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Dr Satish Tiwari
Founder President IMLEA & the editorial board

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INDIAN MEDICO LEGAL & ETHICS ASSOCIATION

Aims & Objectives

- To promote, support and conduct research related to medico-legal, ethical and quality care issues in the field of medicine.
- To help, guide, co-ordinate, co-operate and provide expert opinion to the government agencies, NGO, any semi-government, voluntary, government agencies, legal bodies / institutions and judiciary in deciding settled or unsettled laws or application of laws / rules related to medico-legal or ethical issues.
- To train the medical professionals in doctor-patient relationship, communication skills, record maintenance and prevention of litigations.
- To promote and support the community members and individuals in amicable settlements of the disputes related to patient care, management and treatment.
- To provide specialized training in related issues during undergraduate or postgraduate education.
- To organize conferences, national meets, CME, updates, symposia etc related to these issues.
- To identify, establish, accreditation and promote organizations, hospitals, institutes, colleges and associations working on the related and allied issues.
- To promote goodwill, better care, quality care, professional conduct, ethical values.
- To establish and maintain educational institutes, hospitals, medical colleges, libraries, research centers, laboratories etc. for the promotion of its objects and to provide scholarships, fellowships, grants, endowments etc. in these fields.
- To print and publish the bulletins, books, official journal / newsletters or periodicals etc on related and allied subjects.
- To co-operate, co-ordinate, affiliate and work with other bodies, agencies or organizations to achieve the objects.

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Dear Colleague,

Warm regards.

Please accept our heartiest season's greetings .The practice of medicine has changed drastically in the twenty first century. There have been much great advancement but, at the same time, there have also been many negative changes. The good age-old doctor-patient relationship has suffered and seems to be in dire straits. The communication skills have deteriorated. Commercialization is the obvious agenda ,especially with the emerging corporate culture in the health sector. The concept of privatization has added fuel to the fire. The patient who are willing to pay, feel that even life can be purchased with money. This has resulted in their soaring expectations. Doctors are not only affected by medico-legal cases but also many other legal problems arising out of other related issues of staff, instruments & infrastructure. The Government is coming up with newer and newer laws and restrictions on medical fraternity and hospitals. We have experienced this on many occasions which prompted us to form, along with likeminded colleagues & friends ,to form this medico-legal & ethics association.

In last few years we have encountered various medico legal problems, which as medical consultants / medico-legal experts, we have tried to solve are trying to solve, sometimes single handedly. It was then, that we realized the need of a fleet of experts to work in co-ordination. The association has thus been formed to help you in solving legal disasters in your practice. We hope that we will succeed in achieving the aims and objects of guiding the medical practitioners in their difficult times. The various membership benefits include:

1) Personal / individual professional indemnity cover of Rs.1 lac (Amount and terms decided by Executive Board) for up to five years is included (for cases after becoming member) in life membership fee.
2) Hospital insurance at concessional rate (as compared to other insurance / risk management companies).
3) Free medico-legal guidance in hours of crisis.
4) Services of crisis management committee at the city / district level.
5) Free expert opinion if there are cases in court of law.
6) Services of legal experts at concessional rates (wherever available).
7) Participation in academic activities related to medico-legal issues.

All this can't be achieved without the help of dedicated, hard working and sincere members of the association. Hence, we would like you to become the member of this association. We hope that with active & enthusiastic members like you, our association will attain greater heights as we progress further. Please send your constructive criticism, suggestions, and programs for the future.

Yours truly,

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Police, Doctors and Society

EDITORIAL

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The third millennium has seen many turbulent changes in the society. The **"Zero tolerance"** is obvious in the behavior of each and every citizen in the community. The more we are educated the more we are moving away from each other as far as human relations are concerned. This deterioration has resurfaced the principle of 'eye for eye' 'hand for hand' or 'life for life' concept of the ancient era before law and judiciary had evolved. In those days, every man was constituted a judge in his own cause, and might was the sole measure of right.[1] The respect for human life has declined at the cost of 3 'M' i.e. "Money, Material and Muscle power". The doctor-patient relationship has also been affected by these negative changes in the last few years. Every relationship is a dynamic process and doctor patient relationship is no different. It has gone a sea change since its beginning thousands of years back. It will be a futile exercise to look back and remember the good old days when the doctor was an all powerful "demigod".[2] The relations between doctors, patients and police are on the verge of breakdown if definitive and constructive efforts are not initiated by all concerned with immediate effect. We cannot overlook the fact that two wrongs do not really make a right. A wrong done over and over again by a large number of people, and highly educated people at that, soon becomes the order of the day.

Role of Doctors:

The word doctor is derived from 'docere' which means "to teach". But today's doctors have no time to teach health education to their patients neither the patients want to learn the preventive aspect of medical science. As discussed earlier, both the parties have become materialistic and commercialized, interested only in the final and favorable outcome. The medical graduates, who are buying the qualifications and experiences from the private institutions or corporate hospitals have to settle the loans or financial advances that too with interest as soon as they enter the practice or even before. Similarly the patients or relatives who have insurance and have paid the premium feel that the **'money can buy life'**. But this doesn't happen in actual life. The life can be maintained with money but can't be purchased. One can guarantee the care but not the cure or quality of life. The soaring expectations, increasing accountability, decreasing communication and judicial activism have torn apart the fabric of doctor- patient relationship.

Role of Police:

The condition and situation of police is more pitiable. The selection process is full of corruption, the service conditions most of the times are inhuman and though they are implementers of law but as a routine they have to obey unlawful orders of their seniors or policy makers. The situation is so bad that the Supreme Court had to declare them as **"Caged parrot".**[3] Because of all these it is unfair to expect them to work sincerely, without pressure, unbiased and to their optimal potential. Their duty hours are unlimited even during festive seasons or when other members in the society are enjoying the vacation or holidays. Everybody can sleep but police has to remain awake in order to maintain the law and order. Many times they may have to protect the corrupt at the cost of innocent. In fact many times their action against the innocent is target based. They have to prove that they are working by completing their target based action against those who may not be the real culprits, criminals or major law breakers in the society. It is said that; ***"Power corrupts the individual and excess power results in excessive corruption".*** Administration, especially police officers implement the laws enacted by the parliament or assemblies or the precedents set out or directives given by the honorable courts. Many times it is at this stage that the medical practitioners face the maximum problems which may even go to the extent of arrest and/ or imprisonment till the court directive. This can happen because of ignorance of law about the kind of sections or clauses that are to be applied. The offence belonging to Sec 304 or 304-A of IPC exemplifies this best. It is also known that every action has reaction.

Hence if we want to have a cordial relation between the doctors and law makers we have to listen and understand the views of all concerned. There is an urgent need to plan, think and develop effective ways to solve the problem of the deteriorating scenario in the community.

Role of Media:

The media is supposed to be one of the pillars of democracy. But in the present era of yellow journalism even the credibility of media is questionable. We are in the era of **"Paid news"** where one can publish or transmit the news favorable to him/ her by paying some amount to media. It is also possible to defame someone by pressurizing the media. Because of the technical advances it is very easy to create **'media hype'**. But unfortunately the technological explosion has also some drawbacks which we forget to understand. Doctor-patient relationship is probably one area where involvement of media has probably resulted in negative impact rather than a positive outcome. It has been observed that some of the law-fearing or media- shy doctors have started defensive practice in order to minimize future problems. It is a well accepted fact that a positive aspect should be highlighted more than the negative aspect. But, in order to increase their viewership the media is giving more exposure to negative changes in the society.

Role of Society:

Public opinion can hardly influence the unjust and the turbulent members of society. ***The influence of public censure is least felt by those who need it the most.*** The individuals in the society are at the receiving end from all the directions. The individual member is the maximum sufferer because of these turbulent changes in the community. Everybody, be it a professional, authority, law makers or even implementers are trying to exploit the common man. The common man is churned by day to day happenings in the society. He has to face not only the financial constraints but also ethical, moral, legal, emotional and so many other hurdles in the life. An average common man has to bear the brunt of the few so called educated or qualified members of the society. Everybody is targeting the classes and not the masses. *Hence if we want to improve the situation, we will have to come out strongly against those who are exploiting us. The society will have to protect the sincere, dedicated, service oriented medical professionals*. The members will have to look into the competency rather than the quantity of the practitioners and health facilities. In the era of advertisement and globalization most of the commodities are of "use and throw" variety. Can we also have "**disposable doctors**" for our health care needs? Can we dispose off a doctor and select another one if we are not satisfied with the services of the previous one? What about the damage already caused to the patient? Can doctors and health care system become commodities, which can be hired or purchased with money? Doctors can be pulled up by society every now and then, with or without reason. Who will tell the society about its responsibilities?[4] People will have to act as a 'watch-dog'. If they shirk their responsibilities today, they may not have a second chance tomorrow. The society requires need-based health care set-ups and not only the five star hospitals. If there is need for big hospitals in cities then it is equally needed in rural set up also.

Role of Associations:

The various associations are formed with the aim of providing services to the masses and to help and guide their members in the hours of crisis. But, in the present scenario, most of the associations have become political organizations functioning for the personal gains. The associations must understand their aims and objectives and work for achieving the same. This is the time to understand the difficult situation in which the medical practitioners have to work and give their optimal services. There is need for the members to have **'self introspection'** and to find out where and with whom lies the fault? According to Medical Council of India, regulations; chapter 1.7, A Physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.[5] The associations should help the members in formulating the programs which will help in improving the present scenario.

Role of Government/ Judiciary:

The administration of justice is the modern and civilized substitute for the primitive practice of private vengeance and violent self-help. The ultimate responsibility rests in the judiciary, policy makers and

the Government. If they fail in their duties probably the era of 'eye for eye' 'hand for hand' or 'life for life' may return. Very often one incidence led to another, and the consequent act would not confine itself to one individual, but along with him other related would be the victims of retaliation. The state should make sure that this does not happen. If one has to prevent this in the present **"So called Modern age"** scenario, the role of judiciary and government can't be neglected. The deterrent theory tries to put an end to the wrong by causing the fear of punishment in the mind of the wrong–doer, while the preventive theory aims at preventing a wrong action by disabling the wrong–doer. There is no political willingness to improve the deteriorating situation. The apathy and anarchy in the political system is very obvious as the politicians are interested in protecting their own position at any cost. The policy makers have came out with many laws, Acts, ordinances, legislations etc but now there is need to implement these without any bias, differentiations and corrupt practices. There is need to have a coordination between different sections of society.

Most of the states in India have come out with Ordinance or Acts which seeks to Prohibit Violence against Medicare Service Persons and Damage to Property in Medicare Service Institutions and for Matters Connected Therewith and Incidental Thereto. Any offender, who commits any act in contravention of Section 3, shall be punished with imprisonment for a period of three years and with fine, which may extend up to Rupees fifty thousand. Any offence committed under Section 3, shall be cognizable and non-bailable. In addition to the punishment specified in Section 4, the offender shall be liable to a penalty of twice the amount of purchase price of medical equipment damaged and loss caused to the property as determined by the court trying the offender.[6]

The hon'ble SC in, **C A no. 3541 of 2002, Martin F. D'Souza v Mohd. Ishfaq** has observed that, frivolous complaints against doctors have increased by leaps and bounds in our country particularly after the medical profession was placed within the purview of the CPA. We warn the police officials not to arrest or harass doctors unless the facts clearly come within the parameters laid down in Jacob Mathew's case otherwise the policemen will themselves have to face legal action. It is true that the medical profession has to an extent become commercialized and there are many doctors who depart from their Hippocratic Oath for their selfish ends of making money. However, the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence just because of some bad apples.

On 22 September 2006, the Supreme Court of India delivered a historic judgment in ***Prakash Singh vs. Union of India*** instructing central and state governments to comply with a set of seven directives laying down practical mechanisms to kick-start police reform. The Court's directives seek to achieve two main objectives: *functional autonomy for the police* - through security of tenure, streamlined appointment and transfer processes, and the creation of a "buffer body" between the police and the government - and *enhanced police accountability*, both for organizational performance and individual misconduct. After decades of public pressure, lack of political will and continued poor policing, a police reform process is finally budding.[7]

Crisis management committee:

In the present scenario, the doctors, police, media and the society should **work as friends and not as foes.** If we want to improve the situation these components of the society should come together, more so in the hours of crisis. One of the solutions to the deteriorating doctor- patient relationship can be a crisis management committee. The experts from different sections of society, policy makers, judiciary and government must look in this direction with a positive attitude. Most of the times whenever there is some untoward incidence the situation can be tackled if the various section of the society are handled tactfully and peacefully. The need is to convince that no sane person will damage his own reputation, image and interest by doing something wrong or unwanted. Many untoward happenings are mere accidents and there is no "Mens rea".

Finally, one has to remember that, ethics cannot be practiced by few individuals it has to become both a norm and a standard. There is need to launch a major drive to educate doctor fraternity to begin with.[8] Standards of medical care are rising, as also the patient's expectations. This race may convert medical practice into a battle ground between the doctors and the patients. Even verbal threats need to be taken

cognizance of in the stated law although there is a problem of providing for proof of such threats by the service providers. The police officer needs to be trained in this regard and should be held accountable for the same. At present there is hardly a provision for refresher courses in law available for police officers. Responsibility for the same lies with the Government. It is also incumbent on government to hold guilty police officers responsible and take corrective actions for the same. There is need to have a compromise between different sections of society without causing harm to any particular individual. Someone has to become the "whistle blower" whenever need arises. We must take steps to create a space for ethical doctors to be able to learn a living while practicing their profession with dignity and self-respect.

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MODEL FORMAT

Discharge Against Medical Advise

(Can be printed/filled in local/vernacular language)

My patient _____ s/o,d/o _____ is admitted in this hospital _____ <*name of the hospital*> since _____ <date of admission>. He/She been suffering from _____.

The condition of the patient is serious and the treating doctors are continuing their treatment .They have asked me not to take discharge. They have also informed, in clear language, the possible consequences after discharge or during the transfer of the patient. But it is difficult for me, due to my own reasons, to keep the patient in this hospital and to continue the treatment here. Hence I am taking discharge against medical advice and transferring the patient on our own risk and responsibility. The doctors shall not be responsible for any unexpected complications/consequences.

I/We have been explained all these in the language known to me/us and I'm/we're signing this form without any pressure/coercion and after satisfying my queries/doubts.

Name of the patient _____ age/sex _____

Name of the relatives _____

Relationship _____ Witnesses

Signature 1)

Date & time 2)

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Clinical Governance (CG): Principles and its Relevance in Indian Context

REVIEW ARTICLE

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Indian Healthcare scenario is largely unstructured. Once a doctor qualifies, (s)he is free to practice without any obligation on updates.

Clinical governance (CG) is a Quality Control tool. Therefore, its relevance in Indian context cannot be over-emphasized. Even the qualification conferred to a doctor is not beyond doubt in this country in reality. There is still legal lack of clarification between the qualifications of a doctor and an alternative healer. This is a sheer Quality Control issue, which cannot be overlooked the way we can overlook it in India. This is a country where "anything goes". But a country cannot progress without its health. Health is a matter of discipline. "Anything goes" is no discipline. Therefore, more than anywhere else perhaps, India needs CG and needs it badly.

Doctors in Distress [DnD]

Why are doctors in Distress? Why are doctors in Distress in India? We will try to answer these two fundamental questions from the Indian perspective. Let us begin in some loose unstructured discussion to bring the point home as follows:

Once a doctor obtains his or her basic MB BS qualification, they usually find themselves torn between various options open to them. Some succeed in getting in to post-graduation (PG) courses, some pursue other options.

Many, who enroll at PG courses, do so as a 'must do', rather than pursuing their actual areas of interest. Some gain entry unparliamentarily! One can easily imagine what sort of a PG doctor (s)he can become as a finished product!

However, one must not overlook the real-life scenario. These young minds are baffled by the stark reality staring at them when they were raring to go as a serving soul. They have already milked their parents dry (often) financially in completing the basic graduation course. Yet, they are in no position of making a living by themselves through honorable means. Economic realities are interwoven in to our traits of succumbing easily in face of adversities, often forcing them to choose the unethical means.

This is a person in distress! Here, the distressed person is a young doctor, prone to making wrong choices at the cross roads of his/her commencement of journey professionally! The path is often slippery from then onwards.

Then the doctor again faces distress, when (s)he starts professional life, PG or no PG. The patient and relatives seem ungrateful, often conniving. Pathological laboratories allure with bribery of such vehemence, that individually, defeat seems imminent (or, at least the doctor convinces him/herself so). Without touts, professional success feels like mirage (allegory is unintended!). Pharma companies seem unavoidable menace. Where does the doctor turn!

So, the Doctor is in Distress!

It is therefore, imperative that we understand how in Indian real-life context, a doctor can pull her/himself out of such peril. Doctors in Distress [DnD] initiative talks about some of the following issues in the context of CG in India:

Communication

One of the major bones of contention is commotion with patients and their relatives. A significant proportion of this aggravation is provoked by the doctors themselves by making unprofessional or inadvertent comments (i) about the patient's condition, (ii) about a fellow doctor, (iii) about the care of the patient or (iv) about the behaviour of the patient or relatives etc.

Doctors often think that the lay public will understand medical topics and conditions. They are ill-trained about how it feels to be on the other side of the table. So, their often well intended (not always, unfortunately) comments create misunderstanding.

Communication is a science, which must be formally and systematically learnt before any practitioner should be let loose on the community. DnD proposes

a basic course like the diploma of Integrative Medicine of the University College of London, without which a doctor is bound to misstep today or tomorrow. Communication must be intensely trained in medical curricula at every level. Without regular updates, it is so easy to get sloppy on communication.

A significant majority of complaints may be avoided in the first place, if discussion with patients and relatives are sincere, truthful, objective and professional. For all these things, the communication does not have to be lengthy. If conducted competently, it can be completed promptly without giving an impression that the doctor was rushing.

In MRCPCH (UK) examination preparatory courses, counseling training is given as examinees will be given tests on communication to see, if the candidate is fit to be a post-graduate doctor who should be able to communicate health related issues with patients and their relatives efficiently without spending too long a time.

In India, we need similar standardization.

Objectivity

There is so much that an Indian doctor can put on resource crunch, that the entire fraternity often show a tendency to digression into excuses of using anecdotes! Where established norms and guidelines are followed, legal distresses could go away! For example, in *Kanhiyalal Dudey vs. Sanjay Jain I* (2007) CPJ 295, while treating a case of malaria medical experts agreed that the treatment was not contrary to the established norms. The treating doctor thoroughly explained his conduct and line of treatment and was successfully acquitted.

Probity

It is easy to fall prey to the confusions and allures of the day to day reality in medicine. But, at the end of the day, it is up to the doctor, whether (s)he wants to tread phony paths. It is an individual decision and the budding doctor (and since then) must realize that (s)he has a choice at such cross roads, which will determine how distressed (s)he will get in his/her professional life.

So, although it seems difficult, but an honest line of walk, no matter what the dire situation is, could hardly go wrong in the long run. CG principles help ***prevent*** such occurrences.

DnD is nothing new. Almost all such relevant issues have been discussed in various medico-legal text books. The new bit in DnD is an honest effort in putting it all together avoiding unnecessary confusion so that ***implementation*** becomes possible in the long run, reducing confusion; as we all know, in India ***implementation*** is most often the final challenge! DnD hopes to create Indian CG, which is implementable!

CG in India

Now we will examine applicability of each component of CG in three Indian contexts *viz*.

1. Doctors in Public (Government) Sector
2. Doctors in Private Sector
   a. In private hospitals and
   b. In lone private practices

We will start with Risk Management for being probably most relevant and easily discussed topic amongst CG in Indian context.

CLINICAL RISK MANAGEMENT

Doctors in Public Sector

Requirements

a. Designated Doctor as Health & Safety Officer
b. Cannot be a Doctor who is involved in clinical activity while exercting this role
c. Can be rotational post for clinician. This will improve their understanding of compliance
d. A senior manager (may or may not be a doctor) in supervisory position

Limitations

a. Dependent on institutes' attitudes towards these positions
b. Depends on leadership of the organizational heads
c. Dependent on courage and dedication of the employee
d. Dependent on implementation of recommendations etc.

Please refer to the section of Addendum 1 (Case Study) below (see end)

Doctors in Private Healthcare Institutes

Requirements

a. Mandatory requirement of Quality Control Officer, who should have no other responsibilities

b. Mandatory inspections with rotational inspectors

c. First 5 years, inspectors should advise on improvements needed

d. After the set date 5 years on non-compliance should be statutorily accounted for

Limitations

a. Nexus formation

b. De facto or phantom posts

c. Poor commitment

d. Poor implementation

Doctors in Lone Private Practices

Requirements

a. Barefoot inspectors designated for an area but rotational duty to help the doctors

b. Short, sharp, modular courses with regular updates to the doctors

c. Helpful initiatives, to find out local requirements and take a staged approach

d. Helpful attitudes of personnel, but committed to improvements

Limitations

a. Personnel cutting corners

b. Poor understanding of what can be done under the circumstances

c. Rigid application of rules, making initiative look punitive and not helpful

d. Leniency without understanding the ethos of 'learn and move on'

In all of the above, a fundamental question will be – who will fund all these initiatives?

But, let us first examine the other components of CG under Indian context. Let us take up the example of EBM (Evidence Based Medicine) next.

PRACTICING EVIDENCE BASED MEDICINE [EBM]

Doctors in Public Sector

Requirements

a. National and Statewide vetting of developed Clinical Protocols and Guidelines

b. National and statewide formulation of necessary Clinical Protocols and Guidelines

c. Establishment of National Institutes of Clinical Excellence

d. Monitoring of compliance through transparent mechanisms

Limitations

a. Lack of fundamentals e.g. experts who command (as opposed to demand or negotiate) leadership authority in his or her respective field of clinic-academic world

b. Lack of culture of Inclusivity and Consultative Process

c. Institutional culture of mistrust embedded in our psyche

d. Misuse of freedom of expression by members of the profession

Doctors in Private Healthcare Institutes

Requirements

a. Mandate in implementing vetted/formulated protocols

b. Inclusivity of wealth of expertise available in private healthcare sector

c. Allowing for local limitations *i.e.* staged approach in culturally sensitive matters but a resolve to root out poor standards in the name of culture, religion or local practices with time – the pace of which must be sensitively but not too slowly determined by standard approaches

d. Empower Whistle Blowing (also essential in Risk Management)

Limitations

a. Partisan attitude between professionals in private and public healthcare sectors

b. Excuses for poor execution and too lenient

c. Institutional subversion and dodging

d. Corporate bullying, especially with whistle blowing (there are case studies e.g. in the Bristol Heart cases where the Whistle Blower was supported to the hilt despite governmental pressure etc. Makes interesting reading)

Doctors in Lone Private Practices

Requirements

a. Clear Care Pathways (Clinical and Administrative) for lone practitioner to follow e.g. MRCGP

b. Provide strong support for training and re-training (see CPD/CME section or Staff Development)

c. Incentive schemes for compliance (transparent and clear cut – Evidence Based)

d. Voluntary participation for older generation (Dodos have died down!)

Limitations

a. Angry reactions and resistance to change

b. Risk of the system need overwhelming the need to support the lone practitioner

c. One more gigantic layer of bureaucracy

d. Need for constant training of the implementing personnel

It might be worthwhile at this stage just to recuperate the reasons for gap in standards and practices:

Reasons for the gap between evidence and practice include:

- Lack of knowledge and /or lack of confidence
- Fear of legal or patient pressure or loss of income
- Lack of physical skill
- Inadequate resources
- Pressure of work
- Old habits.

The next CG module set for discussion in Indian context would be Staff Development.

STAFF DEVELOPMENT

It is worthwhile to familiarize yourself with all the terms like CPD, CME, PDP, RITA, Appraisal or Revalidation as Staff Development through life-long-learning is an essential component of CG.

It is heartening to see that recently, MCI approved CME hours are in vogue. Therefore, in India, there is already an atmosphere to assure quality of on-going medical training and education in a structured way from now on. CPD portfolios with PDPs should follow suit.

Doctors in Public Sector

Requirements

a. Heads accountable for supporting the staff

b. PDP through regular (e.g. annual) formal Appraisal process

c. Institutional support to learning activities

d. All learning should eventually translate to better standards of care

Limitations

a. Existing culture of nepotism and subjecting to obedience

b. Risk of being abusive and discriminatory unless leadership skill is monitored

c. Existing culture of expecting to move through professional career without needing to perform

d. Learning becomes the main goal where patient care ultimately suffers

Doctors in Private Healthcare Institutes

Requirements

a. Clear chain of command. Mentor cannot be professional competitor

b. Institutional understanding that empowering staff development eventually translates in to increased and sustainable revenue generation

c. Documentation process is least hurtful *i.e.* user-friendly *e.g.* available on mobile phone apps; not time consuming and auto updating *e.g.* no need to duplicate etc. One suggestion could be bar coding, once scanned against the medical registration number, should automatically upload itself on the CPD apps with all details *e.g.* which course, how many hours etc.

d. Carrot and stick model *i.e.* minimum required CME points and high points translating into rewards like percentage reduction in conference registration fees etc.

Limitations

a. Conflict of interest. The best performing clinician may not be the biggest earner of CME

b. Used rigidly without factoring in other modalities of clinical good practice recognition process

c. Useless mix of CME points, without logical flow of learning path *e.g.* no clear PDP reflection

d. Huge assessing machinery needed for this to be of any use with fairness

Doctors in Lone Private Practices

Requirements

a. Properly trained and qualified Mentor

b. Understanding the complexities and uniqueness of each lone practice

c. Balance between compassion and quality assurance *e.g.* remoteness cannot be an excuse of not being able to use ORS for profuse diarrhea

d. Locality mapping every few (5 to 7) years

Limitations

a. Lack of quality mentors in large numbers

b. Too much unstandardized variability

c. Quackery

d. Might simply be a deterrent to deliver healthcare professionals to remotest areas

Please refer to the section of Addendum 2 (Case Study) below (see end)

WHO WILL BELL THE CAT?

A legitimate criticism of all these aspirations is that who will fund and manage all these?

The answer to this fundamental question lies in cascading the following stream of logic and suggestions of Action Points:

Are Indian doctors distressed by the current situations?

If yes, then do the doctors believe that something must be done?

If yes, then who do they think should do and what should be done?

Is there any point in concluding that nobody will come forward to do anything or nothing is possible to be done by this stage?

Do we have a choice as a professional group to just give up? Would that help?

If answer to the last question is 'NO', then shall we try to make a start?

Shall we get to the basic and re-do the exercise of brainstorming and coming up with some Action Points as a start?

Do we agree that we may not make a perfect start but making a renewed effort is welcome?

Do we have to re-invent the wheel or closely examine how much of a proven successful model elsewhere be adopted in Indian scenario?

Can we agree that CG model is not a panacea to all our maladies but it is trying to do only two basic things *viz*. (i) establish a Quality Control practice frame in Personal Practices of a doctor practicing in India with uniformity and (ii) de-clutter the system of errors, risks, lack of update, retrospection or realistic standard of practice to ensure what doctors were trained to do in the first place *i.e.* save and heal, without having fear of reprimand while ensuring high quality standard of care?

As individual doctors we may not be in a position to make system change, but there are organizations professional, governmental and otherwise who can come together to establish the norms and executions. For example, Indian Academy of Pediatrics can liaise

with Central and State Ministries and invite organizations like GMC, UK to pledge commitments to CG implementation (and not railroading it). CG is important in every medical field but probably mostly so where children are concerned.

Two decades back, nobody would have probably believed that all doctors could be asked to register with state medical councils or asked to renew their licenses to practice. But such impossibilities of yesterday are a commonplace reality of today in every nook and corner of India. Therefore, what sounds utopian today can certainly become reality tomorrow. CG has come to be in place in the developed world for a reason – out of necessity – and not for any fancifulness.

The more complex and advanced a society becomes, human life is valued better and demand for better healthcare becomes inevitable. Better healthcare cannot be delivered without a managed system. CG has already delivered this management umbrella to the best possible way out of all other possibilities tested.

We may choose to delay its adoption and suffer for longer until we have no other choice left and we have made our experiments and mistakes in the process or we can try to put the advanced system suiting it to our local needs but not necessarily destroying its fundamentals in the name of Indianization sooner!

It is a choice of our fraternity, which represents this (healthcare) stream of our society. And what we choose today will determine how much of professional distress we can reduce and how good a quality of service we can provide to our clients, who, in our case, are minors.

Therefore, we must find a way to fund this initiative, privately, publicly or jointly. In the west, a lot of funding comes from philanthropy dedicated to such projects of national importance. India probably is not in that league. But who knows? Probably time only can tell!

WHO SHOULD FUND ALL THIS?

This is a fundamental question without which, CG cannot be implemented and India will fall short of modernization, which are not only necessary, they are imperative in today's context.

India already has the superstructure, while west already has the model. Medical Council of India needs to be headed by ***trained*** professionals of unquestionable character. This is a fundamental pre-requisite for it to be the apex body of CG, which it ought to be. MCI is equivalent to GMC (General Medical Council) of the UK.

Academic bodies throughout the world usually behold CG mechanism, wherever it is in existence. Indian Academy of Pediatrics (IAP) and Indian Medico Legal & Ethics Association (IMLEA) should implement a National CG protocol in Pediatrics like that of RCPCH (Royal College of Paediatrics & Child Health) of the UK and similarly in the other disciplines.

RCPCH and GMC are funded through Royal accord. IMA (Indian Medical Association), IAP, IMLEA and similar academic bodies, through a Health Ministry decree must pull funds for CG (DnD) initiative. CG principles may be brought into force to ensure that the unethical power that the Pharma companies holds over Indian physicians through direct and indirect means, are wiped away in one decisive blow.

Company sponsorship will not be allowed at individual levels or even group levels without taking it through the designated academic bodies. Pharma companies will save unprecedented amount of money in not having to sustain unholy alliances to ensure push sells (read unnecessary and/or unethical prescriptions).

Doctors and certain academic bodies, who are inclined to favour some academic topics over some vital but non-commercial ones, in overt and covert influences, will be free to pick up academic exercises free from commercial pressures. It will of course, be a challenge to keep the decision making bodies free of petty pests, a large majority of who tend to push their way through by being vociferous and go getters, finally to empower our country glow on the merit of knowledge and honest professionalism.

Health Ministry of Government of India can bestow such power on MCI so as to ensure that every Pharma company operating in India must give a certain percentage of their annual book profit to MCI, which MCI will disburse to the academic bodies of 'Good Standing' (defined) to hold CME approved academic

events. MCI can initially delegate the survey to a globally reputed organization like Mackenzie's to map current state of Health Educational activities for practicing doctors.

State Governments should be mandated to support this decree without any power of stopping it but they may all first be allocated the bursary according to their level of participation. Central Government should allocate the fund and monitor it and they will have overriding power to allocate separately to academic bodies in each state, in case the state's bursary is under used, improperly used or if their action does not fall in line with the Central Health Ministry's Medical Educational Plan.

Currently our CME (Continuing Medical Education) Program in India remains disjointed and often without vision and PDP (Professional Development Plan). A doctor often either has to repeat same theme in courses or attends unrelated courses, which may not be the best use of their intellectual resources.

A part of the CME with built-in PDP can be funded through such decree to Pharma companies, as they are already funding such activity, often to an unholy end. CME activity with built-in PDP exists in the UK's CPD (Continuing Professional Development) activity, which now has taken a whole new dimension with Revalidation.

Revalidation is something that India must work towards (may be in a slow phasic manner, as otherwise it has a potential to be extremely unfair, given Indian passion for poorly thought of quick fix solutions with consequent human tragedies, which are shoved under the carpet without care or conscience).

Since CG or DnD are huge subject in themselves and there are volumes written about them already, it is not possible to encompass every issue in this chapter alone. We invite readers of this chapter in particular to write their suggestions to improve future chapters with concrete examples and case studies.

CG and Indian Law

India has a strong law base. Our judiciary has remained at the forefront of their discipline with prompt updates and upholding newer principles emerging globally. But implementation usually fell far behind in India.

Judiciary applies common sense to understand medicine whenever there is a brush with the law. It is a safeguard against medical man playing God. However, medicine has become rather too complex and simple common sense may not be enough to apply law for or against any medical matter anymore.

For example, regarding custody in surrogate parenthood, the complexities of ethics and law must be mastered before a lawyer can argue a case for or against or the judge or jury can contemplate a verdict.

DnD initiative can help formulate Medicine Specialist lawyers and judges, which can also take awareness building exercises for the jurors of the future. There must be initiative in creating specialist Law practitioners and Judges on branches of medicine. CG committee should oversee such education and qualification. This should be stretched to Law enforcing agencies, namely Police and Social Services. This is especially true in Child Welfare related litigations.

The case of the Kolkata children at Norway ought to highlight the gaping deficiencies in Indian expertise in the field with consequent quick fixes, which rely on matter of chances where society washes its hands off rather easily! Instead, CG principles could have generated proper expertise development initiatives nationally.

Our law might be great. But our interpreters probably need to walk long miles before our practices can reach that pinnacle. After all CG is about "doing the right thing the right way round, every time". Simple to say, but only together, we can – without being flippant about it.

Addendum 1

Jaspal Singh vs PGI-Chandigarh (2000): Death due to transfusion of wrong group of blood.

A burn victim was given two units of B + ve blood on two separate days where her blood group was A + ve. When she expired, allegation was made for negligence. The State Commission of Chandigarh held that there was negligence on the part of doctors and staff of the hospital leading to death! It is a classical textbook case of common pitfall in institutionalized medical practice. It keeps repeating

itself. In the above example, a small error seems to have snowballed in to death of a patient.

In terms of Clinical Risk Management, the CG Officer will see this as a 'Sentinel Event' or the event that finally leads to a catastrophe. Risk Managers will know that for each sentinel event, there must have been scores of 'Near Misses'.

For example, in passing, 10 times in the past 12 months, there might have been instances where doctors might have written 'A' instead of 'B' or *vice versa* and '-'s instead '+'s or *vice versa*. Nurses might have hung wrong blood bags only to realize moments later that a mistake was committed which could have led to catastrophe and it was averted.

Unless, there is a system of logging these near misses and document these in a systematized manner, it is only a matter of time that a preventable catastrophe or such proportion will happen easily. Logging them and presenting these data in annual reports or conferences keep people aware and alert every time they walk in to such minefields, which every clinical situation has potentiality to be.

Once the first mistake is made, unless there is a safety consciousness in the culture of practice of the institute, no one will go back to that bag of blood and re-check it. Moreover, next time, the mistake will be repeated, as in this case, assuming that B+ was the right blood group, as it was given the day before without apparent immediate consequences.

It is easy to make a small error which is fatal. Then it does not stay small and consumes everyone around it!

Unless Risk Management activities are part and parcel of the institute, the lessons learnt from this case may be forgotten with time. Or, the lesson learnt in one institute may not be utilized in another.

Cost Effectiveness was proven time and again, when the cost of fighting a case of this sort including the compensations that follows is taken in to account, a Risk Management team can be funded a couple of times over without any hesitation. Moreover, it will save life, limbs and body functions!

Human behaviour is predictably risky and error prone. CG tools have proven track record of minimizing their incidences by modifying our innate behavior for the better.

Errors in blood transfusion is so widely known and read about and yet it still happens simply because, to prevent one sentinel event, Risk Management tools need to be operating in the background constantly. The busier and hectic the place, the more is the need for CG accuracy.

Otherwise, lives will be lost and bright careers will be destroyed as Clinical Risks are like Black Swans – you do not see them. They just come and hit you, if you are not too careful. Individually, you need to be careful without jeopardizing your ability to function. At institutional level, the support must be given so that the accountability chain is foolproof and procedures are made as risk free as possible. Western examples have shown that a lot is really possible, although ideals may never be achieved. That is no excuse for not trying our level best. Otherwise the consequences are simply unacceptable.

Do we want our patients to die from our mistakes? No. Do we want to destroy our careers or have to pay compensations? Surely no! Moreover, you may not get any insurance cover in criminal negligence cases! As a doctor, you will be in a lot of distress, which is preventable at the outset. A lot of CG activity already takes place in bits and pieces. Some do it better than others. What is lacking in India is a lack of standard procedures, data collection and joined up actions, all of which are cost-savers and efficiency boosters.

Addendum 2

A. In a ***case of AM Mathew vs Director, Karuna Hospital,*** an 8½ year old son of the complainant had fever and tonsillitis. On advice of the doctor, nurse gave an injection over his left buttock. The boy developed foot drop. Sciatic nerve palsy was diagnosed by a Neurologist. Pediatrician opined that this is a well accepted complication of IM injections. Court has accepted this. But Rs. 1.06 lakh was awarded to the complainant as actionable negligence was proved since it was given by a nurse who was not qualified. Therefore, the court held that the hospital was liable to pay for getting a specialized job done by an unqualified person, thereby contributing directly to negligence.

Such examples are of glaringly obvious implications in Staff Development for Lone Practices in India

where even a doctor's driver can double up as his/her OT assistant!

B. In ***Dr. Baleshwar Prasad & Ors. vs Firtu Das Mahant*, 2003(2) CPR 112:2003(2) CPJ 457 (*Jharkhand SCDRC*),** complainant has taken his son to the dispensary for headache and high fever. Compounder has given some injection and the boy collapsed. He was immediately taken to a nearby hospital. But he was pronounced 'brought dead' on arrival. Negligence was held for instituting treatment with known possible complication of collapse and yet not having any back up for basic resuscitation until reaching resourced facility.

Lone practices must ensure that, if they give injections (which they should), they should equip themselves with basic equipment for management of shock and staff should be trained and updated on Basic Life Support (BLS) skills regularly. The medications like Adrenalin and Chlorpheniramine must be within their expiry dates. It is advisable to have Ambu Bags and Portable Oxygen bottle, if injections are given.

These could be universally adopted in India. If this CG principle is followed, then no doctor has to face distress. These are easy steps to follow, only if doctors understand that they need to be organized in managing their practices to make it safe for their patients. Such practices will not only make it safe for the patients, it will also make it safe for the doctors concerned. For the reasons of safety, UK is changing their GP practices into group practices as Evidence mounts for Lone Practices to be unsafe for patients. This is an issue that may see importance in India after a couple of decades or so. But, using CG knowledge, our fraternity may be embracing these principles for similar changes for the future.

References / Further Reading

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MODEL FORMAT

Police Information Report

(Can be printed/filled in local/vernacular language)

To,
The In-Charge
_____ Police Station.
_____<Name of Town/City>

Date: _____
Time: _____

Name of the Patient _____ D/O ,S/O _____
Address _____
Date of Admission _____ Registration no. _____
Diagnosis _____

That this patient had problem, developed complications and deteriorated/ has been referred to higher center/ discharged/left against medical advise/ has been declared dead/ was brought dead.

The relatives are not willing for post mortem and / are expected to create nuisance.

This is for your information and necessary action.

Name/signature of the receiver

Name & Signature of informant

Buckle no

Seal of the hospital/doctor

Reproduced from "Textbook on Medicolegal Issues - Related to Various Medical Specialties" By Jaypee Bros

Woman Empowerment, Health and Legislation

REVIEW ARTICLE

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Globalization has presented new challenges for the realization of the goal of women's equality. The development of a nation solely depends on the social status of women. On one side, woman is worshipped as goddess and on the other side she is oppressed, suppressed, depressed, exploited and victimized. A report of the United Nations say that *"Women constitute half of the world population, perform nearly two thirds of work hours, receive one tenth of the world's income and own less than one-hundredth per cent of the world's property."*[1]

As far as India is concerned, the principle of gender equality is enshrined in the Constitution in its Preamble, Fundamental Rights, Fundamental Duties and Directive Principles. The National Commission for Women was set up in 1990 to safeguard the rights and legal entitlements of women. The Government of India declared 2001 as the Year of Women's Empowerment (*Swashakti*). The National Policy for The Empowerment of Women was passed in 2001. India has also ratified various international conventions and human rights instruments to secure equal rights of women. Key among them is the ratification of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993. The International Women's Day was given official recognition by the United Nations in 1975. This opened up opportunities for a large number of women's organizations the world over for acting on the economic and social rights of their fraternity. In spite of all these efforts, women still suffer from discrimination, exploitation and victimization.

The empowerment of woman is everyone's responsibility and to everyone's benefit. It aims at getting participation of deprived sections of people in decision-making process and elimination of discrimination and challenging gender inequality. It means giving voice for voiceless. It is seen that even when woman is equally educated and experienced as men, they are generally paid less for the same work. This devaluation of the work that women do is a critical indicator of the gender-based inequities. The time has come for women to stop seeing themselves only in the historical role of care-giver whether in the home or in the workforce. In this modern world where the economic realities require that both men and women need to be in the work force doing the work of the "provider", the social realities equally require that both men and women do the work of the "care giver". There has to be a *fundamental revaluation* of the work that women have traditionally done.[2] In this regard, it is most important to sensitize the public that violence is unacceptable for settling differences, as a means of entertainment and as an expression of power.

Women specific legislations:[3]

Legislative Initiatives towards Empowerment of Woman [1]

In India there are numerous laws aimed at empowerment of women. The Fundamental Law of the land namely Constitution of India guarantees equality for women. Let us have a look at some of the most important legislations pertaining to empowerment of woman.

1. Constitution of India, 1950:

The Universal Declaration of Human Rights has declared that the woman belongs to a vulnerable group and it is a mandatory duty of every State party to protect the woman and to enact special statutes to uplift them.[4] Even the constitution of India is also found in the tune of U.D.H.R where it has been specifically stated in the constitution that, the state has a power to make special provision for the protection of the women and child to protect their interest. The Constitution of India not only guarantees equality to women but also empowers the State to adopt measures to positive discrimination in favor of women. Article 14 of the Constitution of India guarantees equality before law. Article 15 prohibits discrimination on the grounds of sex. The article 15(3) aims to eliminate the socio-economic backwardness of women and empower them in such manner to

bring about effective equality between men and women[5]. Article 16 states about equality of opportunity for all citizens in matters relating to employment and equal pay for equal work [Article 39(d)]. In addition, it allows special provisions to be made by the State in favor of women and children [Article 15(3)], renounces practices derogatory to the dignity of women [Article 51(a)(e)], and also allows for provisions to be made by the State for securing just and humane conditions of work and for maternity relief (Article 42). Article 19, 21 and 23 are also the key articles favoring woman empowerment. The time to time amendments to the Constitution of India provided for reservation of seats in the local bodies of Panchayat, Municipalities, Parliament and State Legislature.

2. Indian Penal Code, 1860:

Sections 292, 293 and 294 provide for punishment for sale and exhibition of obscene books and for obscene act in public place. Section 304(b) deals about murder of women in connection with demand of dowry. Sections 312 to 318 deal about punishment for causing miscarriage. Section 354 provides punishment for outraging the modesty of any woman, Section 366 deals about kidnapping for marriage against her will. Section 366-A deals about procuration of minor girls for sexual purpose. Section 376 deals about punishment for rape. Section 494 protects women from bigamy. Section 497 deals about protection of married women from adultery. Section 498-A of Indian Penal Code deals about subjecting women to cruelty by her husband or relatives and Section 509 provides punishment for uttering words and gesture or act intended to insult the modesty of a woman.

3. Code of Criminal Procedure, 1973:

Under Section 125, Code of Criminal Procedure, a woman has got right to maintenance.

4. Indian Evidence Act, 1872:

Sections 113(a), 113(b) and 114(c) provide for presumptions as to abetment of suicide by a married woman within 7 years of marriage, as dowry death of a woman and as to absence of consent of woman for sexual intercourse.

5. Hindu Adoption Maintenance Act, 1956:

Section 18-A provides for obligations of husband to maintain his wife. Section 18(2) provides right of wife to live separately and S. 19 provides for maintenance of widow by her father-in-law.

6. Hindu Succession Act, 1956:

Section 14 of the Act provides for property of female Hindu to be her absolute property. Section 23 provides right of female legal heirs in the dwelling house.

7. The Hindu Minority and Guardianship Act, 1956:

Section 6 of the Act provides for mother as a natural guardian for minors below 5 years.

8. The Hindu Marriage Act, 1955:

Section 13(2) of the Act provides for wife to present a petition for divorce. Section 13(b) provides equal right for wife for getting divorce by mutual consent. Section 24 of the Act provides for relief for interim maintenance and expenses. Section 25 of the Act provides for right to a wife to seek permanent alimony and maintenance and S. 26 of the Act provides right to claim custody of children.

9. The Dowry Prohibition Act, 1961:

Under the provisions of this Act, demand of dowry either before marriage, during marriage and or after the marriage is an offence.

10. The Muslim Women (Protection of Right on Divorce) Act, 1986:

Under the provisions of the Act provides for maintenance of women by the relatives after the iddat period.

11. The Factories Act, 1948:

The provisions of this Act provide for health, safety, welfare, and working hours for women laborers working in factories.

12. The Equal Remuneration Act, 1976:

It provides for payment of equal wages to both men and women workers for the same work or work of similar nature. It also prohibits discrimination against women in the matter of recruitment.

13. The Employees State Insurance Act, 1948:

The Act provides for insurance pension and maternity benefits to women workers.

14. The Maternity Benefit Act, 1961:

It provides for maternity benefit with full wages for women workers.

15. The Medical Termination of Pregnancy Act, 1971:

The Act safeguards woman's reproductive right to terminate unwanted pregnancy and to decide the number of children.

16. The Child Marriage Restraint Act, 1976:

The Act provides safeguards for girls from child marriage.

17. The Immoral Trafficking (Prevention) Act, 1986:

The Act safeguards women from prostitution.

18. The Pre- Conception and Pre- natal Diagnostic Technique Act 1994:

This Act prohibits diagnosing of pregnant women and also identification of child in the womb whether it is male or female.

19. The Indecent Representation of Women (Prohibition) Act, 1986:

The Act safeguards women from indecent representation.

20. The Commission of Sati (Prevention) Act, 1992:

It safeguards women from Sati.

21. The National Commission for Women Act, 1992:

The Act provides for setting up a statutory body namely the National Commission for Women to take up remedial measures, and facilitate redressal of grievances and advise the Government on all policy matters relating to women.

22. The Family Courts Act, 1984:

The Act provides for setting up a Family Court for in-camera proceedings for women.

23. The Tamil Nadu Prohibition of Eve-teasing Act, 1988:

The Act provides punishment for eve-teasing.

24. The Protection of Women from Domestic Violence Act, 2005:

The Act provides for punishment for domestic violence committed by husband and his relatives and also provides legal assistance for women suffering from domestic violence. It also provides interim maintenance to women and also for compensation and damages.

Women's Health and Law:

National Commission for Women was constituted on 31 January 1992[6].

Its main area of activities includes review of the constitutional and legal safeguards for women, recommending remedial measures, facilitating redressal of grievances, undertaking studies and investigations, participation and advice in the planning process and generally advising the Government on all matters of policy affecting the welfare and development of women in the country. The Indian Delegation participated in the fourth World Conference on Women held in Beijing from 4-15 September 1995. During finalization of the Beijing Declaration, India fought for equal inheritance rights for girl children and women and had *inter-alia* made the commitment of formulation of a National Policy on Women. In keeping with that assurance the Government in the year of Women's Empowerment had themes concerned with all round development including health and nutrition.

National Policy For The Empowerment Of Women was made in 2001 with the goal to bring about the advancement, development and empowerment of women[7]. Specifically, amongst many of the objectives of this Policy, equal access of women to health care, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office and strengthening legal systems aimed at elimination of all forms of discrimination against women were the noteworthy objectives concerned with women's health and all round development. The policy prescriptions included **Social Empowerment of Women which lay down guidelines related to Health, Nutrition and Sanitation as follows:**

Health

* A holistic approach to women's health which includes both nutrition and health services will be adopted and special attention will be given to the needs of women and the girl at all stages of the life cycle. The reduction of infant mortality and maternal mortality, which are sensitive indicators of human development, is a priority concern. This policy reiterates the national demographic goals for Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) set out in the National Population Policy 2000. Women should have access to comprehensive, affordable and quality health care. Measures will be adopted that take into account the reproductive rights of women to enable them to exercise informed choices, their vulnerability to sexual and health problems together with endemic, infectious and communicable diseases such as malaria, TB, and water borne diseases as well as hypertension and cardio-pulmonary diseases. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases will be tackled from a gender perspective.
* To effectively meet problems of infant and maternal mortality, and early marriage, the availability of good and accurate data at micro level on deaths, birth and marriages is required. Strict implementation of registration of births and deaths would be ensured and registration of marriages would be made compulsory.
* In accordance with the commitment of the National Population Policy (2000) to population stabilization, this Policy recognizes the critical need of men and women to have access to safe, effective and affordable methods of family planning of their choice and the need to suitably address the issues of early marriages and spacing of children. Interventions such as spread of education, compulsory registration of marriage should impact on delaying the age of marriage so that by 2010 child marriages are eliminated.
* Women's traditional knowledge about health care and nutrition will be recognized through proper documentation and its use will be encouraged. The use of Indian and alternative systems of medicine will be enhanced within the framework of overall health infrastructure available for women.

Nutrition

* In view of the high risk of malnutrition and disease that women face at all the three critical stages viz., infancy and childhood, adolescent and reproductive phase, focused attention would be paid to meeting the nutritional needs of women at all stages of the life cycle. This is also important in view of the critical link between the health of adolescent girls, pregnant and lactating women with the health of infant and young children. Special efforts will be made to tackle the problem of macro and micro nutrient deficiencies especially amongst pregnant and lactating women as it leads to various diseases and disabilities.
* Widespread use of nutrition education would be made to address the issues of intra-household imbalances in nutrition and the special needs of pregnant and lactating women. Women's participation will also be ensured in the planning, superintendence and delivery of the system**.**

Drinking Water and Sanitation

Special attention will be given to the needs of women in the provision of safe drinking water, sewage disposal, toilet facilities and sanitation within accessible reach of households, especially in rural areas and urban slums. Women's participation will be ensured in the planning, delivery and maintenance of such services.

The policy also mentions about Rights of the girl child as under:

Rights of the Girl Child[7]

All forms of discrimination against the girl child and violation of her rights shall be eliminated by undertaking strong measures both preventive and punitive within and outside the family. These would relate specifically to strict enforcement of laws against prenatal sex selection and the practices of female feticide, female infanticide, child marriage, child abuse and child prostitution etc. There will be special emphasis on the needs of the girl child and earmarking of substantial investments in the areas relating to food and nutrition, health and education, and in vocational education. In implementing

program for eliminating child labor, there will be a special focus on girl children**.**

Reproductive Rights and woman empowerment:

The reproductive rights belong to special group of human rights which are directly or indirectly connected to the sexual and reproductive health of woman. They are the exclusive rights of woman which give the true and complete meaning to the life of women, a dignified life as mentioned in Article 21 of Indian Constitution. It is one of the tools to overcome the disparities between the genders in India. Reproductive rights of women constitute a special branch of women's rights and their demand is increasing day by day as women are getting more conscious about their image, about their sexual and reproductive life. The recognition of these rights empowers the women causing their upliftment. The reproductive rights are legally sanctioned to each and every woman irrespective of race, religion, caste and economic status. In India, women are not granted with reproductive rights as such but they are available to women by different names. Right To Legal and Safe Abortion, Right to Control one's Reproductive Functions, The Right to Access Quality Reproductive Healthcare, Right to Education about Contraception and Sexually Transmitted Infections, Right to Protection from Forced Sterilization, Right to Sexual Health, Right to get Divorce on the Ground of Impotency of Husband, Right to make reproductive Choices free from Coercion, Discrimination and Violence are the reproductive rights concerned with woman's health and empowerment[8].

Reproductive Rights and the Constitutional Provisions:

The Indian Constitution does not recognize reproductive rights separately but part III of the constitution favors these rights. They are implicit in right to equality under Article 14, right to life and personal liberty, right to freedom under Article 19. Article 21 has guaranteed right to dignified life to all which includes Right to privacy.

Reproductive Rights and Statutory provisions:

The Medical Termination of Pregnancy Act 1971, The Pre-Conception and Pre-natal Diagnostic Technique Act 1994, The Indecent Representation (Prohibition) Act 1986, The Immoral Traffic (Prevention) Act 1956, The Hindu Marriage Act 1955, The Indian Penal Code 1860, The Consumer Protection Act 1986 are the statutory provisions concerned with reproductive health especially that of women**.** The participation of both male and female partners is necessary in the process of reproduction and hence both should be allowed to enjoy the reproductive rights but women need special attention.

In the present era, the women are becoming more and conscious of their reproductive rights as the percentage of literacy in women is increasing day by day. The implementation of these rights lack uniformity at national and international level. But the judiciary has started showing positive attitude towards their rights by giving favorable verdicts.

Crimes against women:[9]

The status of women in India has been subject to many great changes over the past few millennia. From equal status with men in ancient time through the low points of the medieval period to the promotion of equal rights by many reformers, the history of women in India has been eventful. In modern India, women have held high offices in India including that of the President, Prime Minister, Speaker of the Lok Sabha and Leader of the Opposition. However, women in India continue to face atrocities such as rape, acid throwing, and dowry killings while young girls are forced into prostitution; as of late, rape has seen a sharp increase following several high profile cases of young girls brutally raped in public areas. According to a global poll conducted by Thomson Reuters, India is the **"fourth most dangerous country"** in the world for women.

Female infanticide and sex-selective abortion

In India, the male-female sex ratio has fallen down dramatically in favor of males, the chief reason being the high number of females who die before reaching adulthood. Tribal societies in India have a less skewed sex ratio than other caste groups. This is in spite of the fact that tribal communities have far lower income levels, lower literacy rates, and less adequate health facilities. It has been found that the higher number of males in India is mainly due to female infanticides and sex-selective abortions affecting approximately one million female babies per year. The government stated that in 2011 India was missing three million girls and there are now 48 fewer girls per

1,000 boys than there were in 1981. Ultrasound scanning proved a boon in providing care to mother and baby, and with portable scanners, these advantages could be accessed by rural populations. However, as happens with other technologies, ultrasound scans were often misused to reveal the sex of the baby, allowing pregnant women to decide to abort female fetuses and try again later for a male child. This practice is usually considered the main reason for the change in the ratio of male to female children. To control over this situation, in 1994 the Indian government passed a law forbidding women or their families from asking about the sex of the baby after an ultrasound scan (or any other test which would yield that information) and also expressly obstructed doctors or any other persons from providing that information. However, in practice this law (like the law forbidding dowries) is widely ignored, and incidence of sex selective abortion remains high and the sex ratio at birth keeps getting more affected. Female infanticide (killing of girl infants) is still prevalent in some rural areas. Sometimes this is infanticide by neglect, for example families may not spend money on critical medicines or withhold care from a sick girl. Continuing of the dowry tradition has been one of the main reasons for sex-selective abortions and female feticide disturbing the sex ratios.

Rape

Rape in India is one of India's most common crimes against women and described by the UN's human-rights chief as a "national problem". In the 1980s, women's rights groups lobbied for marital rape to be declared unlawful, as until 1983, the criminal law (amendment) act stated that "sexual intercourse by a man with his wife, the wife not being under fifteen years of age is not rape". Marital rape is now illegal in India but is still widespread. While per-capita reported incidents are quite low compared to other countries, even developed countries, a new case is reported every 20 minutes. New Delhi has the highest rate of rape-reports among Indian cities. Sources show that rape cases in India have doubled between 1990 and 2008. According to the National Crime Records Bureau, 24,206 rape cases were registered in India in 2011, although experts agree that the number of unreported cases is much higher. In the wake of several brutal rape attacks in the capital city of Delhi debates held in other cities revealed that men believed women who dressed provocatively deserved to get raped, many of the correspondents stated women incited men to rape them. But then what about the sexual exploitation of village girl, elderly woman or own sister or daughter. There is a need of education, awareness and counseling, amendment in the laws, its enforcement and fast track courts. Feminist activism in India gained momentum in the late 1970s. One of the first national-level issues that brought women's groups together was the Mathura rape case. The acquittal of policemen accused of raping a young girl Mathura in a police station led to country-wide protests in 1979-1980. The protests, widely covered by the national media, forced the Government to amend the Evidence Act, the Criminal Procedure Code, and the Indian Penal Code; and created a new offence, custodial rape. After Delhi gang rape case, the three-member committee headed by the former CJI Mr J.S. Verma submitted its report to the government on amendments to criminal laws and advocated for stricter anti-rape laws. (Reform in anti-rape laws)[10].

Eve teasing

Eve teasing is a euphemism used in India and sometimes Pakistan, Bangladesh and Nepal for public sexual harassment, street harassment or molestation of women by men, with Eve being a reference to the biblical Eve. Many activists blame the rising incidents of sexual harassment against women on the influence of "Western culture". In 1987, The Indecent Representation of Women (Prohibition) Act was passed to prohibit indecent representation of women through advertisements or in publications, writings, paintings or in any other manner.

Of the total number of crimes against women reported in 1990, half related to molestation and harassment in the workplace. In 1997, in a landmark judgment, the Supreme Court of India took a strong stand against sexual harassment of women in the workplace. The Court also laid down detailed guidelines for prevention and redressal of grievances. The National Commission for Women subsequently elaborated these guidelines into a Code of Conduct for employers.

Trafficking

The Immoral Traffic (Prevention) Act was passed in

1956. However many cases of trafficking of young girls and women have been reported. These women are either forced into prostitution, domestic work or child labor.

Other concerns regarding Health

The average female life expectancy today in India is low compared to many countries, but it has shown gradual improvement over the years. In many families, especially rural ones, girls and women face nutritional discrimination within the family, and are anemic and malnourished.

The maternal mortality in India is the second highest in the world. Only 42% of births in the country are supervised by health care professionals. Most women deliver with help from women in the family who often lack the skills and resources to save the mother's life if it is in danger. According to UNDP Human Development Report (1997), 88% of pregnant women (age 15-49) were found to be suffering from anemia.

Family Planning (Birth control and Birth spacing)

The average woman in rural areas of India has little or no control over becoming pregnant. Women, particularly women in rural areas, do not have access to safe and self-controlled methods of contraception. The public health system emphasizes permanent methods like sterilization (Vasectomy/ Tubectomy) or temporary methods like IUDs, pills, injectable contraceptives, hormone implants, barrier methods, emergency contraceptives etc. The MTP Act 1971 has brought much needed relief to a long suffering multitude of women. It was a culmination of a prolonged struggle for the establishment of a woman's right to exercise control over her reproductive career. A major Indian woman can undergo termination of pregnancy with her consent, though it is common practice, also to take husband's consent to avoid marital conflicts. Thus the law provides legal procedure to terminate unwanted pregnancy and to conserve physical, mental, social and financial status of mother.

Sanitation:

In 2011 a "Right to Pee" (as called by the media) campaign was undertaken in Mumbai. Women, but not men, had to pay to urinate in Mumbai, despite regulations against this practice. Women had also been sexually assaulted while urinating in fields. Thus, activists had collected more than 50,000 signatures supporting their demands that the local government should immediately stop charging women to urinate, build more toilets, keep them clean, provide sanitary napkins and a trash can, and hire female attendants. In response, city officials had agreed to build hundreds of public toilets for women in Mumbai.

Judicial Initiative Towards Empowerment of Women:[1]

Though plethora of legislations exists, due to ineffective enforcement, women are exploited by the male dominated society. Due to the ineffective implementation of the legislations judiciary has come forward and has completely revolutionized constitutional provisions. The judiciary has encouraged widest possible coverage of the legislations by liberally interpreting the terms. The judiciary has shifted from doctrine approach to the pragmatic approach. The judiciary by its landmark judgments has shown concern for women's right in recent times; it has been greatly influenced by the international declaration and covenants on women's rights. Following are few of its golden judgments.

* In Municipal Corporation of Delhi v. Female Workers (Muster Roll) (AIR 2000 SC 1274), the Supreme Court extended the benefits of the Maternity Benefit Act, 1961 to the Muster Roll (Daily Wagers) female employees of Delhi Municipal Corporation. In this case, the Court directly incorporated the provisions of Article 11 of CEDAW, 1979 into the Indian Law.
* In Chairman, Railway Board v. Chandrima Doss (AIR 2000 SC 988), the Supreme Court awarded compensation of 10 lakhs to an alien woman under Article 21 of Constitution, who has been a victim of rape.
* In Githa Hariharan v. Reserve Bank of India (AIR 1999 SC 1149), the Supreme Court interpreted Section 6(a) of Hindu Minority and Guardianship Act, 1956 and Section 19(b) of the Guardians and Wards Act, 1890 in such a way that father and mother get equal status as guardians of a minor.
* In Municipal Corporation of Delhi v. Female Workers (AIR 2000 SC 1274, 1281), the Supreme

Court held that a just social order could be achieved only when inequalities are obliterated and women, which constitute almost half of the segment of our society, are honored and treated with dignity.

* In Bodhisattwa v. Ms. Subhra Chakraborty (AIR 1996 SC 922), the Supreme Court held that rape is a crime against basic human rights. In this case the Supreme Court observed that rape was not only an offence under the criminal law, but it was a violation of the fundamental right to life and liberty guaranteed by Article 21 of Indian Constitution.
* In Vishakha v. State of Rajasthan (AIR 1997 SC 301), the Supreme Court took a serious note of the increasing menace of sexual harassment at workplace and elsewhere. Considering the inadequacy of legislation on the point, the Court even assumed the role of legislature and defined sexual harassment and laid down instruction for the employers.
* In Delhi Domestic Working Women's Forum v. Union of India ((1995) 1 SCC 14), the Supreme Court suggested the formulation of a segment for awarding compensation to rape victims at the time of convicting the person found guilty of rape. The Court suggested that the Criminal Injuries Compensation Board or the Court should award compensation to the victims by taking into account, the pain, suffering and shock as well as loss of earnings due to pregnancy and the expenses of child birth if this occurs as a result of rape.

Thus, it is observed that not only the legislature but judiciary also plays a very vital and important role in case of women empowerment. Judiciary empowers the women by both its traditional and its activist role. The traditional role of judiciary is to provide through interpretation of laws. Another role of judiciary is the activist role which is popularly known as "Judicial Activism". As our society is dynamic, the need of the society is also dynamic. Because of the rigidity of law or because of the long and time taking procedure of enactments of laws by legislature, it is unable to keep pace with the fast changing society. There is always a gap between the advancement of the society and the legal system prevailing in it. This sometimes causes hardships and injustice to people. Now women empowerment is a burning issue of our country. So, there are so many areas of women empowerment where there is no law for the protection of women, in that case judiciary is the last hope.

Conclusion:

Thus we come to know that the legislations, which take care of rights and privileges of women, are numerous in number. But due to ignorance and illiteracy those legislations are not properly enforced. The plethora of Indian Legislations aims at women empowerment. The judicial decisions rendered by the Indian Courts depict the active role played by the judiciary to protect women from exploitation at a stage where legislations are not strictly implemented due to lack of adequacy of enforcement machinery. Similarly special legislative and judicial measures have been undertaken for the positive health of women. They have placed the women in a better place in the society. Yet the woman in India has to go for miles. It requires strong political will along with whole hearted support from the society.

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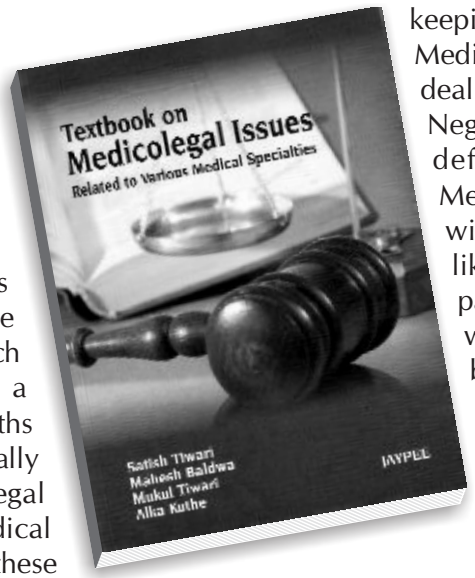
Book Review

By: **Dr.Piyali Bhattacharya**
DCH, MD(Ped)
SGPGI, Lucknow



The question of ethics in Medicine and the application of Indian Penal laws has been pertinent for a long time. The doctors are sometimes in dilemma while handling some cases in which there is a margin to be dragged to a court of law. Under such circumstances and conditions, a textbook dispelling the various myths on medico-legal issues has finally arrived. Textbook on Medicolegal Issues Related to Various Medical Specialties tries to deal with these challenges successfully. The book has been edited by a team of doctors who are specialists their respective fields. One of the contributors Mahesh Baldwa is a specialist both in medicine and in law, while the other editors Satish Tiwari, Mukul Tewari & Alka Kuthe are doctors with specialization in the respective fields.

There are about 47 highly specialized doctors from all over India with a high level of expertise in medicine, teaching as well as as hospital administration who have enriched the book with their experience and expertise.

The structure of the book makes it easy to read and understand. It is divided into five sections and to a separate section of Appendices. The Appendices contain the basic formats and guidelines issued by the Government of India for sterilization, NACO, MCI code of Ethics Regulation, 2002, the Medical Termination of Pregnancy Act, 1971 and the Transplantation of Human Organs Act, 1994.

The first section deals with the basic issues that concern every doctor like the Duties and Rights of a Doctor, Communication Skills and Legal Hurdles in Medical Practice. The second section contains very informative guidelines and articles on record keeping, consent and the kind errors in Medical Practice. It also has articles dealing with issues like Medical Negligence, Vicarious Liability and defences, Criminal Liability in Medical Profession and law to deal with difficult situations in practice like breaking the news to the patients, sudden death and dealing with the situation when a patient is brought dead.

The Third section of the book is also well researched and very informative. It gives information on how to defend a case, responding to legal notices as well as preparing a written statement. Information is also provided as to how to calculate the amount for compensation. To help understand those issues in better way some landmark judgments also have been provided. It also has very useful information on the Medicolegal issues in the use of web like the liability of a website that provides medical consultation.

Generally, the books available on Medicolegal issues only with allopathic treatment in hospitals. However, the editors of textbook on Medicolegal issues have devoted on entire section to issues on various specialities like Dentistry, Homeopathy, pathology, Anaesthesia and Euthanasia as well.

Despite the content of the book being exhaustive and informative, the book has only 421 pages in good quality paper. The book is a ready reckoner for all the medical professionals as well as lawyers who deal with Medicolegal cases. The common people can also benefit a lot by this book as it makes them aware of their rights as well as the legal help available to them.

By: Dr Rohini S Deshpande
MD, MRCOG, Solapur

This is most enriched text book that I have come across in the field of Medico-legal issues. One of the

challenges faced by Medical practitioners in India today is increasing litigations in the field of medicine. Since Consumer protection act was applied to medical profession, it has changed the face of medical profession. Medical practitioners have become more aware of medico-legal problems and hence more defensive. This textbook is a ready rekoner for the medico-legal issues involved in different specialties.

This text book emphasizes on the responsibilities of the doctor. It has made the practitioner aware of how to deal with difficult situations of litigation. Doctors are required to practice profession in the framework of law. Hence, knowledge of laws related to medical profession is mandatory for all practitioners. This book summarizes the related laws of CPA, MTP, PCPNDT , ethics, etc.

One of the important causes of litigation is misunderstanding between doctor and patient due to lack of proper communication, although doctor may be clinically excellent. This text book elaborates importance of communication skills. Authors have made sincere attempt to highlight important issues e.g., informed consent. I appreciate the information provided on record keeping and its essential elements, which is fundamental of our profession. This textbook provides very clear cut guideline on record keeping, which is very useful to all medical practitioners.

No doubt, this book has brought out issues such as medical negligence in different specialties. What I appreciate is the chapter on Safe practices to reduce errors in the professional practice. Medical practitioner whether individual or in corporate sector can face difficult situations like table death, unexpected drug reactions, violence, brought in dead patients etc. In this book, you will find proper solutions and correct ways to deal with such situations. This gives confidence to the practitioner.

Introduction of land mark judgments adds to the knowledge of law related to different situations. Certain specialties like Obstetrics and Gynecology, surgery, orthopedics, trauma, critical care units, anesthesia, pediatrics, organ transplantation, are vulnerable more to litigations. This book has more information related to these specialties specifically.

This textbook also provides information on legal issues in medical education, medical tourism, media, advertising in medical field too. Relevant information on different sections of IPC are very useful to the readers. As we are now aware about liability in profession, vulnerability for punishment and litigations, this book gives information on different indemnities and protection policies.

I would rate this book as one of the best guide to understand implications of law and medicine. Hence I would like to recommend this text book to all medical professionals. I thank authors for their wonderful contribution and appreciate their efforts.

MODEL FORMAT

Sickness Certificate

(Can be printed/filled in local/vernacular language)

This is to certify that Shri / Ms./Master _____, is/was suffering from _____.

He/She is/was under my treatment for the same between _____.

He/She is/was advised rest during this period.

In continuation of previous Certificate dated _____, he/she is further advised rest for _____.

He/She is now fit to resume his/her duties.

Identification marks:

a) b)

Signature of patient Signature of doctor

Date: Seal of Hospital/Doctor

Reproduced from "Textbook on Medicolegal Issues - Related to Various Medical Specialties" By Jaypee Bros

Research Briefs

Ethical and legal implications of the risks of medical tourism for patients:
a qualitative study of Canadian health and safety representatives' perspectives.
(BMJ Open. 2013 Feb 8;3(2))

A study was done in the Canadian Province of British Colombia to explore views of health and safety experts concerning health and safety risks that medical tourists may be exposed to when taking medical care in another country: Seven professionals representing the domains of tissue banking, blood safety, health records, organ transplantation, dental care, clinical ethics and infection control participated. : Five dominant health and safety risks for outbound medical tourists were identified by participants:

(1) complications;
(2) specific concerns regarding organ transplantation;
(3) transmission of antibiotic-resistant organisms;
(4) (dis)continuity of medical documentation and
(5) (un)informed decision-making.

It was concluded that medical tourism might have unintended and undesired effects upon patients' home healthcare systems. The individual choices of medical tourists could have significant public consequences if healthcare facilities in their home countries must expend resources treating postoperative complications. Participants also expressed concern that medical tourists returning home with infections, particularly antibiotic-resistant infections, could place others at risk of exposure to infections that are refractory to standard treatment regimens and thereby pose significant public health risks.

Adverse events following immunization
with vaccines containing adjuvants
(Immunol Res. 2013 Jul;56(2-3):299-303)

A cross sectional study was done to assess the frequency of post-vaccination clinical syndrome induced by vaccine adjuvants. Adverse event following immunization was defined as any untoward medical occurrence that follows immunization 54 days prior to the event. Forty-three out of 120 patients with moderate or severe manifestations following immunization were hospitalized from 2008 to 2011. All patients fulfilled at least 2 major and 1 minor criteria suggested by Shoenfeld and Agmon-Levin for ASIA diagnosis. The most frequent clinical findings were pyrexia 68%, arthralgias 47%, cutaneous disorders 33%, muscle weakness 16% and myalgias 14%. Three patients had diagnosis of Guillain-Barre syndrome, one patient had Adult-Still's disease 3 days after vaccination. A total of 76% of the events occurred in the first 3 days post-vaccination. Two patients with previous autoimmune disease showed severe adverse reactions with the reactivation of their illness. Minor local reactions were present in 49% of patients. Vaccines containing adjuvants may be associated with an increased risk of autoimmune/inflammatory adverse events following immunization

Understanding of informed consent by parents of children enrolled in a genetic biobank
(Genetics in Medicine(2013), Published online 27.06.2013 Article. Date accessed 15.12.13)

Prior research suggests that parents undervalue long-term risks associated with their children's participation in research studies. A study was done to evaluate parental understanding of informed consent for a pediatric biobanking study. The study population included parents who provided consent for their child to participate in a study examining the genetic aetiology of congenital cardiovascular malformations. Informed consent understanding was measured by adapting the Quality of Informed Consent assessment to our study. A total of 252 individuals representing 188 families completed the study. The Quality of Informed Consent items best understood by parents included consent to participate in research, the main purpose of the study, and the possibility of no direct benefit. The items least understood by parents were those involving the indefinite storage of DNA, the possible risks of participation, and the fact that the study was not intended to treat their child's heart defect. Parent age and medical decision making by one versus both parents were frequent predictors of individual Quality of Informed Consent items.It was concluded that Parents overestimate personal benefit and underestimate the risks associated with their child's participation in a bio banking study.

Readers Ask, Experts Answer

Expert
Dr. Charu Mittal
MBBS, MD, DNB
Consultant Obstetrician & Gynecologist
Managing Editor, JIMLEA
Email: charumittal@rediffmail.com

Question No 1. : **A Myelomeningocele was discovered by USG in 27th week of pregnancy**

A. What is the implication on the Ultrasonologist?

B. Can a termination be allowed at this time?

Answer :

A. Implication on ultrasonologist?

There are some clarifications needed in above query:

1. Was ultrasound done earlier in this patient at 18-20 weeks where such diagnosis was not detected? If done earlier then onus lies on ultrasonologist to explain why it was missed on earlier USG. Because this anomaly can usually be detected in 2nd trimester anomaly scan done between 18-20 weeks. However there are references the ultrasonologist can use which quote that it may be missed in some cases.

Ref 1: EUROCAT study: The overall prenatal detection rate for severe structural congenital malformations was 64% (range, 25–88% across regions). Gestational age at discovery for prenatally diagnosed cases was less than 24 weeks for 68% (range, 36–88%) of cases. Garne, E., Loane, M et al (2005), Prenatal diagnosis of severe structural congenital malformations in Europe. Ultrasound Obstet Gynecol, 25: 6–11. doi: 10.1002/uog.1784

Table 1

Frequency of prenatal ultrasound MMC diagnosis according to the detection time and the level of lesion.

Level of MMC	Diagnosed			Un-diagnosed	Total
	1st trimester n (%)	2nd trimester n (%)	3rd trimester n (%)	n (%)	n (%)
Cervical/ Cervicothoracic	0 (0)	0 (0)	0 (0)	5 (100)	5 (100)
Thoracic/ Thoracolumbar	2 (6.6)	2 (6.6)	8 (26.8)	18 (60)	30 (100)
Lumbar/ Lumbosacral/ Sacral	0 (0)	8 (8)	13 (13)	79 (79)	100 (100)
Total	2 (1.4)	10 (7.4)	21 (15.5)	102 (75.5)	135*(100)

* One patient was omitted due to double MMC sacs in cervical and sacral regions that could not be placed in this categorization.

Kazmi *et al. Reproductive Health* 2006 **3**:6 doi:10.1186/1742-4755-3-6

Ref 2: The prenatal ultrasonographic detection of myelomeningocele in patients referred to Children's Hospital Medical Center: a cross sectional study. Syed Shuja Kazmi, Farideh Nejat, Parvin Tajik and Hadi Roozbeh. Reproductive Health 2006, 3:6 doi:10.1186/1742-4755-3-6. http://www.reproductive-health-journal.com/content/3/1/6

Ref 3: Ultrasound can detect anencephaly from the 12th week and spina bifida from 16-20 weeks (may occasionally be missed, especially in the L5-S2 region). Among all cases with prenatal diagnosis of MMC, 3.4% were detected in the first, 31% in the second and 65.5% in the third trimester.

Ref 4: Myelomeningocele can be missed when present without intracranial signs of Chiari II malformation especially when the defect is covered by intact skin. J Perinat Med. 2008;36(4):330-4. doi: 10.1515/JPM.2008.052.

B. Can a termination be allowed at this time? Termination of pregnancy cannot be allowed at 27 weeks under MTP Act.

With the advent of prenatal surgery, early repair of postnatal myelomeningocele, shunting to prevent hydrocephalus and expectant management of complications, most patients born with spina bifida survive into adulthood and develop relatively normally intellectually.

Question No. 2. : **Is separate consent required for removing ovaries during hysterectomy?**

Answer : Yes, informed, written consent must cover the issue of removal of ovaries along with uterus during hysterectomy done for any gynecological disease since ovaries are individual organs with unique endocrinal functions and removal is equivalent to castration. Pre-menopausal patient requires information about menopausal symptoms to be expected following removal of ovaries hence separate consent must be taken for removal of ovaries.

Professional Assistance / Welfare Scheme

1. The scheme shall be known as PAS **"Professional Assistance Scheme"**.
2. **ONLY the life member of IMLEA** shall be the beneficiary of this scheme on yearly basis. The member can renew to remain continuous beneficiary of this scheme by paying renewal fees every year. The scheme shall assist the member ONLY as far as the medical negligence is concerned.
3. This scheme shall be assisting the members by:
   i. **Medico-legal guidance** in hours of crisis. A committee of subject experts shall be formed which will guide the members in the hours of crisis.
   ii. **Expert opinion** if there are cases in court of law.
   iii. **Guidance of legal experts.** A team of Legal & med-legal experts shall be formed which will help in guiding the involved members in the hours of crisis.
   iv. **Support of crisis management committee** at the city / district level.
   v. **Financial assistance** as per the terms of agreement.
4. The fund contribution towards the scheme shall be decided in consultation with the indemnity experts. The same will depend on the type & extent of practice, number of bed in case of indoor facilities & depending upon the other liabilities.
5. A trust / committee / company/ society shall look after the management of the collected fund.
6. The Financial assistance will be like Medical Indemnity welfare scheme, where indemnity part shall be covered by government / IRDA approved companies or any other private company. The association shall be responsible only for the financial assistance. Any compensation/cost/ damages awarded by judicial trial shall be looked after by government / IRDA approved insurance companies or any other similar private company.
7. Experts will be involved so that we have better vision & outcome of the scheme.

Admission Fee (One Time, non-refundable)		
1	Physician with Bachelor degree	Rs. 1000
2	Physician with Post graduate diploma	Rs. 2000
3	Physician with Post graduate degree	Rs. 3000
4	Super specialist	Rs. 4000
5	Surgeons, Anesthetist etc	Rs. 5000
6	Surgeons with Super specialist qualification	Rs. 6000

		Annual Fee for Individual	**Annual Fee for Hospitals Establishment**
1	Physician / doctors with OPD Practice	Rs. 60 / lakh	Rs. 340 / lakh + Re. 1 / OPD Pt + Rs. 5 / IPD Pt + 7.5 % of basic premium + Service Tax 10.3 % on the Total
2	Physician / doctors with Indoor Practice	Rs. 115 / lakh	
3	Physician / doctors with Indoor Practice of Surgeon	Rs. 230 / lakh	
4	Physician / doctors with superspecialty, Anesthetist etc	Rs. 340 / lakh	
5	• **Rs/- 1000 (One thousand) per year** shall be collected to develop the fund of the IMLEA towards emergency assistance, risk management and conducting trainings, CME, workshops etc. • Physician / doctors visiting other hospitals shall have to pay 5% extra. • For unqualified staff extra charges of 8% shall be collected. • The additional charges 15 % for those working with radioactive treatment. • The additional charges can be included for other benefits like OPD/ indoor attendance, instruments, fire, personnel injuries etc.		

8. The payment to the experts, Legal & med-legal experts shall be done as per the pre-decided remuneration. Payment issues discussed, agreed and processes shall be laid down by the members of these scheme.
9. If legal notice / case are received by member he should forward the necessary documents to the concerned person.
10. Reply to the notice/case should be made only after discussing with the expert committee.
11. A discontinued member if he wants to join the scheme again will be treated as a new member.
12. Most of the negligence litigations related to medical practice EXCEPT the criminal negligence cases shall be covered under this scheme. The scheme will also NOT COVER the damages arising out of fire, malicious intension, natural calamity or similar incidences.
13. All the doctors working in the hospital (Junior, Senior, Temporary, Permanent etc) shall be the members of the IMLEA, if the hospital wants to avail the benefits of this scheme.
14. The scheme can cover untrained hospital staff by paying extra amount as per the decision of expert committee.
15. A district/ State/ Regional level committee can be established for the scheme.
16. There will be involvement of electronic group of IMLEA for electronic data protection.
17. Flow Chart shall be established on what happens when a member approaches with a complaint made against him or her [Doctors in Distress (DnD) processes].
18. Telephone Help Line: setting up and manning will be done.
19. Planning will be done to start the Certificate/ Diploma/ Fellowship Course on med-leg issues to create a pool of experts.
20. Efforts will be made to spread preventive medico-legal aspects with respect to record keeping, consent and patient communication and this shall be integral and continuous process under taken for beneficiary of scheme by suitable medium.

List of Members
Professional Assistance Scheme
(PAS) IMLEA

Name	*Place*	*Speciality*
Dr. Dinesh B Thakare	Amravati	Pathologist
Dr. Satish K Tiwari	Amravati	Pediatrician
Dr. Rajendra W. Baitule	Amravati	Orthopedic
Dr. Usha S Tiwari	Amravati	Hosp./N Home
Dr. Yogesh R Zanwar	Amravati	Dermatologist
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Request

For Article Submission

All the members, reviewers, well wishers are requested to contribute articles, case reports, happenings, original studies, research publications as per the guidelines for the authors published in the inaugural issue of the journal.

Medico Legal News

Illegible handwriting costs $ 380000 in damages

A local physician whose illegible handwriting led to the fatal overdose of an elderly patient was ordered by a civil court jury Thursday to pay $380,000 in damages to the woman's family. The doctor , a kidney specialist, initially had prescribed 10 millimoles of potassium to a dialysis patient.Later,he changed his mind and increased it to 20 millamoles.However, instead of clearly crossing out the original dose , he wrote a "2" over the "1,".The result was a misinterpretation by nurses and pharmacists that Alvarez had ordered 120 millimoles — a dosage very obviously fatal. The jury, which deliberated about eight hours over two days, also gave the daughters $110,000 — for their mental anguish. The group also gave the amounts requested for funeral expenses and Hernandez's own pain and suffering.

Those amounts, however, were altered at a later date by the jury which decided that the doctor held 10 percent of the blame for the patient's death. The hospital, which has already reached an undisclosed settlement with the family, held the other 90 percent of the blame, jurors determined.

(http://www.mysanantonio.com. October 3, 2013, accessed 15.12.13)

Audio-visual recording of the informed consent is now mandatory

The Union Health Ministry has made audio-visual recording of the informed consent of each subject mandatory in a clinical trial. This is in addition to obtaining his/her written consent. This decision came after Supreme Court questioned the Ministry for lack of transparency in clinical trials. In its order dated 21st October 2013, in response to a writ petition filed by an NGO of Indore, the court said an appropriate provision should be made to ensure that audio-visual recording of the informed consent process was done and the documentation preserved, adhering to confidentiality principles. In the order of the DCGI, all sponsors / investigators / institutes /organisations and other stakeholders involved in clinical trials have been instructed to adhere to this requirement with immediate effect. This issue arose in context of the five global clinical trials, which was approved by the Drugs Controller-General of India (DCGI) office from January 1, 2013, to August 31, 2013,

The Indian Society for Clinical Research has found flaws in the order. It said the lack of guidance and direction on operational and logistical issues of managing the audio-visual recording process (like the kind of equipment to be used, and where and how information should be stored) could leave room for confusion and inconsistencies in execution.

More pragmatic approach was required on how confidentiality of patients should be protected and maintained in an 'audio-visual' context. The association also asked what processes needed to be followed in instances where, for religious and socio-cultural reasons, patients might not want to be videographed.

(NEW DELHI, November 23, 2013 The Hindu)

Poor staff skills are top cause for claims

Poor staff knowledge, skills or competence were the highest risk factors for medico legal claims against doctors and hospitals ,Irish medical Times reports. The clinical risk team of the State Claims Agency reviewed the 166 cases closed in 2010. They found poor staff knowledge, skills or competence as the main causes identified in 44.2 per cent of the medico legal cases. Communications failure was the second (14.4 per cent of cases).A lack of effective leadership (9.6 per cent), safety culture issues (8.7 per cent), the lack of protocols or guidelines (6.7 per cent), lack of supervision (5.8 per cent) and inadequate staffing levels/skill mix (in 2.9 per cent) followed next. According to the Clinical Risk Advisor.By specialty, surgery again had the most cases closed in 2010 (27.1 per cent), followed by emergency medicine (25.9 per cent), obstetrics (18.7 per cent), medicine (11.4 per cent) and gynaecology (5.4 per cent). Over 50 per cent of these cases were within the specialties of surgery and emergency medicine.

(Irish Medical Times, February 23, 2012)

Medical negligence cases should be probed by experts from various fields

There is cause for more worry! At present only doctors can enquire into cases of medical negligence, but that is going to change soon. A parliamentary panel has recommended that medico legal cases should be investigated by a committee, the members of which shall be drawn from various fields including social activists and patient's representatives.

The committee ,headed by Brajesh Pathak, in its report on the Indian Medical Council (Amendment) Bill, 2013, which was presented to the Lok Sabha on Monday, said medical professionals probing into allegations are inclined to be soft on their colleagues guilty of medical negligence.

"The effect of current arrangement is that the percentage of prosecution in the medical negligence cases by MCI is almost negligible," said the committee.It was said that in other countries non medical personnel like patients and social workers are mandatorily made members of the Medical Councils and on occasions they may even lead the Council.

(Indian Medical Times, Wednesday, December 11, 2013)

MODEL FORMAT

Consent Form for Indoor Admissions

(Can be printed/filled in local/vernacular language)

I/we, have been explained and informed (in detail), regarding the disease process, probable outcome and period of hospitalization of the patient. I/We have been explained regarding the provisional diagnosis of the patient _____ and the chances/likelihood of common and major risks, side effects and complications that may occur during the hospital stay or in future.

_____

_____

It is quite possible that during treatment some new findings or complications may arise which may be totally out of control of treating physician. I have been explained that there can be a risk to the life of an otherwise healthy person also. Hence we have been explained that the doctor will take proper care and doesn't guarantee for cure.

I/We have been informed that there are different modalities of treatment for the illness of the patient and the proper mode will be followed as per the need of the patient from time to time. If there is need for any special investigations, procedures or operations we will be informed accordingly.

For the proper management of the patient there may be need of other specialists, residents, assistants, nursing staff etc. I give consent for the help of any qualified staff/person in such situation.

We have also been informed regarding the average expenses that may be incurred during the treatment of the patient. All the facilities/modalities of treatment are not available in this hospital. I/We also understand that these expenses may increase if there is need for sophisticated special investigations, treatment or referral. I/We are willing to pay deposit/advances from time to time.

We understand that it will be our responsibility to bring different medicines, disposables etc. whenever required and asked for.

I/We have been explained all these in the language known to me/us and I/we are signing this consent form without any pressure/coercion and after satisfying my queries/doubts.

Name of the patient _____ age/sex _____

Name of the relatives _____

Relationship _____ Witnesses

Signature 1)

Date & time 2)

Reproduced from "Textbook on Medicolegal Issues - Related to Various Medical Specialties" By Jaypee Bros

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Case scenario / case report / case discussion & letter to editor: 500 words without abstract with 2-3 references in Vancouver style, & 3-5 key words

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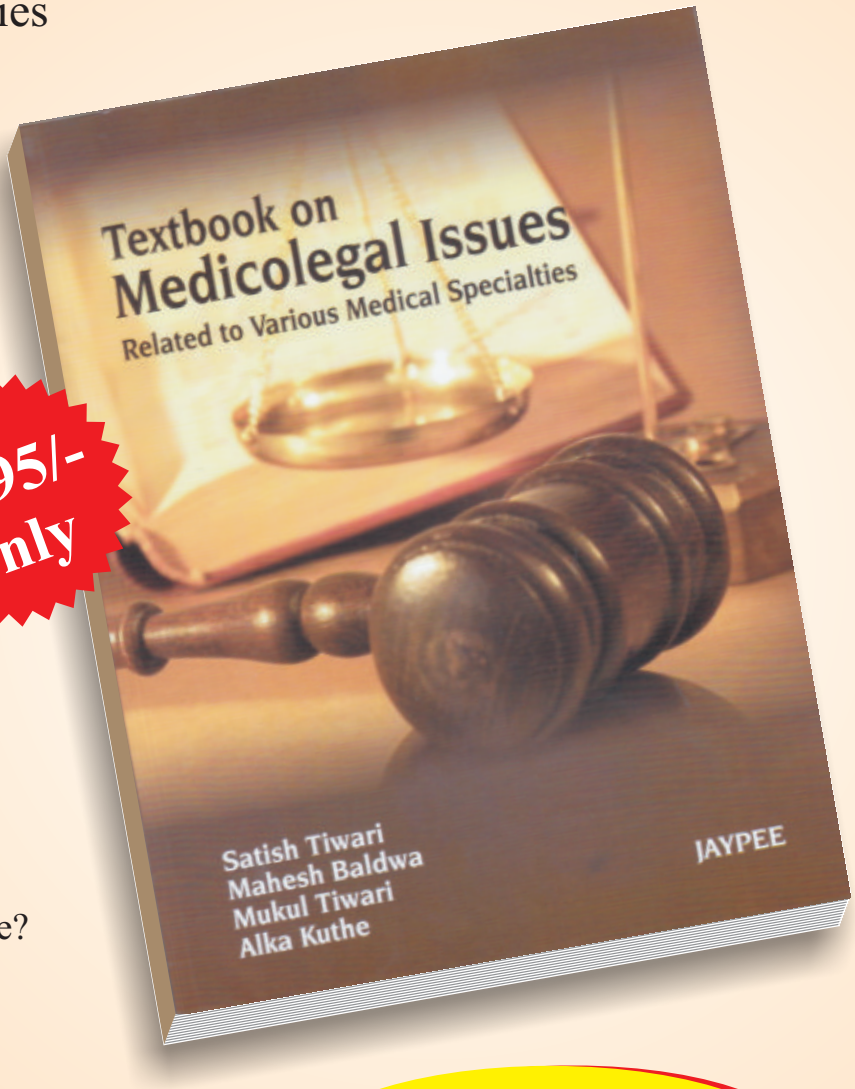

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