitutional structure. A National Telemedicine Registry under the National Medical Commission would reconcile practitioner mobility with state oversight. Sector-specific health data rules under the Digital Personal Data Protection Act would align privacy protection with the imperatives of clinical continuity. Specialised adjudicatory mechanisms for interstate telemedicine disputes would restore coherence to liability and grievance redressal.

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<sup>26</sup> *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37.

These proposals do not expand regulatory power so much as rationalise it. They aim to transform telemedicine regulation from a patchwork of provisional fixes into a durable institutional settlement capable of adapting to technological change without sacrificing constitutional values.

Ultimately, the question telemedicine poses to Indian law is not whether digital healthcare should be regulated, but how regulation should be structured in a constitutional democracy marked by federalism, diversity, and deep social inequality. To insist on territorial rigidity in the face of borderless care is not regulatory caution; it is regulatory abdication. Telemedicine offers India an opportunity to rethink how law mediates space, authority, and access in the digital age. Whether that opportunity is realised will depend on the willingness of legal institutions to move beyond inherited forms and toward coordinated, constitutionally grounded governance.