CHAPTER VI- A SPECIAL REVIEW: TRIDIMENSIONAL PERSPECTIVE IN MEDICAL PRACTICE

6.1 Ethical Perspective in Medical Practice

Ethical Ingredients in Medical Practice is an ever changing phenomenon subjected to amends by way of time, place, and situation and with ever changing technology which have made an impact concurrently.

The Hippocratic Oath
(Original Version)

I SWEAR by Apollo the physician, AEsculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgement, I will keep this Oath and this stipulation.

TO RECHON him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look up his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according the law of medicine, but to none others.

I WILL FOLLOW that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give a woman a pessary to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves.
WHATEVER, IN CONNECTION with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

Hippocratic Oath is a noble oath taken by earlier day’s medical practitioners depicts how ethical ingredients became integral part of medical professionals since immemorial time making this profession noble. Hippocrates the illustrious Greek physician was born in the island of Cos between 470 and 460 B.C and belonged to the family that claimed successor of mythological Greek Apollo. He is thought to have inherited medical tradition through his predecessor Herodicus and he became expert through extensive travel and thus enhanced medical skills. He advised to make efforts to control the great plague which devastated Athens at the beginning of the Peloponnesian war. He died at Greek city Larissa between 380 and 360 B.C. The works attributed to Hippocrates is the famous “Hippocratic Oath.” This appealing document shows that at ancient times itself physicians were organized into a conglomerate society incorporated regulations for the training of medical professionals with an esprit de corps (a feeling of pride in belonging to a group and a sense of identification with it). Medical professionals were among the philosophicals having highest ethical standards which with changing times remained in the same in continuum with variations of pragmatic realism. Taking oath itself means that professional is mentally prepared to follow the strict ethics of this noble profession through out his/her life holding those values higher in this materialistic world. Words of philosopher Hippocrates have achieved universal endorsement though the medical practices to-day are the major transformations of ancient times.

The expressions quoted in the oath about confidentiality still is a foremost ethics of medical practice. Life is short and the Art long; the occasion fleeting; experience fallacious, and judgment difficult hold good for medical practice yet with inexhaustible modern tools available in hand. The physician must not only be prepared to do what seems right to himself but to consider for the benefit of my patients shows the basic concept does not change along with times.
I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous is an eye opener for medical professionals involved in irrational practice. Will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves suggest the purity of mind a medical professional has to apply in practice when a sick patient trusts a doctor with a humanly surrender for examining & treatement. This oath suggest the passion one must have towards profession and teacher as TO RECHON him who taught me this Art equally dear to me as my parents, I will impart a knowledge of the Art to my own sons, and to my teachers, and to disciples bound by a stipulation and oath according the law of medicine, but to none others indicates the art of medical science is ever a learning exercise the individual will keep on improving this art with exercise.

Today also peer review and continued medical/nursing education has qualitative impact on practice. The quote nor counsel any such thing nor perform the utmost respect for every human life from fertilization to natural death and reject abortion that deliberately takes a unique human life relevant in the scenario of female foeticide as the abortion became legal only to safeguard the women and child health. Hence Hippocrates oath leads us towards the truth of this noble profession.

**Hippocratic Oath Modern Version as follows:**

I SWEAR in the presence of the Almighty and before my family, my teachers and my peers that according to my ability and judgment I will keep this Oath and Stipulation.

TO RECKON all who have taught me this art equally dear to me as my parents and in the same spirit and dedication to impart knowledge of the art of medicine to others. I will continue with diligence to keep abreast of advances in medicine. I will treat without exception all who seek my ministrations, so long as the treatment of others is not compromised thereby, and I will seek the counsel of particularly skilled physicians where indicated for the benefit of my patient.

I WILL FOLLOW that method of treatment which according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is harmful or mischievous. I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing nor perform the
utmost respect for every human life from fertilization to natural death and reject abortion that deliberately takes a unique human life.

WITH PURITY, HOLINESS AND BENEFICENCE I will pass my life and practice my art. Except for the prudent correction of an imminent danger, I will neither treat any patient nor carry out any research on any human being without the valid informed consent of the subject or the appropriate legal protector thereof, understanding that research must have as its purpose the furtherance of the health of that individual. Into whatever patient setting I enter, I will go for the benefit of the sick and will abstain from every voluntary act of mischief or corruption and further from the seduction of any patient.

WHATEVER IN CONNECTION with my professional practice or not in connection with it I may see or hear in the lives of my patients which ought not be spoken abroad, I will not divulge, reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this Oath unviolated may it be granted to me to enjoy life and the practice of the art and science of medicine with the blessing of the Almighty and respected by my peers and society, but should I trespass and violate this Oath, may the reverse by my lot.

Medicine is most noble of all the arts the. Ignorance of those people who practice this profession can lead to a situation of criticism for falling far behind other professions. Professionals face disgrace; begin to give false explanations for failure in their duties.

Medical professional with a proficient knowledge of medicine has advantages of degrees where as time and experience imparts strength to degrees and brings them to maturity. Having brought many ethics to the study of medicine and also having acquired a true knowledge of it physicians are still under scope of experience. Underestimated inexperience is a bad support for lacking the self-reliance and contentedness.

Those effects which are sacred are to be passed to only to sacred persons and it is not lawful to impart them to the wicked is important in commercialization of medical education.
Indian Medical Council is the highest authorities is in allopath system of medicine and have the following code of ethics-

**Indian Medical Council has stipulated Professional Conduct, Etiquette and Ethics for Indian medical featernity time to time and Regulations, 2002 is as follows:**

Indian Medical Council -(Professional Conduct, Etiquette and Ethics) Regulations, 2002

(Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002) MEDICAL COUNCIL OF INDIA NOTIFICATION New Delhi, dated 11th March, 2002 No. MCI-211(2)/2001/Registration. In exercise of the powers conferred under section 20A read with section 33(m) of the Indian Medical Council Act, 1956 (102 of 1956), the Medical Council of India, with the previous approval of the Central Government, hereby makes the following regulations relating to the Professional Conduct, Etiquette and Ethics for registered medical practitioners, namely:- Short Title and Commencement: (1) These Regulations may be called the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002. (2)They shall come into force on the date of their publication in the Official Gazette.

1. CODE OF MEDICAL ETHICS A. Declaration: Each applicant, at the time of making an application for registration under the provisions of the Act, shall be provided a copy of the declaration and shall submit a duly signed Declaration as provided in Appendix 1. The applicant shall also certify that he/she had read and agreed to abide by the same. B. Duties and responsibilities of the Physician in general: 1.1 Character of Physician (Doctors with qualification of MBBS or MBBS with post graduate degree/diploma or with equivalent qualification in any medical discipline): 1.1.1 A physician shall uphold the dignity and honour of his profession. 1.1.2 The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Who- so-ever chooses his profession, assumes the obligation to conduct him self in accordance with its ideals. A physician should be an upright man, instructed in the art of healings. He shall keep himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient, prompt in discharging his duty without anxiety; conducting himself with propriety in
his profession and in all the actions of his life. 1.1.3 No person other than a doctor having qualification recognised by Medical Council of India and registered with Medical Council of India/State Medical Council (s) is allowed to practice Modern system of Medicine or Surgery. A person obtaining qualification in any other system of Medicine is not allowed to practice Modern system of Medicine in any form. 1.2 Maintaining good medical practice: 1.2.1 The Principal objective of the medical profession is to render service to humanity with full respect for the dignity of profession and man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion. Physicians should try continuously to improve medical knowledge and skills and should make available to their patients and colleagues the benefits of their professional attainments. The physician should practice methods of healing founded on scientific basis and should not associate professionally with anyone who violates this principle. The honoured ideals of the medical profession imply that the responsibilities of the physician extend not only to individuals but also to society.

2 1.2.2 Membership in Medical Society: For the advancement of his profession, a physician should affiliate with associations and societies of allopathic medical professions and involve actively in the functioning of such bodies. 1.2.3 A Physician should participate in professional meetings as part of Continuing Medical Education programmes, for at least 30 hours every five years, organized by reputed professional academic bodies or any other authorized organizations. The compliance of this requirement shall be informed regularly to Medical Council of India or the State Medical Councils as the case may be. 1.3 Maintenance of medical records: 1.3.1 Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3. 1.3.2. If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours. 1.3.3 A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address
and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2. 1.3.4 Efforts shall be made to computerize medical records for quick retrieval. 1.4 Display of registration numbers: 1.4.1 Every physician shall display the registration number accorded to him by the State Medical Council / Medical Council of India in his clinic and in all his prescriptions, certificates, money receipts given to his patients. 1.4.2 Physicians shall display as suffix to their names only recognized medical degrees or such certificates/diplomas and memberships/honours which confer professional knowledge or recognizes any exemplary qualification/achievements. 1.5 Use of Generic names of drugs: Every physician should, as far as possible, prescribe drugs with generic names and he / she shall ensure that there is a rational prescription and use of drugs. 1.6 Highest Quality Assurance in patient care: Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education. Physician shall not employ in connection with his professional practice any attendant who is neither registered nor enlisted under the Medical Acts in force and shall not permit such persons to attend, treat or perform operations upon patients wherever professional discretion or skill is required. 1.7 Exposure of Unethical Conduct: A Physician should expose, without fear or favour, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. 1.8 Payment of Professional Services: The physician, engaged in the practice of medicine shall give priority to the interests of patients. The personal financial interests of a physician should not conflict with the medical interests of patients. A physician should announce his fees before rendering service and not after the operation or treatment is under way. Remuneration received for such services should be in the form and amount specifically announced to the patient at the time the service is rendered. It is unethical to enter into a contract of "no cure no payment". Physician rendering service on behalf of the state shall refrain from anticipating or accepting any consideration. 3 1.9 Evasion of Legal Restrictions: The physician shall observe the laws of the country in regulating the practice of medicine and shall also not assist others to evade such laws. He should be cooperative in observance and enforcement of sanitary laws and regulations in the interest of public health. A physician should observe the provisions of the State Acts like Drugs and Cosmetics Act, 1940; Pharmacy Act, 1948; Narcotic Drugs and Psychotropic substances Act, 1985; Medical Termination
2. DUTIES OF PHYSICIANS TO THEIR PATIENTS

2.1 Obligations to the Sick

2.1.1 Though a physician is not bound to treat each and every person asking his services, he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he discharges in the course of his professional duties. In his treatment, he should never forget that the health and the lives of those entrusted to his care depend on his skill and attention. A physician should endeavour to add to the comfort of the sick by making his visits at the hour indicated to the patients. A physician advising a patient to seek service of another physician is acceptable; however, in case of emergency a physician must treat the patient. No physician shall arbitrarily refuse treatment to a patient. However for good reason, when a patient is suffering from an ailment which is not within the range of experience of the treating physician, the physician may refuse treatment and refer the patient to another physician.

2.1.2 Medical practitioner having any incapacity detrimental to the patient or which can affect his performance vis-à-vis the patient is not permitted to practice his profession

2.2 Patience, Delicacy and Secrecy: Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the State. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidence as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would wish another to act toward one of his own family in like circumstances.

2.3 Prognosis: The physician should neither exaggerate nor minimize the gravity of a patient’s
condition. He should ensure himself that the patient, his relatives or his responsible friends have such knowledge of the patient’s condition as will serve the best interests of the patient and the family. 2.4 The Patient must not be neglected: A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family. Provisionally or fully registered medical practitioner shall not willfully commit an act of negligence that may deprive his patient or patients from necessary medical care. 2.5 Engagement for an Obstetric case: When a physician who has been engaged to attend an obstetric case is absent and another is sent for and delivery accomplished, the acting physician is entitled to his professional fees, but should secure the patient’s consent to resign on the arrival of the physician engaged.

**DUTIES OF PHYSICIAN IN CONSULTATION**

3.1 Unnecessary consultations should be avoided: 3.1.1 However in case of serious illness and in doubtful or difficult conditions, the physician should request consultation, but under any circumstances such consultation should be justifiable and in the interest of the patient only and not for any other consideration. 3.1.2 Consulting pathologists/radiologists or asking for any other diagnostic Lab investigation should be done judiciously and not in a routine manner. 3.2 Consultation for Patient’s Benefit: In every consultation, the benefit to the patient is of foremost importance. All physicians engaged in the case should be frank with the patient and his attendants. 3.3 Punctuality in Consultation: Utmost punctuality should be observed by a physician in making themselves available for consultations. 3.4 Statement to Patient after Consultation: 3.4.1 All statements to the patient or his representatives should take place in the presence of the consulting physicians, except as otherwise agreed. The disclosure of the opinion to the patient or his relatives or friends shall rest with the medical attendant. 3.4.2 Differences of opinion should not be divulged unnecessarily but when there is irreconcilable difference of opinion the circumstances should be frankly and impartially explained to the patient or his relatives or friends. It would be opened to them to seek further advice as they so desire. 3.5 Treatment after Consultation: No decision should restrain the attending physician from making such subsequent variations in the treatment if any unexpected change occurs, but at the next consultation, reasons for the variations
should be discussed/ explained. The same privilege, with its obligations, belongs to the consultant when sent for in an emergency during the absence of attending physician. The attending physician may prescribe medicine at any time for the patient, whereas the consultant may prescribe only in case of emergency or as an expert when called for. 3.6 Patients Referred to Specialists: When a patient is referred to a specialist by the attending physician, a case summary of the patient should be given to the specialist, who should communicate his opinion in writing to the attending physician. 3.7 Fees and other charges: 3.7.1 A physician shall clearly display his fees and other charges on the board of his chamber and/or the hospitals he is visiting. Prescription should also make clear if the Physician himself dispensed any medicine. 3.7.2 A physician shall write his name and designation in full along with registration particulars in his prescription letter head. Note: In Government hospital where the patient–load is heavy, the name of the prescribing doctor must be written below his/her signature. CHAPTER 4 4. RESPONSIBILITIES OF PHYSICIANS TO EACH OTHER 4.1 Dependence of Physicians on each other: A physician should consider it as a pleasure and privilege to render gratuitous service to all physicians.

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4. RESPONSIBILITIES OF PHYSICIANS TO EACH OTHER 4.1 Dependence of Physicians on each other: A physician should consider it as a pleasure and privilege to render gratuitous service to all physicians and their immediate family dependants.

5 4.2 Conduct in consultation: In consultations, no insincerity, rivalry or envy should be indulged in. All due respect should be observed towards the physician in-charge of the case and no statement or remark be made, which would impair the confidence reposed in him. For this purpose no discussion should be carried on in the presence of the patient or his representatives. 4.3 Consultant not to take charge of the case: When a physician has been called for consultation, the Consultant should normally not take charge of the case, especially on the solicitation of the patient or friends. The Consultant shall not criticize the referring physician. He / she shall discuss the diagnosis treatment plan with the referring physician. 4.4 Appointment of Substitute: Whenever a physician requests another physician to attend his patients during his temporary absence from his practice, professional courtesy requires the acceptance of such appointment only when he has the capacity to discharge the additional
responsibility along with his / her other duties. The physician acting under such an appointment should give the utmost consideration to the interests and reputation of the absent physician and all such patients should be restored to the care of the latter upon his/her return.

4.5 Visiting another Physician’s Case: When it becomes the duty of a physician occupying an official position to see and report upon an illness or injury, he should communicate to the physician in attendance so as to give him an option of being present. The medical officer / physician occupying an official position should avoid remarks upon the diagnosis or the treatment that has been adopted.

5 DUTIES OF PHYSICIAN TO THE PUBLIC AND TO THE PARAMEDICAL PROFESSION 5.1 Physicians as Citizens: Physicians, as good citizens, possessed of special training should disseminate advice on public health issues. They should play their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should particularly co-operate with the authorities in the administration of sanitary/public health laws and regulations. 5.2 Public and Community Health: Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic occurs a physician should not abandon his duty for fear of contracting the disease himself. 5.3 Pharmacists / Nurses: Physicians should recognize and promote the practice of different paramedical services such as, pharmacy and nursing as professions and should seek their cooperation wherever

6. UNETHICAL ACTS: A physician shall not aid or abet or commit any of the following acts which shall be construed as unethical - 6.1 advertising:

6.1.1 Soliciting of patients directly or indirectly, by a physician, by a group of physicians or by institutions or organisations is unethical. A physician shall not make use of him / her (or his / her name) as subject of any form or manner of advertising or publicity through any mode either alone or in conjunction with others which is of such a character as to invite attention to him or to his professional position, skill,
qualifications, achievements, specialties, appointments, associations, affiliations or honours and/or of such character as would ordinarily result in his self aggrandizement. A physician shall not give to any person, whether for compensation or otherwise, any approval, recommendation, endorsement, certificate, report or

6 statement with respect of any drug, medicine, nostrum remedy, surgical, or therapeutic article, apparatus or appliance or any commercial product or article with respect of any property, quality or use thereof or any test, demonstration or trial thereof, for use in connection with his name, signature, or photograph in any form or manner of advertising through any mode nor shall he boast of cases, operations, cures or remedies or permit the publication of report thereof through any mode. A medical practitioner is however permitted to make a formal announcement in press regarding the following: (1) on starting practice. (2) On change of type of practice. (3) On changing address. (4) On temporary absence from duty. (5) On resumption of another practice. (6) On succeeding to another practice. (7) Public declaration of charges.

6.1.2 Printing of self photograph, or any such material of publicity in the letter head or on sign board of the consulting room or any such clinical establishment shall be regarded as acts of self advertisement and unethical conduct on the part of the physician. However, printing of sketches, diagrams, picture of human system shall not be treated as unethical. 6.2 Patent and Copyrights: A physician may patent surgical instruments, appliances and medicine or Copyright applications, methods and procedures. However, it shall be unethical if the benefits of such patents or copyrights are not made available in situations where the interest of large population is involved.

6.3 Running an open shop (Dispensing of Drugs and Appliances by Physicians): - A physician should not run an open shop for sale of medicine for dispensing prescriptions prescribed by doctors other than himself or for sale of medical or surgical appliances. It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient. Drugs prescribed by a physician or brought from the market for a patient should explicitly state the proprietary formulae as well as generic name of the drug. 6.4 Rebates and Commission: 6.4.1 A physician shall not give, solicit, or receive nor shall he offer to give solicit or receive, any gift, gratuity, commission or bonus in consideration of or return for the referring, recommending or procuring of any patient for medical, surgical or other treatment. A physician shall not directly or indirectly, participate in
or be a party to act of division, transference, assignment, subordination, rebating, splitting or refunding of any fee for medical, surgical or other treatment. 6.4.2 Provisions of para 6.4.1 shall apply with equal force to the referring, recommending or procuring by a physician or any person, specimen or material for diagnostic purposes or other study / work. Nothing in this section, however, shall prohibit payment of salaries by a qualified physician to other duly qualified person rendering medical care under his supervision. 6.5 Secret Remedies: The prescribing or dispensing by a physician of secret remedial agents of which he does not know the composition, or the manufacture or promotion of their use is unethical and as such prohibited. All the drugs prescribed by a physician should always carry a proprietary formula and clear name. 6.6 Human Rights: The physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights. 6.7 Euthanasia: Practicing euthanasia shall constitute unethical conduct. However on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in charge of the patient, Chief Medical Officer / Medical Officer in charge of the hospital and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.

7 The Clause No. 6.8, as under, is included in terms of Notification published on 14.12.2009 in Gazette of India & the same is also enclosed as Annexure - I. “6.8 Code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry. 6.8.1 In dealing with Pharmaceutical and allied health sector industry, a medical practitioner shall follow and adhere to the stipulations given below:- a) Gifts: A medical practitioner shall not receive any gift from any pharmaceutical or allied health care industry and their sales people or representatives. b) Travel facilities: A medical practitioner shall not accept any travel facility inside the country or outside, including rail, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc as a delegate. c) Hospitality: A medical
practitioner shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext. d) Cash or monetary grants: A medical practitioner shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions by modalities laid down by law / rules / guidelines adopted by such approved institutions, in a transparent manner. It shall always be fully disclosed.

e) Medical Research: A medical practitioner may carry out, participate in, work in research projects funded by pharmaceutical and allied healthcare industries. A medical practitioner is obliged to know that the fulfillment of the following items (i) to (vii) will be an imperative for undertaking any research assignment / project funded by industry – for being proper and ethical. Thus, in accepting such a position a medical practitioner shall:- (i) Ensure that the particular research proposal(s) has the due permission from the competent concerned authorities. (ii) Ensure that such a research project(s) has the clearance of national/ state / institutional ethics committees / bodies. (iii) Ensure that it fulfils all the legal requirements prescribed for medical research. (iv) Ensure that the source and amount of funding is publicly disclosed at the beginning itself. (v) Ensure that proper care and facilities are provided to human volunteers, if they are necessary for the research project(s). (vi) Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way. (vii) Ensure that while accepting such an assignment a medical practitioner shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU or any other document / agreement for any such assignment. f) Maintaining Professional Autonomy: In dealing with pharmaceutical and allied healthcare industry a medical practitioner shall always ensure that there shall never be any compromise either with his / her own professional autonomy and / or with the autonomy and freedom of the medical institution.

8 g) Affiliation: A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a medical practitioner shall always: (i) Ensure that his professional integrity and freedom are maintained. (ii) Ensure that patients interest are not compromised in any way. (iii) Ensure that such
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affiliations are within the law. (iv) Ensure that such affiliations / employments are fully transparent and disclosed. h) Endorsement: A medical practitioner shall not endorse any drug or product of the industry publically. Any study conducted on the efficacy or otherwise of such products shall be presented to and / or through appropriate scientific bodies or published in appropriate scientific journals in a proper way”.

7. MISCONDUCT : The following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action 7.1 Violation of the Regulations: If he/she commits any violation of these Regulations. 7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of three years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it as per the regulation 1.3.2. 7.3 If he/she does not display the registration number accorded to him/her by the State Medical Council or the Medical Council of India in his clinic, prescriptions and certificates etc. issued by him or violates the provisions of regulation 1.4.2. 7.4 Adultery or Improper Conduct: Abuse of professional position by committing adultery or improper conduct with a patient or by maintaining an improper association with a patient will render a Physician liable for disciplinary action as provided under the Indian Medical Council Act, 1956 or the concerned State Medical Council Act. 7.5 Conviction by Court of Law: Conviction by a Court of Law for offences involving moral turpitude / Criminal acts. 7.6 Sex Determination Tests: On no account sex determination test shall be undertaken with the intent to terminate the life of a female foetus developing in her mother’s womb, unless there are other absolute indications for termination of pregnancy as specified in the Medical Termination of Pregnancy Act, 1971. Any act of termination of pregnancy of normal female foetus amounting to female foeticide shall be regarded as professional misconduct on the part of the physician leading to penal erasure besides rendering him liable to criminal proceedings as per the provisions of this Act. 7.7 Signing Professional Certificates, Reports and other Documents: Registered medical practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give certificates, notification, reports and other documents of similar character signed by them in their professional capacity for subsequent use in the courts or for administrative purposes etc. Such documents, among others,
include the ones given at Appendix -4. Any registered practitioner who is shown to have signed or given under his name and authority any such certificate, notification, report or document of a similar character which is untrue, misleading or improper, is liable to have his name deleted from the Register 7.8 A registered medical practitioner shall not contravene the provisions of the Drugs and Cosmetics Act and regulations made there under. Accordingly, a) Prescribing steroids/ psychotropic drugs when there is no absolute medical indication; b) Selling Schedule „H” & „L” drugs and poisons to the public except to his patient;

9 in contravention of the above provisions shall constitute gross professional misconduct on the part of the physician. 7.9 Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical, surgical or psychological indication. 7.10 A registered medical practitioner shall not issue certificates of efficiency in modern medicine to unqualified or non-medical person. (Note: The foregoing does not restrict the proper training and instruction of bonafide students, midwives, dispensers, surgical attendants, or skilled mechanical and technical assistants and therapy assistants under the personal supervision of physicians.) 7.11 A physician should not contribute to the lay press articles and give interviews regarding diseases and treatments which may have the effect of advertising himself or soliciting practices; but is open to write to the lay press under his own name on matters of public health, hygienic living or to deliver public lectures, give talks on the radio/TV/internet chat for the same purpose and send announcement of the same to lay press. 7.12 An institution run by a physician for a particular purpose such as a maternity home, nursing home, private hospital, rehabilitation centre or any type of training institution etc. may be advertised in the lay press, but such advertisements should not contain anything more than the name of the institution, type of patients admitted, type of training and other facilities offered and the fees. 7.13 It is improper for a physician to use an unusually large sign board and write on it anything other than his name, qualifications obtained from a University or a statutory body, titles and name of his speciality, registration number including the name of the State Medical Council under which registered. The same should be the contents of his prescription papers. It is improper to affix a sign-board on a chemist’s shop or in places where he does not reside or work. 7.14 The registered medical practitioner shall not disclose the secrets of a patient that have been learnt in the exercise of his /
her profession except – i) in a court of law under orders of the Presiding Judge; ii) in circumstances where there is a serious and identified risk to a specific person and / or community; and iii) notifiable diseases. In case of communicable / notifiable diseases, concerned public health authorities should be informed immediately. 7.15 The registered medical practitioner shall not refuse on religious grounds alone to give assistance in or conduct of sterility, birth control, circumcision and medical termination of Pregnancy when there is medical indication, unless the medical practitioner feels himself/herself incompetent to do so. 7.16 Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed. 7.17 A registered medical practitioner shall not publish photographs or case reports of his / her patients without their permission, in any medical or other journal in a manner by which their identity could be made out. If the identity is not to be disclosed, the consent is not needed. 7.18 In the case of running of a nursing home by a physician and employing assistants to help him / her, the ultimate responsibility rests on the physician. 7.19 A Physician shall not use touts or agents for procuring patients. 7.20 A Physician shall not claim to be specialist unless he has a special qualification in that branch. 10 7.21 No act of invitro fertilization or artificial insemination shall be undertaken without the informed consent of the female patient and her spouse as well as the donor. Such consent shall be obtained in writing only after the patient is provided, at her own level of comprehension, with sufficient information about the purpose, methods, risks, inconveniences, disappointments of the procedure and possible risks and hazards. 7.22 Research: Clinical drug trials or other research involving patients or volunteers as per the guidelines of ICMR can be undertaken, provided ethical considerations are borne in mind. Violation of existing ICMR guidelines in this regard shall constitute misconduct. Consent taken from the patient for trial of drug or therapy which is not as per the guidelines shall also be construed as misconduct. The following Clause No. 7.23 & 7.24 are deleted in terms of Notification published on 22.02.2003 in Gazette of India & the same is also enclosed as Annexure - II. 7.23 If a physician posted in rural area is found absent on more than two occasions during inspection by the Head of the District Health Authority or the Chairman, Zila Parishad, the same shall be construed as a misconduct if it is recommended to the Medical Council of India/State Medical Council by the
State Government for action under these Regulations. 7.24 If a physician posted in a medical college/institution both as teaching faculty or otherwise shall remain in hospital/college during the assigned duty hours. If they are found absent on more than two occasions during this period, the same shall be construed as a misconduct if it is certified by the Principal/Medical Superintendent and forwarded through the State Government to Medical Council of India/State Medical Council for action under these Regulations.

8 PUNISHMENT AND DISCIPLINARY ACTION 8.1 It must be clearly understood that the instances of offences and of Professional misconduct which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which calls for disciplinary action, and that by issuing this notice the Medical Council of India and or State Medical Councils are in no way precluded from considering and dealing with any other form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances as in all others, the Medical Council of India and/or State Medical Councils have to consider and decide upon the facts brought before the Medical Council of India and/or State Medical Councils. 8.2 It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for Disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of committing professional misconduct, the appropriate Medical Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register of the name of the delinquent registered practitioner. Deletion from the Register shall be widely publicized in local press as well as in the publications of different Medical Associations/ Societies/Bodies. 8.3 In case the punishment of removal from the register is for a limited period, the appropriate Council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed. 8.4 Decision on complaint against delinquent physician shall be taken within a time
limit of 6 months. 8.5 During the pendency of the complaint the appropriate Council may restrain the physician from performing the procedure or practice which is under scrutiny. 11 8.6 Professional incompetence shall be judged by peer group as per guidelines prescribed by Medical Council of India. 8.7 The following Clause No. 8.7 & 8.8 are included in terms of Notification published on 27.05.2004 in Gazette of India & the same is also enclosed as Annexure - III. “8.7 Where either on a request or otherwise the Medical Council of India is informed that any complaint against a delinquent physician has not been decided by a State Medical Council within a period of six months from the date of receipt of complaint by it and further the MCI has reason to believe that there is no justified reason for not deciding the complaint within the said prescribed period, the Medical Council of India may- (i) Impress upon the concerned State Medical council to conclude and decide the complaint within a time bound schedule; (ii) May decide to withdraw the said complaint pending with the concerned State Medical Council straightaway or after the expiry of the period which had been stipulated by the MCI in accordance with para(i) above, to itself and refer the same to the Ethical Committee of the Council for its expeditious disposal in a period of not more than six months from the receipt of the complaint in the office of the Medical Council of India.” “8.8 Any person aggrieved by the decision of the State Medical Council on any complaint against a delinquent physician, shall have the right to file an appeal to the MCI within a period of 60 days from the date of receipt of the order passed by the said Medical Council: Provided that the MCI may, if it is satisfied that the appellant was prevented by sufficient cause from presenting the appeal within the aforesaid period of 60 days, allow it to be presented within a further period of 60 days.

A. DECLARATION At the time of registration, each applicant shall be given a copy of the following declaration by the Registrar concerned and the applicant shall read and agree to abide by the same: 1) I solemnly pledge myself to consecrate my life to service of humanity. 2) Even under threat, I will not use my medical knowledge contrary to the laws of Humanity. 3) I will maintain the utmost respect for human life from the time of conception. 4) I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient. 5) I will practice my profession with conscience and dignity. 6) The health of my patient will be my first consideration. 7) I will respect the secrets which are
confined in me. 8) I will give to my teachers the respect and gratitude which is their
due. 9) I will maintain by all means in my power, the honour and noble traditions of
medical profession. 10) I will treat my colleagues with all respect and dignity. 11) I
shall abide by the code of medical ethics as enunciated in the Indian Medical Council
(Professional Conduct, Etiquette and Ethics) Regulations 2002. I make these promises
solemnly, freely and upon my honour.
Signature
Name
Place
Address
Date

MEDICAL COUNCIL OF INDIA AMENDMENT NOTIFICATION New Delhi,
the 10th December, 2009

No.MCI-211(1)/2009(Ethics)/55667 - In exercise of the powers conferred by Section
33 of the Indian Medical Council Act, 1956 (102 of 1956), the Medical Council of
India with the previous sanction of the Central Government, hereby makes the
following Regulations to amend the “Indian Medical Council (Professional Conduct,
Etiquette and Ethics) Regulations, 2002:

1. (i) These Regulations may be called the “Indian Medical Council (Professional
Conduct, Etiquette and Ethics) (Amendment) Regulations, 2009 Part-I”.

(ii) They shall come into force from the date of their publication in the Official
Gazette.

2. In the “Indian Medical Council (Professional Conduct, Etiquette and Ethics)
Regulations, 2002”, the following additions/modifications/deletions/ substitutions,
shall be, as indicated therein: -

3 The following clause shall be added after clause 6.7:-

“6.8 Code of conduct for doctors and professional association of doctors in their
relationship with pharmaceutical and allied health sector industry. 6.8.1 In dealing with Pharmaceutical and allied health sector industry, a medical
practitioner shall follow and adhere to the stipulations given below:-

a) Gifts: A medical practitioner shall not receive any gift from any pharmaceutical or allied health care industry and their sales people or representatives.

b) Travel facilities: A medical practitioner shall not accept any travel facility inside the country or outside, including rail, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc. as a delegate.

c) Hospitality: A medical practitioner shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext.

d) Cash or monetary grants: A medical practitioner shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions by modalities laid down by law / rules / guidelines adopted by such approved institutions, in a transparent manner. It shall always be fully disclosed.

e) Medical Research: A medical practitioner may carry out, participate in, work in research projects funded by pharmaceutical and allied healthcare industries. A medical practitioner is obliged to know that the fulfillment of the following items (i) to (vii) will be an imperative for undertaking any research assignment / project funded by industry – for being proper and ethical. Thus, in accepting such a position a medical practitioner shall:-

(i) Ensure that the particular research proposal(s) has the due permission from the competent concerned authorities.

(ii) Ensure that such a research project(s) has the clearance of national/ state / institutional ethics committees / bodies.

(iii) Ensure that it fulfils all the legal requirements prescribed for medical research.

(iv) Ensure that the source and amount of funding is publicly disclosed at the beginning itself.

(v) Ensure that proper care and facilities are provided to human volunteers, if they are necessary for the research project(s).
(vi) Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way.

(vii) Ensure that while accepting such an assignment a medical practitioner shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU or any other document / agreement for any such assignment.

f) Maintaining Professional Autonomy: in dealing with pharmaceutical and allied healthcare industry, a medical practitioner shall always ensure that there shall never be any compromise either with his / her own professional autonomy and / or with the autonomy and freedom of the medical institution.

g) Affiliation: A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a medical practitioner shall always:

(i) Ensure that his professional integrity and freedom are maintained.

(ii) Ensure that patient’s interest is not compromised in any way.

(iii) Ensure that such affiliations are within the law.

(iv) Ensure that such affiliations / employments are fully transparent and disclosed.

h) Endorsement: A medical practitioner shall not endorse any drug or product of the industry publically. Any study conducted on the efficacy or otherwise of such products shall be presented to and / or through appropriate scientific bodies or published in appropriate scientific journals in a proper way”.

(Lt. Col. (Retd.) Dr. A.R.N. Setalvad)
Secretary
Medical Council of India
Discussion:

Any aggrieved person can complain about medical negligence to state /central medical council. Medical Council is unable to investigate cases of medical negligence and take decisions on tort principles like a judicial entity. In Western countries courts take complaints of medical negligence and decide upon compensation to sufferer. However Indian courts due to huge work load were unable to bring timely justice to all consumer complaints which itself would decline the quality of goods or service when there is no fear of timely punishment. The consumer Act and redressal system are easy platform to bring justice to the sufferer and there by having, influence quality of goods and service.

We can see the simple but clear-cut ethics as early as 400-300 B.C. in Hippocrates time oath and elaborative code of professional Conduct, Etiquette and Ethics for Indian doctors including amendment of 2009 from IMC. Similarly, nurses also take oath and have code of conduct. However, code of conducts and regulatory agencies can they deal with all grievances of patient and relatives are a matter of controversy.

We can see since the era of bolum to as on today medical negligence are a matter of legal concern. The State Medical Councils, India have power to punish the doctors by giving warnings and suspending their registrations (temporarily or permanently) but they do not have power to order compensation to the patient.

Conflicting medical/clinical knowledge, ethics and social condition at certain point of time gives rise to changes in thinking lead to redefinition of ethical and legal perspectives for the betterment of the society illustrated with examples-

Hippocratic Oath mentions about physician house visit, however now in the 21-st century patients going to doctors clinic or hospitals is a common practice.

India during 20th century witnessed tremendous neonatal tetanus .Even in 21 st centuries more than 5 lakh (15 Percentage of neonatal deaths) newborns are estimated to die each year from serious neonatal infections globally. Applications of cow dung or ash to the cord was common practice. At the time of childbirth infections transmitted and have early onset of symptoms resulting in 30-40 Percentage of neonatal sepsis deaths. In low income countries about 60 Percentage of births occur without a skilled attendant and at home and 60 million births happen without proper
medical facilities worldwide. World Health Organisation’s (WHO) has advised for home deliveries to follow “six cleans” - hand washing of birth attendant before birth, clean birth surface, clean perineum, cutting of the umbilical cord using a clean implement, clean cord tie, and a clean cloth for drying. These practices can be used for reduction in neonatal mortality. The concept of a clean birth kit is promoted for many years and acceptable in several countries is important in areas with limited facilities. Clean practices at birth and in the postnatal period could prevent neonatal and infant deaths in regions with high neonatal mortality. The benefits of a clean birth as practicable action can save over 100,000 lives each year.

As per researchers from Oxford University, the first time mothers do have to take care extra as they face more complications. Those who are not under danger can have the right to select the kind of giving birth. There are debates about relevance of birth setting still safety of the baby and mother is important. Study has shown that first-time mothers wishing to deliver at home have an increased risk for their babies as per Dr. Tony Falconer, President of the Royal College of Obstetricians and Gynecologists. Jul 13, 2007.

15 Percentage of deaths of women in the reproductive age in India are maternal deaths and more than 90 Percentage of maternal deaths are preventable. 40 Percentage of all pregnant women have some complications. 15 Percentage need obstetric care for complications, which are potentially life threatening to mother and baby. Maternal mortality ratio in India is 308 per 100,000 live births and is 40 per 100,000 live births in Sri Lanka. Unsafe abortions lead to the deaths of 200 women everyday globally. One unsafe abortion takes place every 7 births. India spends a mere 0.9 Percentage of GDP on health in the public sector.

In India, about 300 women die every day due to pregnancy and childbirth complications and 90 Percentage of these deaths are preventable. India’s apex body, the Federation of Obstetric and Gynecological Societies of India (FOGSI) took an innovative step to spread the message of Safe Motherhood through India’s national network radio and television with a documentary drama having dramatized depiction of various complications of pregnancy and childbirth discussions with healthcare professionals for radio and television for focusing on maternal mortality in India. This was broadcasted on radio stations in the Indian states of Bihar, Madhya Pradesh,
Rajasthan, Uttar Pradesh and Jharkhand. “The unique character of this first-of-its kind initiative is that doctors are involved in producing this serial, aimed at reducing maternal mortality through education of mothers-to-be & their families, to deliver at the hospital under supervision of a qualified medical practitioner,” said Dr. Pankaj Desai, President, FOGSI. AstraZeneca Pharma India Ltd. supported the project as part of its ongoing efforts to promote Safe Motherhood.

Immunization programmes aim to reduce mortality and morbidity due to vaccine preventable diseases (VPDs). Following the successful global eradication of smallpox in 1975 through effective vaccination programmes and strengthened surveillance, the Expanded Programme on Immunization (EPI) was launched in India in 1978 to control other VPDs. Initially, six diseases were selected: diphtheria, pertussis, tetanus, poliomyelitis, typhoid and childhood tuberculosis. The aim was to cover 80 Percentage of all infants. Subsequently, the programme was universalized and renamed as Universal Immunization Programme (UIP) in 1985. Measles vaccine was included in the programme and typhoid vaccine was discontinued. The UIP was introduced in a phased manner from 1985 to cover all districts in the country by 1990, targeting all infants with the primary immunization schedule and all pregnant women with Tetanus Toxoid immunization. Delivering effective and safe vaccines through an efficient delivery system is one of the most cost effective public health interventions. The size and diversity of India make successful implementation of RI program more challenging.

India has the problem of population explosion. Although the fertility rate (average number of children born per woman during her lifetime) in India has been declining but not reached replacement rate (total fertility rate at which newborn girls would have an average of exactly one daughter over their lifetimes). The replacement rate is approximately 2.1 in most industrialized nations and about 2.5 in developing nations (due to higher mortality). A nation that crosses below the replacement rate is on the path to population stabilization and less than 1 is phase of population reduction.

India's fertility rate is lower than some countries in its neighborhood, but significantly higher than China. Family Planning in India is based on efforts largely sponsored by the Indian government. From 1965 to 2009 usage of contraceptive has increased more than thrice and the fertility rate has declined by more than 50
Percentage (from 5.7 in 1966 to 2.6 in 2009). However the fertility rate is still enough to result in long-term population growth with addition of approximately 10 lakh people to its population every 15 days. Awareness of contraception is near-universal among married women in India, but low female literacy and the limited accessibility and availability of birth-control methods is reasons for non usage of contraception. About three-fourths of couples opt for female sterilization, a most prevalent birth-control method in India and condoms, at a mere 3 Percentage were the next most prevalent method. Comparative studies have indicated that increased female literacy is correlated strongly with a decline in fertility and is an independent strong predictor of the use of contraception, even when women do not otherwise have economic independence. Female literacy levels in India may be the primary factor that help in population stabilization. 1990 study estimated that it would take until 2060 for India to achieve universal literacy at the current rate of progress.

The Medical Termination of Pregnancy Bill was passed by both the Houses of the Parliament and received the assent of the President of India on 10th August, 1971 as the "The MTP Act, 1971". This law guarantees the Right of Women in India to terminate an unintended pregnancy by a registered medical practitioner in a hospital established or maintained by the Government or a place being approved for the purpose of this Act by the Government. Not all pregnancies could be terminated. MTP Act said that pregnancy can be terminated with underling conditions.

In the beginning, India was against abortion because abortion is condemned in Vedic literature. India has legalized abortion in 1971 with certain restriction. Due to the experience of female feticide cases in made Indian government to come up with strict law on abortion. Every year 6.7 million abortions take place in India and 5.7 millions are illegal with the result India has a high maternal mortality rate of 498 per 100,000 women, which is high as compared to other countries. Education is necessary for empowerment of women and to reduce the dependence on. Both legislative and non-legislative measures can reduce female feticide. The PNDT Act and the MTP Act are the two legislations are independent of each other rigid to sustain in real practice. The widespread crusade around the PNDT act has led to high awareness about it among the community.
A code of ethics for blood donation and transfusion is practiced worldwide. The purpose of this code is to describe the ethical principles and rules to be observed in the field of Transfusion Medicine. A donation is considered voluntary and non-remunerated if the person gives blood, plasma or cellular components of his/her own free will and receives no payment for it, either in the form of cash, or in kind which could be considered a substitute for money. Patients should be informed of the known risks and benefits of blood transfusion and/or alternative therapies and have the right to accept or refuse the procedure. Any valid advance directive should be respected. In the event that the patient is unable to give prior informed consent, the basis for treatment by transfusion must be in the best interests of the patient.

Many groups of patients with HIV/AIDS, leprosy, tuberculosis, mental illnesses and other conditions are harshly affected by health-related stigma and discrimination. Stigma is recognized to have a wrong impact on public health interventions. Humans being in the context of refusing to be treated due to stigma In the background of Articles 19(1) (g) and 21 of the Constitution, equality guaranteed. On the ethical plane physician can be compelled to render medical service to an AIDS patient. Most of the AIDS patients and HIV carriers are the innocent victims of an apathetic system, the sufferers (HIV positive child prostitutes, innocent housewives) and trade and trap victims (the adolescent drug addict and the intravenous drug abuser). They deserve to be given medical treatment on adequate precaution without being discriminated and detested.

The Supreme Court in the accident case has issued binding directions towards the approach towards medico-legal cases. A public interest petition filed under Article 32 of the Constitution asking for directions to the Union of India that every injured citizen brought for treatment should instantaneously be given medical aid to preserve life to avoid negligent death and appropriate compensation should be admissible if medically negligent. Supreme Court after considering various aspects, as under the Medical Council of India said it is a part of the medical ethics to start treating the patient as soon as brought. It is paramount obligation of the doctor to save human life and bring the patient out of the risk zone at the earliest with a view of preserving life. There are no provisions in the Indian Penal Code, Criminal Procedure Code; Motor Vehicles Act etc stop Doctors from quickly attending seriously injured persons and
Euthanasia is the termination of a person's life in order to relieve them of their suffering in a terminally ill or highly dependent patient with unbearable suffering. The person involved may ask for euthanasia or requested by others where a person cannot make such a request. 20th century has met limited success in western countries towards euthanasia. Euthanasia policies are developed by a variety of NGOs, notably medical associations and advocacy organizations. As of 2011, active euthanasia is only legal in the three Netherlands, Belgium and Luxemburg. Assisted suicide is legal in Switzerland and Washington, Oregon and Montana (US states). Terminally ill patients are in intractable pain and/or experience an intolerably poor quality of life. Many faith groups within Hindus, Christian, Muslim, Jewish and other religions sincerely believe that God gives life and therefore only God should take it away. Also believe that human suffering can have a positive value for the terminally ill person and for caregivers. Many groups argue that pain experienced by terminally ill people can be controlled to tolerable levels through proper management. Sometimes a terminal illness is so painful that it causes life to be an unbearable burden and euthanasia represent a relief to the intolerable pain. “Passive euthanasia” is withdrawing medical treatment with the deliberate objective of causing the patient’s death. Example, if a patient requires ventilator to survive, the doctors disconnect the ventilator allowing the patient to die. Passive euthanasia is different from “active euthanasia” where the death is caused by the use of fatal substances. With the Supreme Court allowing “passive” euthanasia under “exceptional circumstances”, India joined a few countries, which have legalized mercy killing when judgment came during a hearing into the case of former nurse been in a vegetative state in a Mumbai hospital since being raped & strangled while at work 37 yrs ago. India’s Supreme Court decided that life support can be legally removed for some terminally ill patients in this ruling and allowed passive euthanasia for the first time on Mar 8, 2011.

Disclosing medical errors to patients is emerging ethical concept in 21st century of modern medical practice. Evidence has shown that adverse events, including errors,
Medical Negligence: an Analytical Study Focussing on Legal, Ethical and Clinical Perspectives

Medical Negligence occur frequently in health care in the past decade. The Canadian Patient Safety Institute as defined adverse events as “harm that results from an unexpected and unintentional occurrence in health care delivery”. Some adverse events are preventable called as errors. Either some errors do not cause harm patients as a chance or as the error was corrected before harm could occur and such incidence is called as near misses. Studies done at multiple countries estimated that adverse events affect up to 7.5 Percentage of patients admitted to acute care hospitals. Baker and colleagues estimated 37 Percentage of these adverse events are preventable and system defects changed for correction. Improvement in the recognition and reporting of errors and the disclosure of harmful errors to patients and their families is a diligent act. Disclosing errors to patients is challenge to both medical professionals and health care industry. Disclosing errors also uphold the physician’s ethical duty to tell the truth to patient. Medical professionals should support disclosure of errors for both ethical and useful factors. From an ethical perspective, patients require information about errors to make decisions for subsequent treatment and this process facilitate patient decision-making in the physician–patient relationship. However, open communication with patients about errors is not yet a common practice. Patients can provide a important insight and perspective about preventing such errors. The 2004 Canadian Medical Association Code of Ethics directs to take reasonable steps to prevent harm to patients and should harm occur, disclose it to the patient. Disclosing medical errors can increase medical negligence claims is one of the apprehension.

Quality and patient safety efforts are separate entity but patient safety infrastructure have been critical to accelerating better quality patient care in safe environment. Modernization of the quality and patient safety functions start with a quality officer in the health care industry. Patient Safety Department adds to efficiency, information sharing, teamwork and analysis of errors. Medical professionals dedicate their lives to caring patients. However, providing health care can be complicated. A number of different medical persons involved in the care of a single patient. Patients are ignorant of technical language. Inspite of hospitals taking steps to maintain patients safety medical errors can happen. They are diagnostic errors, wrong-site surgery, medication errors, health care-acquired infections, falls and readmissions. The Patient Safety guidelines worldwide consider education as a valuable tool to prevent medical errors. At various western nations, National Patient Safety
Foundations provides resources to support health care professionals in their role of creating and maintaining a safe health care environment.

Medical ethics started as a oath at the beginning of medical or nursing carrier. A radical change in ethical standards occurred over course hundreds of years. Presently a medical professional with swiftly changing medical ethos has to remodify his thinking and practice many a times in his life time. Certain medical ethics are aimed at a focus of changing the mind set of patients and society at large for the betterment of the world. Some other medical ethics are focused at practices of medical professionals themselves. Medical ethics in general are preventative steps to stop unfairness in medical practices. Hence, the code of ethics is always remains relevant to medical practice.

6.2 Clinical Perspective in Medical Practice

The 20th century witnessed remarkable progress in the patient care and also health care attained the scale of industry especially secondary and tertiary health care. The first decade of the 21st Century, with a number of innovations and tremendous advances in medical sciences remarkably influenced patient's treatment. Also these advances altered many deep-seated beliefs in medicine and unlocked the possibilities beyond what medical professional thought not attainable. Hence is the importance of the clinical perspective in medical practice and medical negligence trials in the 21st century. We can review few diagnostic and clinical progress made.

Medical imaging is the technique and process used to create images of the human body for clinical purposes seeking diagnosis, monitoring or prognosis. Two forms of
radiographic images are in used are projection radiography and fluoroscopy. 2D techniques are still in wide use due to the low cost, high resolution, and lower radiation dosages. Projection radiography commonly known as known as x-rays utilizes a wide beam of X-rays and is preliminary diagnostic test for fractures, lungs disease and cardiac diseases. With contrast media is used to assess structure of the GI tract, diagnose ulcers or certain types of cancers and renal system. Fluoroscopy produces real-time images of internal structures of the body utilizing constant low dose rate input of x-rays used to see the internal organs for catheter guidance and in image-guided procedures. Lead is the protective shield used against X-rays hazards because of its high density, stopping power, simplicity of installation and low cost.

Ultrasonography uses high frequency sound waves to produce images and commonly used to imaging the fetus in pregnant women as this is free of adverse effects of x-rays. Sonography is also useful in imaging the abdominal organs, heart, breast, muscles, tendons, arteries and veins. However, ultrasonography provides less anatomical detail than sophisticated techniques such as CT or MRI. Advantages of sonography are safe, Compact, relatively low-cost and quick to do. A portable ultrasound scanner used to examine critically ill patients in intensive care units. The real time moving image in sonography used to guide drainage and biopsy procedures. Doppler allows the blood flow in arteries and veins assessments. 2D- **Echocardiography** can provide images of the heart and the large vessels. In a 2D-echo, sound waves are directed to the heart from a transducer, heart walls and valves reflect part of the sound waves back to the transducer to produce pictures of the heart. The size of each part of the heart is measured, motion and appearance of the valves and the function of the heart muscle is studied. 2D-Echo is an important test for diagnosis and prognosis of cardiac illness. A Doppler echo at the same time depicts the blood flows in the heart.

Computed Tomography (CT) or Computed Axial Tomography (CAT Scan) produces a 2D image of the structures in a thin section of the body. It uses X-rays and has a greater radiation dose than X-rays and repeated CT scan must be avoided due to adverse health effects. In CT, image of the soft tissues is poor. A magnetic resonance imaging instrument (MRI scanner) uses powerful magnets to produce images of the body. MRI conventionally creates a two-dimensional image of a thin section of the
body and is considered as tomography imaging technique. MRI as does not involve the use of ionizing radiation not associated with the same health hazards. Modern MRI instruments are capable of producing images in the form of 3D blocks, which may be considered a generalization of the single-slice, tomographic, concept. For example, because MRI has only been in use since the early 1980s, there are no known long-term effects of exposure to strong static fields and therefore there is no limit to the number of scans to which an individual can be subjected, in contrast with X-ray and CT-Scan. However, there are well-identified health risks associated with tissue heating from exposure to the Radio frequency field and the presence of implanted devices in the body, such as pace makers. These risks are strictly controlled as part of the design of the instrument and the scanning protocols used. In MRI ,the proton of the hydrogen atom is most widely used, especially in the clinical setting, because it is so ubiquitous and returns a large signal allows the excellent soft-tissue contrast achievable with MRI. The amount of data obtained in a single MR or CT scan is very extensive. Some of the data that radiologists discard could save patients time and money, while reducing their exposure to radiation and risk of complications from invasive procedures.

Positron emission tomography (PET) is a test that uses a special type of camera and a tracer (radioactive chemical) to look at organs in the body. The tracer usually is a special form of a substance such as glucose that collects in cells that are using a lot of energy, ex. cancer cells. During the test, the tracer liquid is injected into a vein. The tracer moves through the body and collects in the specific organ or tissue. The tracer gives off tiny positively charged particles (positrons). The camera records the positrons and sends the recording into pictures on a computer. PET scan pictures do not show details as CT or MRI scans but show only the location of the tracer. The PET picture is matched with CT scan to get detailed information about the tracer is location. A PET scan is used to evaluate cancer, check blood flow or see organs functions ex. study the brain's blood flow and metabolic activity. A PET scan aids a doctor find nervous system diseases.

Nuclear medicine encompasses both diagnostic imaging, treatment of disease. Nuclear medicine uses properties of isotopes, and the energetic particles emitted from radioactive material to diagnose or treat various pathology. Radiotherapy is main
stream of treatment has many adverse effects also. Cancer treatment is complex and has multiple modalities of treatment such as surgery, radiotherapy and chemotherapy depending on type and stage of cancer.

Laboratory Services their and automation has made diagnosis, prognosis and monitoring patient easier than earlier. High workload can be managed easily with automation of laboratory equipments. Laboratory results have become accurate and precise. However, few disadvantages are present in automation. Blood transfusion with blood components separation and plasma fractionation made changes to patient treatment throughout world. Every year more than 81 million units of blood collected worldwide and used for treatment of patients. Safety of blood is important and controlled by law and regulations.

Change in OT technology and high technology surgeries are revolutionized in the 21st century. Cardiac surgery, neurosurgery, laparoscopic surgeries, oncosurgery, orthopedics, transplantation, ophthalmic surgeries, minimally invasive and robotic surgery techniques all have opened new horizon in patient care. Surgeons at the Cleveland Clinic removed kidneys through a single incision in the patient's navel and removed a diseased kidney using a technique called natural orifice translumenal endoscopic surgery (NOTES) through patients’ vagina. Robotic surgery is occurring daily in centers across the developed nations with minute metal hands carefully manipulating sutures deep inside the heart seems. The benefit of minute openings into the body rather than large incisions is shorter stay in hospital and reduction of pain. Robotic surgery also used to improve the accuracy of procedures, especially in cancer cases.

Critical Care also revolutionized because of monitoring and patient support equipments such as ventilators, pulse oxy meters, central monitors, automation of lab results etc.

Organ transplantation is the moving of an organ from one body to another or from a donor. Organs that can be transplanted are the kidneys, liver, heart, lungs, pancreas, intestine and thymus. Tissues include bones, tendons, cornea, skin, heart valves, and veins. Worldwide, the kidneys are the most commonly transplanted organs, followed by the liver and then the heart. The cornea and musculoskeletal grafts are commonly
transplanted tissues; these outnumber organ transplants by more than tenfold. Organ donors may be living, or brain dead. Some organs need to be retrieved from brain dead and still on mechanical support. Tissues on the other hand harvested from donors 24 hours past the stop of heartbeat. Unlike organs, most tissues (except of cornea) can be preserved and stored for up to five years. Transplantation raises a number of several issues such as definition of death and clinical expertise. Law has to be framed for when and how consent ought to be given for an organ transplantation. Transplantation medicine is one of the challenging and complex areas in modern medicine of 21-st century. A problem of transplantation rejection during which the body has an immune response to the transplanted organ may necessitate immediate removal the organ from the recipient is a complex procedure. Transplant rejections are reduced with HLA typing and immune suppression. The emerging field in medical sciences is regenerative medicine. Scientists create organs to be re-grown from the patient's own cells using stem cells or cells from the diseased organs and transplanted within the same individual called as auto graft. Transplantation performed between two individuals of the same species is an allograft. Research in stem cell lead to numerous public controversies and generated many political actions. However, the clinical advances of embryonic and adult stem cells from pilot studies are appealing. Bone marrow cells transplanted into the boys stopped the progress of a fatal brain disease adrenoleukodystrophy. Stem cell seems likely to be the future of regenerative medicine.

Pharmacological drugs developments revolutionised patient treatment. Newer drugs are available in cardiac, renal, liver and oncology care. Patients chronically on medicines is increasing. Increase in geriatric population also lead to increased spending on medicines. Safety of newer drugs is a emerging concept.

Human beings in 21-st century are facing many viral diseases as a challenge in health care industry. They are HIV, HBV, HCV mainly produce chronic illness. Dengue, H1N1, and bird flu viral disease became a pandemic and acute presentation. Lot of work force and financial resources are involved in the patient care. HBV has a vaccine available. Populations are poorly immunized in developing countries. Introduction of highly active antiretroviral therapy made patient survival stretched into decades. In 1996, a 20-year-old person in the U.S. with AIDS expected to live about three to five
years and now with antiretroviral drugs can to live up to 69 years. Next challenge to viral diseases is the cure.

Since the early 1990’s, medicine and health care have taken up the challenge of evidence-based practice and becoming routine in 21st century. “Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” —David. L. Sackett, MD.

Evidence-based medicine defined as the integration of research evidence, clinical expertise, and patient preferences and values in clinical decision-making (Sackett et al., 1996). Evidence-based medical practice submit use of science of evidence with clinical expertise as the basis to make clinical decisions. The practice of evidence-based medicine consist clinical question related to the patient’s problem, evidence for its validity and usefulness and the implementation of the evidence in clinical practice.

The practice of evidence-based medicine necessitates integrating clinical experience with the best available external clinical evidence. The rationale for evidence-based medical practice developed from the need of health care providers accountable for patient care and there is an increase in the availability of information about health and illness to patients through media and Internet. Public awareness support Evidence-based medical practice in order to substantiate and justify clinicians decisions and actions. However, evidence-based medical practice perception faced mixed reviews from those in the academic and research field. Excellent doctors rely on both their clinical expertise and the evidences from diagnostic tests. An ever-expanding medical literature, the complexity of modern medicine, a limited amount of time and clinical uncertainty are encouraging evidence-based medicine and also incorporated in medical education.
The general practitioner/family physician cares for primary and basic health care of the individual in the context of the family and community. He/she is clinically competent doctor to provide the greater part of individual health care in consideration with the cultural, socioeconomic and psychological background of the population. They also arrange for other health personnel to provide services when necessary. In addition, also manages comprehensive and continuing care for patients. They exercise professional role by providing care either directly to patients or through the services of nursing and paramedical staff according to the health needs and resources available within the community. Primary health care quality is dependent upon the well-trained family physicians. The general practitioner / family physician functions as a generalist accepts everyone seeking care, have knowledge of the epidemiology of the community being served , have maximum influence on any health problem in the community. Comprehensive care to the individual is important along with patient orientation and family focus in primary health care. The general practitioner/family physician should know personal as well as clinical details about the patient.

Secondary care is the health care services provided by medical specialist and other health professionals who generally do not have first contact with patients. It includes necessary treatment for a short period for a brief but serious illness, injury or other health condition, such as in a hospital emergency medicine. It also includes skilled attendance during medical services. The "secondary care" used synonymously with "Hospital Care". However many secondary care providers do not necessarily work in hospitals and some primary care services are delivered within hospitals. Depending on
the organization and policies of the national health system, patients may be required to see a primary care provider for a referral before they can access secondary care. For example in the United States, which operates under a mixed health care system, some medical professionals might voluntarily limit their practice to secondary care by requiring patients to see a primary care provider first, or this restriction may be imposed under the terms of the payment agreements in private/group insurance plans. In other cases medical specialists may see patients without a referral, and patients may decide whether self-referral is preferred. In the United Kingdom patient self-referral to a medical specialist for secondary care is rare as prior referral from another physician (either a primary care physician or another specialist) is considered necessary, regardless of the funding and Specialist doctors provide secondary care.

Tertiary care is specialized consultative health care, usually for inpatients and for referrals from a primary or secondary health professional and in a facility that has personnel, advanced medical investigation and treatment in a Tertiary care hospital. Tertiary care services are poly trauma, cancer management, neurosurgery, cardiac surgery, plastic surgery, severe burns care, neonatal special care, organ transplantations and complex medical and surgical interventions. Supra-specialist doctors trained in complex treatment modalities are required in tertiary care hospitals. The term quaternary care is also used sometimes as an extension of tertiary care in reference to medicine of advanced levels which are highly specialized and not widely accessed Ex- Stem cell, genetic therapy. Clinical Research and uncommon procedures and medical services are carried in quaternary care. These services are usually only offered in a limited number of regional or national health care centers.

Many types of health care interventions delivered outside of health facilities. They include many interventions of public health interest, such as food safety, surveillance, distribution of condoms and needle exchange programme for the prevention of transmissible diseases. They also include the services of professionals in residential and community settings in support of self care and home care, long-term care, assisted living, treatment for substance use disorders, other types of health and social care services.

**Team work in hospitals** - One in ten patients admitted to hospitals in developed countries go through injury as a result of medical errors. However, research evidence
Medical Negligence: an Analytical Study Focussing on Legal, Ethical and Clinical Perspectives

indicates that improved team working can decrease medical errors and save lives. Teamwork is all the time more important in 21st century as patient care is becoming increasingly complex, requiring interactions among staff, higher monitoring of patient, modern technology and intricate medication. The chances for error to happen into in the medical system are high and results can be disastrous. Most pressing challenges facing secondary and tertiary care hospitals is to prevent or lessen such hazards. To make progress in medical practices initiatives is needed to engage and support clinical teams and a leadership that can guide and develop teams of clinicians to work together in the effective ways with everyone in team is responsible. Hospitals are traditionally has medical professionals have their own ways of functioning in isolation and without the understanding other departments with delivery of fragmented, inefficient, costly and harmful patient care. With new technologies, new skills and new developments primary focus is the care of hospitalized patients. The clinical success will depend on the capacity to effectively cultivate and coordinate a spirit of teamwork and coordination between nursing, pharmacy, operation theatre, rehabilitation services, case management, social service, laboratory services, blood bank, physiotherapy and many other disciplines. Nursing leadership rests on the principles of the shared control model. This model incorporates unit-based committees whereby nurses have the right to participate in decision-making affecting the clinical care and practice. Shared responsibility committees include, the “Falls Committee,” the “Patient Satisfaction Committee,” and the “Wound Care Committee". These committees are decision-making bodies in which nurses participate in setting goals and priorities and members make decisions touching nursing practice, patient care or other aspects of professional practice.

Developing effective teamwork systems and patterns of care is among the intricate challenges. There are studies of how teamwork in health care improves the complex care of hospitalized patients. In critical care patients are managed by a multidisciplinary team strengthens hospital ability to provide higher quality and efficient care. The care of geriatric patients markedly improved through the implementation of teams of professionals focused on the care of elderly patients. Teamwork is of major importance to hospital management because of the value sited on teamwork by key healthcare stakeholders. Accreditation agencies of Healthcare are strong proponent of teamwork and focus on coordination in health care and the
support of healthcare professionals for each other as members have experience of working together, knowing each other’s strengths and weaknesses, support each other and respond for each other under stress and fatigue situation. Thus teamwork is critical for optimizing quality and safety in the management of hospitalized patients.

Internet and information technology has in reality changed the way medical professionals practice medicine for the better. The computer systems are improving hospital care.

6.3 Legal perspective in Medical Practice and Indian Judiciary System

The Judiciary of India is an independent body & is separate entity from the Executive and Legislative bodies of the Indian Government. The judicial system of India is stratified into various levels. At the apex is the Supreme Court, High Courts at the state level, District Courts at the district level and Lok Adalats at the Village Level. The judiciary of India takes care of maintenance of law and order in the country along with solving problems related to civil and criminal offences. The Indian Judicial System has the Supreme Court of India at its helm, which at present is located only in the capital city of Delhi, without any benches in any part of the nation, and is presided by the Chief Justice of India. The Supreme Court of India has many Benches for the litigation, and this apex court is not only the final court of permissible Appeal, but also deals with interstate matters, and matters comprising of more than one state, and the matters between the Union Government and any one or more states, as the matters on its original side. The President of India can always seek consultation and guidance including the opinion of the apex court and its judges. This court also has powers to punish anybody for its own contempt. The largest bench of the Supreme Court of India is called the Constitution Bench and comprises of 5 or 7 judges, depending on the importance attached of the matters before it, as well as the work load of the court. The apex court comprises only of various benches comprising of the Divisional benches of 2 and 3 judges, and the Full benches of 3 or 5 judges. The Appeals to this court are allowed from the High Court, only after the matter is deemed to be important enough on the point of law or on the subject of the constitution of the nation, and is certified as such by the relevant High Court. In the absence of any
certificate from the High Court: a person may with the leave of the apex court appeal to this court. A person or body may also file a Writ against the violation of Fundamental Rights granted under the Constitution of India, with the permission of the apex court. Certain writs allowed to institute in the apex court directly, against the orders of the Courts of the Court Martial, and the Central Administrative Tribunals.

Justice provided to citizens of India by-
- Civil Law - Law of tort
- Criminal Law –Indian Penal Code
- Consumer Law- Consumer Act and system

Indian Penal Code is the core criminal code of India. It is intended to cover all possible aspects and completeness of criminal Law. It was drafted way back in 1860 and came into force during the British colonial rule of India in 1862 and since been amended several times and is now supplemented by other criminal provisions. The objective of this Act is to provide a general penal code for India. However, not an initial objective, the Act does not repeal the penal laws, which were in force at the time of coming into force in India. This was so because the Code does not contain all the offences and it was possible that same offences might have still been left out of the Code, which were not intended to be exempted from penal consequences. Though this Code consolidates the whole of the law on the subject and is exhaustive on the matters in respect of which it declares the law, many more penal statutes governing various offences have been created in addition to the code. Indian Penal Code, 1860, sub-divided into twenty-three chapters, comprises five hundred and eleven sections. The code starts with an introduction, provides explanations and exceptions used in the code, and covers a wide range of offences. The Code is universally acknowledged as a cogently drafted code, ahead of its time. It has substantially survived for over 150 years in several jurisdictions without major amendments. The efficacy and relevance of Indian Penal Code on completion of 150 years was praised by Nicholas Philips, Justice of Supreme court of United Kingdom. Modern crimes involving technology unheard of during Macaulay's time fit within the Code mainly because of the broadness of the Code's drafting.
Statutory Law Indian Laws and Regulations Related to Health

- Drugs and Cosmetics Act, 1940
- The Pharmacy Act, 1948
- Act & Rules The Prevention of Food Adulteration Act, 1954
- Medical Council of India Act, 1956 & Indian Medical Council Rules, 1957
- Act & Rules Maternity Benefit, 1961
- Insecticides Act & Rules, 1968
- Medical Termination of Pregnancy Act, 1971
- Act & Rules Narcotic Drugs & Psychotropic Substances, 1985
- Rules Environmental Act, 1986
- Rules of Consumer Protection Act and Medical Profession, 1986
- The Pre-Natal Diagnostic (PNDT) Act & Rules, 1994
- The Transplantation of Human Organ Act, 1994
- Acts in Disability, 1995
- Indian Medical Council (Professional Conduct, Etiquette & Ethics) Regulations, 2002
- Karnataka private nursing homes regulation act 2009

Medical professionals have to practice in the ambit of many law and regulations. They have to be aware of the legal system of the nation and Statutory Law Indian Laws and Regulations Related to Health.
REFERENCES:

BOOKS:


3. Dr. Kundu 2006 (Arup Kumar). Bedside Clinics In Medicine, 5/ED. p-48


5. Fauci And Others, 2008 Edi. Harrison's Principles of internal medicine, 17/ED, Set Of 2 VOLS. p-167

6. Fauci And Others. 2010 Edi.Harrison's Principles Of Internal Medicine, 14/ED, VOL.2. p-198


8. FLETCHER (Christopher D.M), 2007. Edi.Diagnostic Histopathology Of Tumors, 3/ED. p- 44


JOURNALS:


35. Legal Correspondent, (1985) "Doctors and Defamation", 290 British Medical Journal 1342. p- 201


WEBSITE-


3. http://The Hindu Karnataka - Bangalore News Probe into death of pregnant woman in final stages.html downloaded on 05.03.2011
