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Journal of Indian Medico Legal And Ethics Association

Vol.09 I Issue : 01 I Jan.-Mar. 2021

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JIMLEA is now Indexed with IP Indexing

Dear Members, Warm regards

We are pleased to inform you that the Journal of Indian Medico- Legal & Ethics Association (JIMLEA) is now indexed with IP Indexing. The highlights of the journal include:

i) Open Access, Peer- reviewed quarterly journal in print form.

ii) The journal is available on the website **(www.imlea-india.org)** of the association.

iii) Topics related to medico-legal and ethical issues can be submitted for publications. This is one of the few journals which publish topics on ethical issues in medical practice.

iv) The ISSN registration number is: 2347- 7458 Print version.

v) This is official publication of Indian Medico- Legal & Ethics Association; a national academic organization working for issues related to Doctor- Patient Relationship, Communication skills, Professionalism, medical negligence, Consumer Protection Act, ethical issues in practice of medicine, quality care and other related issues.

vi) The journal editorial board or the association doesn't charge any money for peer review or publication.

vii) The journal committee doesn't accept advertisement from any companies which manufacture or promote infant milk substitutes and are banned under IMS Act of India.

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Thanks for your contribution, support & cooperation.

Editoral Board, JIMLEA

Editorial :

Controversies, Confusions, Paradoxes and Conflicts of Interests

*** Dr C M Chhajer, **Dr Satish Tiwari**

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Keywords :

Immunization, Junk food, Child Nutrition, Media hype, Cleavage of opinion

Introduction:

The third millennium is known for scientific and technical advances. But, unfortunately the globalization and modernization has badly failed as far as the myths and misconceptions in human mind are concerned. Paradoxically, the confusions, controversies and conflicts have increased with the development of the human race[1]. We are living in an era where most of us believe in ***"you scratch my back and I will scratch yours"***. The evidence based scientific facts have failed in clearing the age-old customs, myths and misconceptions. The unscientific, biased, misguiding rumors or information on various social media are widely circulated, forwarded and easily accepted as true and genuine.

Controversies in Immunizations:

There are lots of controversies regarding immunization practices. The confusions are not only about which vaccines to be given but also about number of doses and duration between the doses. The recommendations are changed every year or alternate year. There are major differences amongst the recommendations by government and academician's schedule. An average physician or pediatrician is confused about following various schedules. It is not clear why the academicians and other stake-holders don't sit on a common platform and decide a single national schedule which can be recommended to all the children irrespective of their financial or economic status, color, caste, creed, religion and geographical location etc[2].

The vaccines available against the major life threatening infection of 2020-21 i.e. Covid -19 has created more controversies rather than their usefulness against the Corona infection. There are lots of discussions and confusions about their availability in open market, efficacy, superiority (of various available brands), interval between two doses, duration of protection, contraindications etc.

Confusions about Nutrition:

Nutrition is one of the essential and basic requirements of each and every individual on this planet. But, the human mind is full of nutrition related myths and misconceptions since the ancient age[3]. Unfortunately not only the relatives but also the health care workers are confused about scientific recommendation and evidence based nutrition education. There are many misconceptions about breastfeeding/ formula milk, "hot and cold foods", home-made and commercially available packaged food, foods with exaggerated health claims, health drinks, junk foods and food supplements etc. Paradoxically, the techno-savvy present generation is no exception to these age-old customs, myths and misconceptions.

Paradoxes in Laws:

The human beings are social animals living in a community / society. It is presumed that in the beginning of societal pattern of living; there was a concept of "might is right". Those in power used to influence the decisions or punishments as per their might. There were no defined or codified laws. The development and education of human race resulted in discussions regarding this situation in the society and gradually guidelines, recommendations, rules, and finally various laws or Acts were framed. But

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unfortunately here also there are lots of confusions, paradoxes and controversies. The laws are there but the implementation is far from satisfactory. There are many loop-holes which are exploited by the violators. Most of the laws are followed or implemented in words forgetting the basic spirit for which the Acts were framed. The interpretation of statute/ laws varies from lower to higher courts and vice-versa in the hierarchy. In many cases the plaintiffs get ***judgments*** and not the ***justice***. These judgments are marred and associated with lots of confusions and controversies amongst the judiciary itself. It is a well-accepted fact that the justice delayed is justice denied; but there are many cases pending in various courts for the decades for minor reasons. The maxim- ***"Ignorantia juris non excusat"*** i.e. ignorance of law is not an excuse; in-spite of all these many of us including those in judiciary are unaware of various laws and the amendments. Most of the law-makers are trying to amend the existing laws as per their own whims and beliefs. The question that everyone is interested– Is law the answer? Overall, it is said that the laws are most multiplied when the state is corrupt.

Conflict of Interests:

In the present scenario the conflicts of interest (CoI) has resulted in lots of flutters and fibrillations amongst the various stake holders. There are debates and discussions going regarding the extent of individual and collective conflicts of interests. There are allegations that everyone is looking at the personal benefits rather than the needs of the society. Many individuals, organizations, multinationals are busy in filling up their **"ever empty wallet"** without considering the requirements and the affordability of the society. In the beginning of Corona pandemic it was thought that the people will now understand that only money is not the ultimate requirement of the human beings, but after about a year there are no major changes in human behaviors or relationships. In fact the commercialization, hoarding, black marketing and exploitation seem to be rampant and continuously increasing.

Role of Media:

Media is supposed to be fourth pillar of democracy but in the last few decades their role seems to be controversial and debatable. It is thought that they are more interested in creating ***"media hype"*** and increasing their TRP (Television rating point) and viewership. It is expected that they should give the scientific, evidence based, unbiased information regarding various issues but, from media reports it seems that they are not trying to verify the authenticity of the information. Many news are circulated or published just to sensationalize the happenings in the society. The endorsements of various nutritional products, junk foods, health drinks, fairness creams, products for alopecia and so called ***"magic foods"*** add fuel to the fire. Paradoxically, if one model/ actor/ actress regrets such advertisements as biggest mistake in his/her life after few months another personality is involved in the same advertisement. It is suggested that media should be more responsible in broadcasting the genuine, reliable, and truthful information in the long-term interest of the community.

Role of Policy makers:

As discussed above, in the present scenario of confusions, controversies, mis-trust and conflicts of interest the role of authorities has tremendously increased. The authorities have many powers to implement the guidelines or recommendations which they should use judiciously. Their action should be in the best interest of the society and not target based. If there are any needs for amendments same shall be done and implemented at proper time.

Role of Academic Organizations:

Academic organizations have the most important role to play in such situations. The recommendations of the associations will be unbiased, scientific and evidence based and acceptable even to the judiciary. The law accepts the "Bolam Principle/ Test" even if there are

differences of opinion amongst of standard practices accepted by the group of experts or their associations. We all agree that there can be ***"cleavage of opinions"*** amongst the consultants or experts. But, this should not add to confusions, controversies and paradoxes. So, the need of the hour is that anyone should not put forward their own theories, protocols in the hours of crisis. There should be a team of experts from various organizations who should collect the information available from various sources, analyze it, make the protocols/ recommendations and finally the president / secretary or the representative of the concerned body shall disseminate the final guidelines. If every consultant starts circulating his own recommendations it results in more confusions and controversies.

Conclusions:

There are many confusions, controversies and conflicts of interest in each and every field of day to day life. The forwarding and dissemination of biased, unscientific information on various digital media platform increases the dilemmas of even educated and qualified people. Wrong messages and information may further worsen the situation and create the unwanted panic. All of us have the moral, ethical and legal liability to verify and authenticate any information before forwarding it in a casual manner. Let us all work for the betterment of future of human race….

Conflicts of Interest: None

Disclaimer:

The views expressed in this article are the personal views of the authors.

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Contribution in JIMLEA

All the readers of this issue and the members of IMLEA are invited for contributing articles, original research work / paper, recent court judgements or case laws in the forth coming issues of JIMLEA. This is a peer-reviewed journal with ISSN registration. Please send your articles to Dr. V. P. Singh,

email : singhvp@gmail.com

New Amendments:
The MTP amendment act 2021

*** Mahesh Baldwa **Sushila Baldwa ***Varsha Baldwa **** Namita Baldwa**

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Keywords :

MTP Act, Women Right, Unsafe abortions, fetal abnormalities

The act is neither progressive nor women centric? Be it the liberalization of abortions through the MTP Act or the penalization of sex-selective abortions through the PCPNDT Act, a woman's bodily autonomy still primarily lays with the state rather than with her[1]. Actually 156 lakh abortions occurred in India in 2015, says Lancet Global Health study. Out of which 78% were outside health facilities [2].

MTP act 1971: long way – yet short sighted

Abortion was legalized 50 years ago, yet 10 women die every year as a result of unsafe abortions; making unsafe abortions the third-leading cause of maternal deaths in the country.

Why do women have unsafe abortions?

Millennial females can't afford another child or because they are at a stage in their careers or lives when they can't assume responsibility for another human life.

Unsafe abortions, is a common recourse for most women in the country, including in the rural pockets, due to various social, economic and logistical barriers. Stigma is another dimension that prevents women from seeking abortion care from approved facilities. Also, when a woman is legally not allowed to abort, or lacks access to trained providers, she is forced to go to illegal providers, who may be untrained, or may perform the procedure under unhygienic conditions and its obvious consequences [3].

The 2018 All India Rural Health Statistics show that there are only 1,351 gynecologists and obstetricians at community health clinics in rural areas. This shortage of qualified medical professionals will limit women's access to safe abortion services. The National Health and Family Survey 4 (2015-2016) data also showed that 47% of abortions in India are carried out by nurses, auxiliary nurse midwives, lady health visitors or family members[1].

Shantilal Shah Committee

The Government of India instituted a Committee in 1964 led by Shantilal Shah to come up with suggestions to draft the abortion law for India. Themes like liberalization vis-à-vis its birth control potential and the possible implications for the country's social and cultural fabric began to appear. As a result, the government appointed the Dr Shantilal Shah committee, and which submitted its report on the legalizing abortion. After this, Parliament passed the MTP Act 1971. The recommendations of this Committee were accepted in 1970 and introduced in the Parliament as the Medical Termination of Pregnancy Bill. This bill was passed in August 1971 as the Medical Termination of Pregnancy Act [4].

The Medical Termination of Pregnancy Act, 1971- salient features

The Medical Termination of Pregnancy (MTP) Act, 1971 provides the legal framework for Termination of pregnancy is permitted up to 20 weeks of gestation as detailed below:

1. When continuation of pregnancy is a risk to the life of a pregnant woman.
2. When there is substantial risk that the child, if born.

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3. When pregnancy is caused due to rape.
4. When pregnancy is caused due to failure of contraceptives.

Where pregnancies can be legally terminated?

1. Form A [Sub-Rule (2) of Rule 5]: Application Form for Approval of a Private Place: This form is used by the owner of a private place to apply for approval for provision of MTP services. Form A has to be submitted to the Chief Medical Officer of the district.
2. Form B [Sub-Rule (6) of Rule 5]: Certificate of Approval: The certificate of approval for private place deemed fit to provide MTP services.

Whose consent is required for termination of pregnancy?

Form C [Rule 9] Consent Form: This form is used to document consent of the woman seeking termination. Pregnancy of a woman who is above 18 years of age can be terminated with only her consent. If she is below 18 years of age or mentally ill, written consent of the guardian is required.

Whose opinion is required for termination of pregnancy under old law?

Form I [Regulation 3] Opinion Form: This form is used to record opinion of the RMPs' for termination of pregnancy. For termination up to 12 weeks of gestation, opinion of one RMP is required whereas for the length of pregnancy between 12 and 20 weeks, opinion of two RMPs is required.

The MTP Regulations, 2003

1. Form III [Regulation 5] Admission Register: This template is used to document details of women whose pregnancies have been terminated at the facility. The register needs to be retained for a period of five years till the end of the calendar year it relates to.
2. Form II [(Regulation 4(5)] Monthly Statement: This form is used to report MTP performed at a hospital or approved place during the month. The head of the hospital or owner of the approved place should send the monthly report of MTP cases to the Chief Medical Officer of the district.

Sex-selective abortions:

The complicated relationship between abortion and sex selective against female fetuses has been a dilemma that the women's movement has been grappling with since the late 1980s. It arises from situations in which women themselves decide to have sex-selective abortions, and which then intersects with the complex understanding of ethics and agency in the context of women's control over their bodies. Many women in India also undergo sex-selective abortions under pressure from their husbands' families, and this is usually not an informed choice. Other reasons to abort are almost always shaped by factors like illegitimacy, lack of social facilities for childcare (placing a disproportionate burden on women), economic constraints, etc[5].

Overlap with POCSO, child marriage restraint (CMR) Act:

In case of a pregnancy of a minor, doctors are often caught between the overlapping portions of the MTP and the POCSO and CMR Acts. On the one hand, the MTP Act's confidentiality clause requires medical practitioners to protect the person's identity, but the POCSO and CMR Act and the Code of Criminal Procedure mandate practitioners to report sexual offences against children.

How far criminalization of abortions for minor shall make abortions "secret":

Some doctors said that mature adolescents who mutually choose to have sex must not be criminalized for a natural desire. The state must protect the right to safe and legal abortions for girls between the ages of 16 and 18 who visit practitioners with accidental pregnancies and infections. While the MTP and the POSCO Acts' aims are diametrically opposite, their contradicting overlap

means consensual sex between matured adolescents must indeed be kept out of criminal purview[1].

Supreme Court recently observed that a more liberal provision could be introduced in POCSO and CRM act so as to distinguish offences in cases of teenage relationships after 16 years from the cases of sexual assault vis-à-vis children.

Ambiguity around the provisions in the MTP Act 1971:

There is ambiguity around the provisions in the MTP Act for unmarried women to terminate pregnancy due to contraceptive failure since considerable stigma is attached to having a non-marital pregnancy or birth. For second trimester abortions, the consent of two medical practitioners is required. This is particularly challenging in rural areas where many a times a second practitioner is not available. If a woman doesn't want a child, according to her will, she should have the sole right over the decision to terminate the pregnancy [6].

The MTP Act 2021: Progressive or women centric?

The Medical Termination of Pregnancy, or MTP, (Amendment) Bill received the President's assent and was notified by the Centre on March 25, 2021[1]. The amendments in the new act increase the time period within which an abortion can be legally conducted. Before the amendment, the Act required one doctor's opinion if the abortion was within 12 weeks of conception and two doctors' opinions if it was between 12 and 20 weeks. The amendment now allows abortions to be conducted within 20 weeks on one doctor's advice and between 20 and 24 weeks on two doctors' advice for specific categories of women, including victims of rape (although excluding marital rape).

The act has also directed states and union territories to set up 'medical boards' to decide if pregnancy may be terminated after 24 weeks in cases of substantial fetal abnormalities.

The amendment has introduced a change in Section 3 of the Act to cover unmarried women. As opposed to using the term "married woman and her husband", the amendment uses the term "woman and her partner". So an unmarried woman can also terminate pregnancies within the gestational limits under the Act. Another addition to the Act is the introduction of Section 5A, which penalizes medical practitioners who fail to protect the privacy and confidentiality of women who wish to terminate their pregnancies.

Abortion has always generated intense moral, ethical, political and legal debates. This is because abortion is not merely a medico-technical issue but lies at the fulcrum of a broader ideological struggle contesting the meanings of the family, the state, motherhood and women's sexuality. The new MTP (Amendment) Bill, 2021, is a milestone which will further empower women, especially those who are vulnerable and victims of rape[1].

Women want a personal liberty guaranteed under Article 21 of the Constitution:

While specific changes like extending gestational limits and including unmarried women are laudable, the amendment still leaves women with various conditionality that in many cases impede access to safe abortion. With the overarching qualifier of "grave injury to her physical or mental health or severe physical or mental abnormality of the fetus", the woman's agency ends up taking a backseat, requiring validation from the law at every step. In Justice K.S. Puttaswamy v. Union of India and Others (2018), Justice Chandrachud stated that reproductive choice is a personal liberty guaranteed under Article 21 of the Indian Constitution. But the verdict, while laying a robust jurisprudence on reproductive rights and the privacy of a woman, didn't fundamentally shift power from the doctor to a woman seeking abortion. Abortion thus remains tied to state-sanctioned conditions and not a woman's rights [7].

Where we were and where we are going?

The 2003 Rules to the MTP Act were amended to allow certified providers outside registered facilities to provide medical abortion services up to seven weeks (with some conditions), given that 81% of abortions in India take this particular route of abortions. As such world over Medical abortion is a safe and non-invasive method in which prescribed drugs are used to terminate a pregnancy.

The new Rules to be framed for the amendment act 2021 may address narrowing down gap by allowing AYUSH practitioners, nurses, medical officers and auxiliary nurse and midwives to provide for medical abortions up to 12 weeks. As such insufficient public healthcare facilities, most abortions are sought at private facilities, resulting in higher costs for poor, uninformed and socioeconomically marginalized groups[1].

Conclusion:

India has legalized abortions in the last four decades. But despite these efforts, abortion has often been critiqued – for lack of access to safe abortions because of complicated implementation process.

Actually in modern era of safe abortions where 'if a woman who actually bears the child in womb, doesn't want a child, according to her will, she should have the sole right over the decision to terminate the pregnancy'- should be essence of MTP act and rules, if India wants to really join women's global emancipation movement related to reproductive health. Abortion morality has put too many women's life in danger. Laws should reflect societal realities. Is it not?

As for terminations after 24 weeks – the Act doesn't reflect the urgency of the woman because it doesn't mention a time frame within which the medical boards will have to examine the pregnancy and share their opinions. The other issue with terminating pregnancy after 24 weeks has to do with medico-legal issues. That is, women who wish to terminate a pregnancy after 24 weeks but don't fall under the purview of "fetal abnormality" may have to knock on the doors of the courts.

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Perspective:

Compensation for Paralytic Poliomyelitis during Polio Eradication Program

*** Dr Yash Paul, **Dr Satish Tiwari**

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Key words :

VAPP, OPV, Physical disability, Compensation

Polio Eradication Program was launched in India on 2nd October 1995. In 1988 the World Health Assembly (WHA) passed resolution WHA-41-28, declaring that "World Health Organization (WHO) takes initiative for global eradication of polio exclusively by OPV." The scientific information available at that point of time, i.e. 1988 regarding OPV was as following:

1) It can cause paralysis in vaccine recipients. It is called vaccine associated paralytic poliomyelitis (VAPP), which in fact is polio disease caused by OPV.
2) Secondary spread of mutant neuro-virulent vaccine polio viruses can cause VAPP in close contact called c VAPP.
3) Some children, especially from Tropical and developing countries show poor response to OPV. India qualifies on both counts.

Neither WHA nor WHO deemed the need to provide any compensation to those children who may develop polio disease because of vaccine failure or because of OPV (VAPP), during this program.

Informed Consent:

Informed consent of the participants in any public health program is held by many to be a necessary requirement for ethical medicine [1]. As the participants in the polio eradication program were children upto the age of five years so the consent should have been obtained from a parent or care taker.

Suppression of Facts:

All national health programs should be implemented by persuasion and not by coercion. During the program the likely adverse effects were not disclosed to the people. Even doctors were instructed not to discuss these issues with people. In fact, through print and audio-visual media the government gave misleading messages to the people that OPV is absolutely safe and very effective vaccine. On the other hand many families were punished for refusing administration of OPV to their children. Hindustan Times dated August 14, 2007, under caption 'Refuse polio drops, lose power and ration cards' reports from Jaunpur, Uttar Pradesh "At least two people in the district have had their ration cards cancelled and power supply to their homes cut for saying no to the immunization of their children."

In any mass public health program some participants may not derive benefits due to some reasons, but harm should not occur to anyone. The facts regarding likely harm which may occur to some children were not disclosed to the people so that some parents may not refuse to administer OPV to their children. However, if it is indeed to be accepted that the benefits of polio eradication outweigh the withholding of information about the risks of harm, then at the very least, an adequate compensation scheme should have been formulated [2]. Natural

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justice demands this.

Given the benefits of OPV, polio cases because of OPV (VAPP) or because of vaccine failure when children developed paralytic polio despite taking adequate number of OPV doses may be viewed as an acceptable 'cost' of the program [3]. Question may be asked: should the cases of those children who developed paralytic polio during the campaign be considered as 'acceptable cost'? If yes, next question would be: who agreed to pay this price? Were it the children and their parents or the policy makers and organizations carrying out the program? It is pertinent to state that not many people born before polio vaccines became available had developed paralytic poliomyelitis.

Dr. Yash Paul had submitted a petition to the National Human Rights Commission on 30th August 2013 to consider compensation to those children who had developed polio disease by participating in the polio eradication program. The petition was forwarded to the Ministry of Health and Family Welfare. The author received a communication from the Ministry of Health and Family Welfare, Ref. No. Z-33011/03/2014-LLSV dated 13th February 2015, which stated: "Under the Public Health System established in India, all types of Acute Flaccid Paralysis cases, whether polio or non-polio, are provided free medical care at all health facilities including corrective surgery, regular physiotherapy and rehabilitation."

It is a right idea to provide above mentioned facilities to all people with disability because of polio disease or other reasons. Disability in persons due to non-polio conditions include congenital anomalies (birth defects), birth injury, neonatal asphyxia, neonatal infections, Kernicterus and many more reasons in a newborn baby which may result in permanent disability. Such disabilities can occur later also because of brain infection, brain injury etc. So those children who had developed disability during this program should not be equated with those who had developed disability due to other causes.

Every person who develops harm due to failure of a drug or adverse drug reaction is entitled for damages and compensation from pharmaceutical house or medical personnel or hospital. On similar grounds, any child who has developed polio disease during polio eradication program, either because OPV failed to provide protection or caused the disease (VAPP). The harm which occurred to some children was un-intentional; but never the less expected.

Who Is Eligible For Compensation?

Pulse polio immunization program was started in India on 2nd October 1995. As no proper records of vaccination are maintained, every child living in India and born on or after 2nd October, 1995, should be presumed to have participated in polio eradication program. Thus, any child who was born on or after 2nd October, 1995, and has developed residual paralysis due to wild polio virus because of vaccine failure or due to vaccine polio virus (VAPP) is entitled for compensation. On 10th February 2016, Dr. Yash Paul sought information under RTI Act regarding the number of VAPP and Polio Compatible cases which had occurred in India from January 2011 to December 2015. Ministry of Health and Family Welfare Immunization Division, Government of India letter no. Z.33013/2016-Imm/dated 8th March 2016 stated that in this regard it is informed that no data on polio compatible cases with VAPP is maintained by this Ministry. The data on compatible cases/cases with VAPP is maintained by WHO and uploaded on their website from time to time.

On 18th March 2016 Dr. Yash Paul sent a memorandum to the Appellate Authority (RTI Act) where I had pointed out "Surprisingly Ministry of

Health and Family Welfare is not aware of the fact that NPSP has stopped displaying figures regarding polio cases since India had been declared Polio free. NPSP had never posted number of VAPP cases on its website 2003 onwards. Moreover it has now removed the information regarding past polio incidences. Still the Ministry has advised me to check WHO website." This reflects poorly on working of the Health Department.

How Much Compensation?

Amount of compensation to be paid should be quantified by some high powered committee constituted by the government of India. The quantum of compensation should be based on the degree of handicap in each individual according to the guidelines laid down in Gazette of India, Part 1, Section I, No. 4-2/83-HW iii. Government of India, Ministry of Welfare, dated 6th August, 1986. Degree of handicap has been described as:

1) Mild: less than 40 percent,
2) Moderate: 40 percent or more but less than 75 percent,
3) Severe: 75 percent or more, and
4) Profound or Total: 100 percent

Who should pay?

Like any drug a vaccine may cause adverse side-effect called Adverse Effect Following Immunization (AEFI), or may fail to provide the required protection.The vaccine manufacturer is held accountable and has to pay for the failure of the vaccine or the damage occurred, but not if it is proved that the vaccine had been mishandled, given in wrong dose, by wrong route or in presence of contra-indications. OPV is contra-indicated for immune-compromised children and those in close contract of immune-compromised persons. WHO and the Government of India had ignored these important guidelines, so both should be held accountable and not the Vaccine manufacturers.

Who should disburse the amount?

The Ministries of Health and Family Welfare, government of India and the state governments should disburse the amount to the affected persons and families.

Need For Screening Committees:

Screening committees should consist of Pediatrician, Neurologist and Orthopedic Surgeon. Such committees should be constituted at least at District levels. As monetary benefits are involved, committees should ensure that no non-polio case is included and similarly no polio case gets excluded.

Funding: Nil

Competing Interests:

Dr. Yash Paul attended the First National Polio Surveillance Project Training Workshop in 1997, held in Jamia Hamdard, New Delhi as IAP nominee. Actively participated in polio eradication program as IAP member and was appointed Observer on two occasions during Pulse Polio Campaign by NPSP.

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Review Article:

Adoption in India: In-Country Adoption (Part II)

*** Dr. Vijay Kamale, ** Dr. Betty Mathai**

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Keywords:

Child welfare, Domestic adoption, Inter-country adoption, Indian adoption, CARA

Introduction:

Adoption is a 'win-win' situation for both, parents as well as the child. The child gets a family to identify with; and a nurturing environment which is very important. Simultaneously, the give and take of love while nurturing a child is a beautiful experience. It is our experience that in most families, the consciousness that the child is adopted fades away as time passes.

In the first part, child protection and certain laws related to adoption were discussed. Here, we will review actual process of adoption in India for citizens of India.

Types of Adoptions under JJ Act 2015[1] and AR 2017 [2].

1. In-country Adoptions
   - Adoption of OAS (Orphan Abandoned Surrendered) Children
   - Relative Adoption
   - Adoption by Step Parents
2. Inter-country Adoption
   - Adoption of OAS Children
   - Relative Adoption

In-country Adoption of OAS Children [3].

Process for Declaring a Child Legally Free for Adoption

- OAS children produced before CWC within 24 hours
- Placed in CCI (Child Care Institute)/SAA (Specialized Adoptive Agency) for immediate care through a written Order
- Procedure for declaring legally free undertaken by DCPU (District Child Protection Unit) and SAA (Sec 38 of the JJ Act and Reg 6, 7 of AR 2017)
- Declared legally free by CWC following due procedure

Child Welfare Committee (CWC) [4].

- It is a 5-member committee (at least one woman member) notified by State Government for each District (Sec 27, 28 of the JJ Act)
- Committee shall function as a bench and shall have powers conferred by the CrPC, 1973 on a metropolitan Magistrate or Judicial Magistrate of First Class (Sec 27(9) of the JJ Act)
- CWC is authorized to dispose of cases for the care, protection, treatment, development and rehabilitation of the children (Sec 29(1) of the JJ Act)
- CWC has the power to deal exclusively with all proceedings under this Act relating to children in need of care and protection (Sec 29(2) of the JJ Act)
- The District Magistrate is empowered to conduct a quarterly review of the functioning of CWC (Sec 27(8)(10) of the JJ Act)

Process for Declaring Orphan/Abandoned Children Legally Free for Adoption [3].

- To be produced before CWC within 24 hours along with the report about the facts and circumstances in which the child was found (Sec 31 of JJ Act and Reg 6(2) of AR 2017).
- A copy of the above report as per Form 17 of JJ Model Rules, 2016 to be submitted to the local Police station within 24 hours.
- Interim care order by CWC to a SAA or CCI to keep the child pending inquiry (Sec 36(1), 37(1) of JJ Act and Reg 6(4) of AR 2017).

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- Photo publication of the child by DCPU in newspaper within 3 working days to trace out the biological parents/legal claimant (Reg 6 (6) of AR 2017).
- Entering of the particulars of the child in the designated Portal for missing and found children by the SAA or CCI concerned (Sec 32(2) of JJ Act &Reg 6(6) of AR 2017).
- Social investigation completed within 15 days and the report be provided to the CWC by the SAA/CCI and DCPU within 30 days to enable the CWC to pass the final order within 4 months of first production of the child (Sec 36(1)(2), 38 of JJ Act and Reg 6(10)(14) of AR 2017)
- CWC to declare the child legally free for adoption if biological parent/legal guardian could not be traced out within a period of 2/4 months in case of a child younger/older than 2 years respectively from the date of production of child (comments under Sec 38 of JJ Act and Reg 6(13) of AR 2017).
- Non receipt of Police report within stipulated time frame of 2/4 months in case of a child younger/older than 2 years respectively shall be deemed to have been given (Reg 6(11) of AR 2017).
- Parent or guardian wanting to relinquish a child due to physical, emotional and social factors beyond their control shall produce the child before CWC for surrendering the child (Sec 5(1) of JJ Act and Reg 7(1) of AR 2017).
- After due counseling, the child can be surrendered 'in camera' (Reg 7(22) of AR 2017) and a surrender deed (as per Schedule V of AR 2017) shall be executed by the parent or guardian before the CWC (Sec 35(2) of JJ Act and Reg 7(2) to 7(9) of AR 2017).
- Two months reconsideration period is available to the parents or guardian surrendering the child from the date of surrender (Sec 35(3) of JJ Act, Reg 7(12) of AR 2017).
- No public notice or advertisement shall be issued in case of surrendered child and due regard to be given to privacy of surrendering parents (Reg 7(13)(14)(20) of AR 2017).

CWC shall issue an order declaring the child legally free for adoption after the expiry of 60 days from the date of surrender as per schedule 1 of AR 2017 (Reg 7(17) of AR 2017)

Assessing Eligibility of PAPs (Prospective Adoptive Parents) for Adoption [3].

- Home study to check the suitability and eligibility of the PAPs is conducted by the social worker of a SAA in the place of PAPs' residence (Reg 9(7)(8) of AR 2017).
- Home Study Report (HSR) is prepared in the format given in Schedule VII of AR 2017 which has a validity of 3 years (Reg 9(10) to (12) of AR 2017).
- PAPs are declared suitable based on the HSR and only then they are eligible for adopting a child depending upon the availability of a suitable child (Reg 9(13)(17) of AR 2017).
- Child Adoption Resource Information and Guidance System (CARINGS)
- Online Application to facilitate, guide and monitor adoption programs.
- It has two databases: one for the children filled by the SAAs and the other is for the PAPs filled by the domestic PAPs or the AFAAs (Authorized Foreign Adoption Agency) for the NRIs/OCIs/foreign PAPs
- It has secure role-based access for various stakeholders

Adoption procedure for resident Indians:[3].

Registration and home study of the prospective adoptive parents.-

- The Indian prospective adoptive parents irrespective of their religion, if interested to adopt an orphan or abandoned or surrendered child, shall apply for the same to Specialized Adoption Agencies through Child Adoption Resource Information and Guidance System by filling up the online application form, as provided in Schedule VI, and uploading the relevant documents thereby registering

themselves as prospective adoptive parents.

- The prospective adoptive parents shall opt for desired State or States by giving option for those particular States at the time of registration.
- Registration on Child Adoption Resource Information and Guidance System would be a deemed registration in all Specialized Adoption Agencies of the State or States they have opted for.
- The registration number of prospective adoptive parents shall be available with all the Specialized Adoption Agencies in those State or States, as the case may be.
- The registration shall be complete and confirmed to the prospective adoptive parents immediately on receipt of the completed application form and requisite documents on Child Adoption Resource Information and Guidance System; provided that the documents shall be uploaded within a period of thirty days from the date of registration failing which the prospective adoptive parents have to register afresh.
- The prospective adoptive parents shall get their registration number from the acknowledgement slip and use it for viewing the progress of their application.
- The prospective adoptive parents shall select a Specialized Adoption Agency nearest to their residence for Home Study Report in their State of habitual residence.
- The Home Study Report of the prospective adoptive parents shall be prepared through the social worker of selected Specialized Adoption Agency and in case they are unable to conduct Home Study Report within stipulated time, they shall take the assistance of a social worker from a panel maintained by the State Adoption Resource Agency or District Child Protection Unit, as the case may be.
- The Specialized Adoption Agency or the empanelled social worker of the State Adoption Resource Agency or District Child Protection Unit shall counsel the prospective adoptive parents during the home study.
- The Home Study Report shall be completed in the format given in Schedule VII, within thirty days from the date of submission of requisite documents and shall be shared with the prospective adoptive parents immediately, thereafter.
- The Home Study Report shall be posted in the Child Adoption Resource Information and Guidance System by the Specialized Adoption Agency as soon as it is complete.
- The Home Study Report shall remain valid for three years and shall be the basis for adoption of a child by the prospective adoptive parents from anywhere in the country.
- The prospective adoptive parents shall be declared eligible and suitable by the Specialized Adoption Agency based upon the Home Study Report and supporting documents and in case any prospective adoptive parent is not declared eligible or suitable, the reasons for the same shall be recorded in the Child Adoption Resource Information and Guidance System.
- The prospective adoptive parents may appeal against the decision of rejection to the Authority as provided regulation 59.
- The appeal referred to in sub-regulation (14) shall be disposed of within a period of fifteen days and the decision of the Authority in this regard shall be binding.
- The District Child Protection Unit shall facilitate online registration of application of prospective adoptive parents, uploading of their documents and also for addressing technical difficulties faced by the Specialized Adoption Agencies.
- The adoption of a child by the prospective adoptive parents, after completion of their registration and Home Study Report, shall depend upon the availability of a suitable child.

Referral of a child from a Specialized Adoption Agency through Child Adoption Resource Information and Guidance System to prospective

adoptive parents.-

(1) The seniority of the prospective adoptive parents for child referral shall be from the date of uploading of documents and completion of registration process in Child Adoption Resource Information and Guidance System.

(2) On the basis of seniority, the prospective adoptive parents shall be referred online profile of three children which will include the photographs, Child Study Report and Medical Examination Report, in their preference category, if any, from one or more Specialized Adoption Agencies through the Child Adoption Resource Information and Guidance System in one or more referrals.

(3) After viewing the profile of the child or children, the prospective adoptive parents may reserve one child within a period of forty-eight hours for possible adoption and the rest of the children would be released by Child Adoption Resource Information and Guidance System for other prospective adoptive parents in the waiting list.

(4) The Specialized Adoption Agency shall get the details of the prospective adoptive parents through the Child Adoption Resource Information and Guidance System for fixing an appointment with the prospective adoptive parents for matching, to assess the suitability of the prospective adoptive parents by an Adoption Committee as defined in sub-regulation (2) of regulation 2 and the Adoption Committee shall prepare the minutes of the meeting as per format provided in Schedule XXVII.

(5) The quorum of the Adoption Committee shall be two members and the quorum of the Adoption Committee in case of adoption from a Child Care Institution shall be three members, while the presence of one official from the District Child Protection Unit would be mandatory.

(6) The Specialized Adoption Agency shall also organize a meeting of the prospective adoptive parents with the child.

(7) The entire process of matching shall be completed within a maximum period of twenty days from the date of reserving the child.

(8) The Specialized Adoption Agency shall counsel the prospective adoptive parents when they visit the agency for matching.

(9) While accepting the child, the prospective adoptive parents shall sign the Child Study Report and Medical Examination Report which may be downloaded from the Child Adoption Resource Information and Guidance System, in the presence of the social worker or chief functionary of the Specialized Adoption Agency and the Specialized Adoption Agency shall record the acceptance by the prospective adoptive parents in the Child Adoption Resource Information and Guidance System.

(10) In case the prospective adoptive parents are not selected for the child by the Adoption Committee, the reason for non-selection of the prospective adoptive parents shall be recorded in the Child Adoption Resource Information and Guidance System.

(11) If grounds of rejection are found to be due to systemic error or on non-justifiable reasons, seniority of the prospective adoptive parents shall be retained.

(12) In case the prospective adoptive parents do not accept the reserved child or the Adoption Committee does not find the prospective adoptive parents suitable, then the prospective adoptive parents shall be relegated to the bottom of the seniority list, as on that date, who may avail a fresh chance when the seniority becomes due and the same procedure shall be followed in the subsequent chances.

(13) In all cases referred to in sub-regulations (12), the reasons for not considering the child have to be clearly stated in Child Adoption Resource Information and Guidance System.

(14)The registration of prospective adoptive parents shall continue till child adoption, with revalidation of the Home Study Report in every three years.

(15)The prospective adoptive parents may also get the Medical Examination Report of the child reviewed by a medical practitioner of their choice before giving their acceptance for adoption of the child.

Pre-adoption foster care :[3]

(1) The child shall be taken in pre-adoption foster care by the prospective adoptive parents within ten days from the date of matching, after signing the pre-adoption foster care undertaking in the format provided in Schedule VIII.

(2) The prospective adoptive parents shall provide original documents or notarized copy of the documents to the Specialized Adoption Agency as specified in Schedule IX.

Legal procedure.-

(1) The Specialized Adoption Agency shall file an application in the court concerned, having jurisdiction over the place where the Specialized Adoption Agency is located, with relevant documents in original as specified in Schedule IX within ten working days from the date of matching of the child with the prospective adoptive parents and in case of inter-country adoption, from the date of receiving No Objection Certificate from the Authority, for obtaining the adoption order from court.

(2) The Specialized Adoption Agency shall file an application in the given format as per Schedule XXVIII or XXIX, as applicable.

(3) In case the child is from a Child Care Institution, which is not a Specialized Adoption Agency and is located in another district, the Specialized Adoption Agency shall file the application in the court concerned, in the district where the child or the Specialized Adoption Agency is located and in such a case, the Child Care Institution will be a co-petitioner along with the Specialized Adoption Agency and the Child Care Institution shall render necessary assistance to the Specialized Adoption Agency concerned.

(4) In case of siblings or twins, the Specialized Adoption Agency shall file single application in the court.

(5) Since an adoption case is non-adversarial in nature, the Specialized Adoption Agency shall not make any opposite party or respondent in the adoption application.

(6) The court shall hold the adoption proceeding in-camera and dispose of the case within a period of two months from the date of filing of the adoption application by the Specialized Adoption Agency, as provided under subsection (2) of section 61 of the Act.

(7) The adoptive parents shall not be asked in the adoption order to execute any bond or make investment in the name of the child, considering the fact that their psycho-social profile and financial status have already been ascertained from the Home Study Report and other supporting documents.

(8) The Specialized Adoption Agency shall obtain a certified copy of the adoption order from the court and shall forward it to the prospective adoptive parents within ten days and it shall also post a copy of the order and update the relevant entries in the Child Adoption Resource Information and Guidance System.

(9) Registration of an adoption deed shall not be mandatory as per the Act.

(10)The Specialized Adoption Agency shall apply to the birth certificate issuing authority for obtaining the birth certificate of the child within three working days from the date of issuance of adoption order, with the name of adoptive parents as parents, and date of birth as recorded in the adoption order and the same shall be issued by the issuing authority within five working days from the date of receipt of the application.

(11) The Specialized Adoption Agency shall submit an affidavit to the court while filing a petition as provided in Schedule XXIII.

Order Sought for By the Adoptive Parents

Adoption of the Child granted to the adoptive parents and they be declared parent of the child for all purpose of the law. The new name as given by the adoptive parents must be recorded along with the date of birth of the child.Direction must be given to the Birth Certificate issuing authority (name and place) to issue Birth Certificate within five working days from the date of receipt of application, with the child's name (as requested by the adoptive parents in the application), the date of birth, adoptive parents (names) as parents and the location of the SAA as place of birth (only the place). Attested photograph of the child affixed in the Court order. Adoption Statistics are given in table 1 [6].

Table 1 : Adoption Statistics

Year	In-country Adoption	Inter-country Adoption
2010	5693	628
2011 (Jan'11 to March'12)	5964	629
2012-2013 (April'12 to March'13)	4694	308
2013-2014 (April'13 to March'14)	3924	430
2014-2015 (April'14 to March'15)	3988	374
2015-2016 (April'15 to March'16)	3011	666
2016-2017 (April'16 to March'17)	3210	578
2017-2018 (April'17 to March'18)	3276	651
2018-2019 (April'18 to March'19)	3374	653
2019-2020 (April'19 to March'20)	3351	394

Follow-up of progress of adopted child:

(1) The Specialized Adoption Agency which has prepared the Home Study Report, shall prepare the post-adoption follow-up report on six monthly basis for two years from the date of pre-adoption foster placement with the prospective adoptive parents, in the format as provided in Schedule XII and upload the same in Child Adoption Resource Information and Guidance System along with photographs of the child.

(2) In case the adoptive parents relocate, they shall inform the agency which has conducted their home study and the District Child Protection Unit of the district where they relocate.

(3) The District Child Protection Unit of the district of the current residence shall prepare the post-adoption follow-up report and upload the same in Child Adoption Resource Information and Guidance System.

(4) The Specialized Adoption Agency or the District Child Protection Unit as the case may be, shall arrange for counselling the adoptive parents and adoptee by social worker or link them to the counseling center set up at the Authority or State Agency, whenever required.

(5) In case the child is having adjustment problem with the adoptive parents, the Specialized Adoption Agency shall arrange the required counseling for such adoptive parents and adoptees or link them to the counseling center set up at the Authority or State Agency, wherever required.

(6) In case of disruption in in-country adoption.-

(a) At the stage of pre-adoption foster care before filing a petition, the child shall be taken back by the Specialized Adoption Agency concerned with information to District Child Protection Unit; (b) At the stage of pre-adoption foster-care after the petition has been filed in the court, the child shall be taken back by the Specialized Adoption Agency and adoption application shall be withdrawn from the court concerned with intimation to District Child Protection Unit; (c) Where the child has been taken to another State during the adoption process, the repatriation of the child shall be coordinated by State Adoption Resource Agency in the State where the child is residing and the State of origin.

In case of dissolution, the application for annulment of adoption order shall be filed in the court which issued the adoption order.

After disruption or dissolution of adoption, as the case may be, the status of the child shall be updated as legally free for adoption in Child Adoption Resource Information and Guidance System by the Specialized Adoption Agency.

Developmental Pediatrician's Perspective

Prevention is better than cure [7].

The Adopted/Fostered children are a particularly vulnerable group in terms of psychosocial morbidity[8]. This is largely preventable by adopting certain Practice Standards during Adoption[9].

1. Regardless of their age of Adoption, children need to know the fact that they are adopted [10-13].
2. The information needs to be shared in
   a. Empathic [14]
   b. Competent[15] and
   c. Developmentally appropriate manner [9,16].
3. Health Promotional Practices[17] including Developmental, Behavioural and Psychosocial Health, needs to be incorporated in Standard Brochures, which should be amenable to statutory audit/review by Adoption Agency[18].
4. Earliest signs of Educational Difficulties need to be brought to notice for Special Educational Prevention and Remediation, as these groups of children are at increased risk[19] and since high quality Prevention and Remediation [20] is available in the country.

Post Adoption Follow Up of In-country Adopted Children

- Post Adoption follow up for In-country adoptions is conducted for two years on 6 monthly basis from the date of pre adoption foster placement of the child with the PAPs and report uploaded in CARINGS as per Schedule XII of AR 2017 (Reg 13(1) of AR 2017).
- In case of adjustment problem or disruption the process to be undertaken is specified in Reg 13(5)(6) of AR 2017.

In case of dissolution the application for annulment of adoption order shall be filed in the court which issues the adoption order (Reg 13(7) of AR 2017)

Challenges in domestic adoption:

Although state approved agencies are providing adoption, the fact is that private adoptions are still taking place in some hospitals through agents and with unorganized sectors. Most of the times, adoption agencies are perceived to be "money makers" and so they are constantly put under "scanner' by the whistle blowers.

There is a lack of consistent and complete data in some states which makes it difficult to conduct research studies. If and when there is a budget downturn, many of the agencies who are normally responsible for collecting data may find it difficult to continue their work. Contrary to the Western countries, Indian culture does not encourage "open adoption". Because India follows "closed adoption", confidentiality is maintaned and identity about the birth, parent/s is not disclosed. As of today, it is observed both in rural and some families in urban areas, adoptive parents are also not comfortable telling their children about the adoption status. If a child gathered this information from others, the trust could become a major issue in parent-child relationship

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Medicolegal News

Compiled by : Dr. Santosh Pande

Tamil Nadu Doctor Sentenced to 3 Years Jail For Violating PCPNDT, MTP Act

Cuddalore: Noting violation of several provisions of the Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT) Act and the Medical Termination of Pregnancy Act, 1971, a district court has sentenced a 55-year-old doctor to three years in jail for conducting illegal sex-determination tests and sex-selective abortions.

Pronouncing the verdict, Cuddalore district munsif cum judicial magistrate G Abarna has also directed the accused medical practitioner to pay a fine of Rs 10,000.

The case against the doctor goes back to May 2014, when the healthcare officials conducted a raid at the clinic of the Neyveli-based doctor based on a complaint forwarded by the then Perambalur District Collector. The complaint alleged that despite sex determination tests being banned in the country to prevent female feticide, the medical practitioner had been disclosing the sex of the fetus and performing sex-selective abortions in his private nursing home.

Medical Dialogues team had earlier reported that an initial investigation by the district authorities had revealed that the doctor had been habitually violating the PCPNDT act. He was found to be routinely revealing the gender of fetus after an ultrasound scan. "It has been pursued since 2014 but we had to check the evidence. We placed it before the ethical committee which took the decision," an official had stated.

The report of an inspection conducted by the Joint Director and the Collector in 2014 was sent to the Director of Medical Services who had further sent the report to the TNMC. Following the inspection report and the recommendation made thereafter, the Council had barred the doctor from practice in 2016.

As per a recent media report in the Times of India, the accused doctor has now been convicted to three years of imprisonment.

Earlier, TOI had report how after the clinic of the accused doctor had been closed down, the sex ratio in Cuddalore and neighbouring districts increased dramatically over the following years.

Ref.:*https://medicaldialogues.in/news/health/doctors/tamil-nadu-doctor-sentenced-to-3-years-jail-for-violating-pcpndt-mtp-act-73746 Accessed on 02/02/2021*

Patient Dies due to Misdiagnosis of Cancerous Cells as Gall bladder Stone: Rajasthan Surgeon directed to Pay Rs 15 Lakh

Rajasthan: The State Consumer Dispute Redressal Commission has directed a surgeon attached to a Churu based hospital to pay a compensation of Rs 15 lakh to the kin of a patient who died due to alleged misdiagnosis of cancer in the gallbladder. According to a recent report by TOI, the doctor conducted an operation and removed the cancerous cells thinking them to be stones. After the operation, the condition of the patient got worse as the cancerous cells spread all through his body to which the patient eventually succumbed.

The wife of the deceased had submitted that the patient sought treatment from the doctor on 15th February 2010 as he was suffering from stomach ache. The doctor conducted a few tests on the patient and informed them that the pain was due to a stone in the gallbladder. Hence, the doctor suggested them to undergo surgery so that the stones can be removed. He also charged the patient Rs 16,000 as his fee and an additional Rs 34,000 for several medications. After a week of treatment, the patient was discharged from the hospital. However, he started facing the same problem and returned to the hospital on May 21st. The doctor

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told the patient that a biopsy at Jaipur confirmed that he was suffering from cancer in the gall bladder (Moderately Differentiated Adenocarcinoma).

Times of India reported that later, the patient was taken to SMS hospital in Jaipur where the doctors confirmed that the previous doctor removed the cyst from the gallbladder as he considered it to be stones. However, the doctors found that it was cancerous cells and not stones in the gallbladder. Thereafter, after the operation, cancer spread through his whole body and it was not possible to save the patient. The patient eventually passed away on June 23rd, 2010. After considering the submission of the petitioner, the state consumer forum of the circuit bench of Bikaner held the doctor guilty of medical negligence and ordered him to pay a compensation of Rs 15 lakh to the kin of the patient.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/patient-dies-due-to-misdiagnosis-of-cancerous-cells-as-gallbladstone-rajasthan-surgeon-dire... Accessed on 10/02/2021*

Newborn Suffers Leg Fracture During Breech Delivery: Consumer Forum Relief To Gynecologist Hospital

Tripura: The District Consumer Dispute Redressal Commission of Tripura has recently dismissed a case of medical negligence against a gynaecologist and the hospital where the petitioner alleged that the right leg of the new born suffered a fracture due to the negligence of the doctors while conducting a breech delivery.

The petitioners had moved the court claiming compensation of 5 lakh while submitting that they had to approach a number of medical facilities and doctors for the treatment of the newborn which caused them serious financial loss and mental agony.However, the commission found that the petitioners did not mention the view of the doctor who himself conducted the caesarean and also found that there was a complication in the pregnancy of the women and the surgery was also breech surgery.

The commission observed that, it is during the surgery that the baby received the fracture in the leg as he was in a left transverse lie (Obstructed). After this the court dismissed the case. The petitioner submitted that she underwent a caesarean delivery in the respondent hospital and a baby was born but soon after the delivery, it was observed that the newborn baby was continuously crying and whenever his right leg is touched his crying is loud.

After that, the petitioner was informed that during operation and delivery and due to accident the fracture happened of shaft of the right femur of the newborn baby during manipulation of emergency LSCS, and the femur bone is in a broken condition of the baby and it is in a delicate position.

As no orthopedic specialist was available in the facility the baby was referred to a better facility. After that, the baby was admitted to two or more different hospitals and the doctors advised for the operation of the right femur. The petitioner alleged that the attending physicians never disclosed that during delivery the right femur leg of the baby has been fractured.

The baby had to be treated for one month but no improvement was detected after which the baby was admitted to a Kolkata based facility for proper and better treatment. After one month it was observed that the baby is moving his right leg quite joyfully, the petitioner submitted.

It was stated that due to the fracture of femur bone the complainant had to incur an expenditure of more than 4 lacs. Moreover, the complainant suffered serious financial loss and severe mental agony, harassment and also the baby suffered from physical discomfort, sufferings and pain due to the deficiency of service of the hospital and the doctor as well as the medical negligence. Hence, they filed the complaint seeking compensation of Rs.5 lacs.

The counsel for the hospital and the doctor denied the allegation of medical negligence and rather alleged that the petitioner had intentionally

hidden the fact that the patient was a regular patient of another doctor who himself conducted the cesarean but he was not made a party. Ultimately the hospital and the doctor in their written statement made prayers for rejection of the complaint and also for a direction to compensate them adequately for causing damage to their reputation and also causing mental pain by making false defamatory allegations against them.

It was also submitted that during the cesarean operation it was found that the baby is in left transversely lie(obstructed) and this complication needed proper management to safe the life of the child and mother and with great difficulty the baby was removed and during the removal of the baby from the womb there was fracture of femur in the right side of the baby.

The doctor in his defence clearly stated that the patient presented the case of 36 weeks of pregnancy that due to cord prolapsed and increasing obstruction and some times maternal complication hence the extraction of the baby from uterus even by cesarean section was difficult as the baby deeply impacted in an abnormal position and the liquor (water where baby moves) drained out completely, they added.

It was also mentioned by the gynecologist that the mechanism of extraction of the baby by internal manipulation and by pulling one leg at the ankle rotating the baby inside and delivery of the baby by breech(buttock) called breech extraction. Since the baby was deeply impacted due to the absence of liquor and abnormal presentation manipulation becomes inevitable in spite of taking all the care during extraction of the baby from the womb(uterus) after which the patient was referred to other facilities for better treatment.

After considering the submission of both the parties, the court questioned why the doctor who followed the case from the beginning was not made a party from the beginning and further added, "Dr. *** took all reasonable cares while doing operation as well as post operation. It is fact the accused doctor is not a pediatric surgeon. So, when he found that during the removal of the baby from the womb there was fracture of femur in the right side of the baby, he suggested the hospital authority to take the necessary measures in respect of the baby."

Mentioning the principles laid down by the Hon'ble Apex Court in respect of medical negligence, the commission further stated, " We have considered the pleadings as well as evidences of both sides very carefully. We have also gone through Dr. D. C. Dutta's text book of Obstetrics which is relied upon by the counsel of the O.Ps. From the text book we find that "Long bones – bones commonly involved in fractures - are the humerus, the clavicle and the femur. These occur in breech delivery. Fractures are usually of greenstick type but may be complete. Rapid union occurs with callus formation. Deformity is a rarity even where the bone ends are not in good alignment." So we find that medical science approves such nature of fracture which may occur in a breech delivery. we find that the event was accidental in nature and there was no negligence on the part of the Opposite parties."

Stating that the hospital authority took the necessary measures for the treatment of the newborn baby, the court also stated, " It is unfortunate that the complainant had to incur huge amount for the treatment of the baby, but for which we can not say that the opposite parties are responsible and liable to compensate the expenditure. While we have appreciated the evidence of both sides, we kept mentioned above. On over all appreciation of evidences of both sides, we do not find that there is/was any negligence or any deficiency of service on the part of the opposite parties.

Ref. : *Newborn Suffers Leg Fracture During Breech Delivery: Consumer Forum Relief To Gynecologist, Hospital Accessed on 10/02/2021*

Woman Dies During Delivery at Private UP Hospital: Four Doctors, Hospital Manager Booked Under IPC 304A

Noida: FIR has been filed against four doctors and a manager of a private hospital under IPC Section 304A (causing death by negligence) after a woman died during delivery.

Notably, medical negligence cases are to be booked under IPC Section 304A (Causing death by negligence) as per various high court and supreme court judgments on medical negligence.

The instant case concerned a woman who was admitted to the hospital on April 24, 2020. She gave birth to a baby girl through normal delivery around 2.04 pm. Around 5.30 pm, the woman's husband was allegedly informed by the hospital staff that his wife's condition was serious and she was being shifted to Max Hospital in Vaishali for further treatment.

However, on reaching Max Hospital the woman was declared dead. As per a recent media report by the Times of India, the next day, the deceased's husband visited the private hospital where he was handed over a bill of Rs 2 lakh and told that he would get the newborn baby after he clears the payment.

Aggrieved, Aditya Ginodia (the deceased's husband) moved the Noida commissioner office on July 2, 2020, to file a complaint against the doctor and the facility alleging negligence that caused the death of his wife. However, his complaint was not lodged by the police. Thereafter, on August 13, he moved to Surajpur court under CrPC Section 156(3).

In his complaint, the petitioner alleged that the removal of his wife's uterus resulted in blood loss and that the baby was pulled out through forceps even though a C- section could have been done. He further alleged that the family was not informed of the developments and his wife was transferred "using lies".

The petitioner also submitted that it was wrongfully mentioned in the discharge summary that the patient stayed in the hospital for two days. Responding to the allegations, the hospital argued that the man was counseled about a "life-threatening condition" the patient had and stressed there was "no deficiency" on part of its team.

A hospital spokesperson further added that the patient had been diagnosed with amniotic fluid embolism (AFE), a rare and life-threatening condition with a very high mortality rate, which would have been confirmed by the autopsy.

"Her attendant was counseled about this condition and the hospital, in consultation with the most experienced doctors, delivered the best medical care to the patient but could not change the outcome. There was no deficiency in service on the hospital team's part," Times of India quotes the spokesperson.

After hearing both the parties, a medical inquiry was conducted by a panel of three doctors, formed by the CMO on the court's directions in October. The panel was of the view that there was a need for an inquiry by a higher medical institution and that the woman did not suffer from hypertension, anemia, or any other condition that suggested she could get a heart attack'

"It was unclear whether her death occurred due to blood loss or something else," the report stated. Subsequently, on January 30, the Surajpur court directed Sector 39 police to lodge an FIR against the four doctors and the hospital manager under IPC Section 304-A (death due to negligence), SHO Azad Tomar told.

Ref. : *Woman Dies During Delivery At Private UP Hospital: Four Doctors, Hospital Manager Booked Under IPC 304A Accessed on 14/02/2021*

Delay in Administering Reteplase Injection: Cardiologist Told To Pay Rs 6 Lakh Compensation for Patient Death

Hyderabad: Observing a delay in administering life-saving Reteplace injection to a patient who was in a serious condition of heart attack, the District Consumer Disputes Redressal Commission has

directed an interventional cardiologist to pay a compensation of Rs 6 lakh for negligence and deficiency in service resulting in the death of the patient.

The direction came following a complaint moved with the Consumer Commission by the deceased patient's husband alleging that the cardiologist was negligent in treating the patient leading to her death.

The case goes back to August 26, 2016, when a 56-year-old patient was brought to the Nalgonda-based cardiology hospital, owned by the cardiologist- with reported chest pain and uneasiness. The cardiologist conducted ECG and 2D Echo on the patient apart from several tests and medication that amounted a bill of Rs.47, 300/-.

It was alleged that while the procedures were being conducted on the patient, the Doctor was not present and had left for his house, leaving the patient in serious condition. The patient had been kept in the hospital for over five hours, but her condition did not improve. Soon after, the patient passed away.

Mentioning that the hospital lacked the adequate infrastructure necessary for the treatment of the patient, the complainant further alleged that the cardiologist, "feigned to treat the patient" with a malafide intention to usurp exorbitant money from them, adding that the doctor neither discharged his professional duties nor did he refer the patient to a better hospital.

Thereafter, a legal notice was sent to the cardiologist in November 2017 claiming an amount of Rs.47,300/- towards medical expenses, Rs.16,700/- towards gold ring finger (that was allegedly stolen by the hospital staff from the patient's finger), Rs.3,36,000/- towards mental agony and Rs.6,00,000/- towards compensation, total Rs.10,00,000/-.but was unanswered. Aggrieved, the complainant moved the Consumer Commission.

During cross-examination, the cardiologist denied all allegations and submitted that after conducting initial treatment and tests (including blood pressure check, ECG, and 2D Echo) the doctor had arrived upon the conclusion that the patient had been suffering from serious heart attack. Following this, the complainant has explained the risk and consequences of a heart attack including the sudden death that may happen to the patient.

He added that after understanding the complications involved in the procedure during the heart attack, the complainant admitted his wife for treatment and consulted for the treatment and signed in the consent letter out of his free will and consent without any pressure from the side of the cardiologist or the staff of the hospital.

The cardiologist has also clarified before the commission that he administrated RETEPLASE injection which had to be given within 30 minutes of heart attack as early as possible according to the protocol followed in the cases of a heart attack. After giving the injection, the patient showed signs of improvement and it was also reflected in the second ECG.

It was further submitted that after coming to a conclusion that the patient should undergo an angiogram, the doctor advised the complainant to take the patient to the higher cardiac centre where the angiogram facility would be available; and maintained that he issued a referral letter to the complainant.

While addressing the legal notice sent by the complainant on 15/09/2019, the cardiologist argued that he had replied to the notice on 10/10/2017 and it had been served to the complainant on 13/10/2017. He further stated that the Complainant, without waiting for the reply from him, lodged this complaint to corner and blackmail him. He further alleged that the complaint had been lodged with an intention to grab money from the hospital at the cost of his reputation.

After hearing both the parties, the commission observed that, during cross examination

about the referral letter and consent letter filed by the cardiologist, he had admitted that, “the complications happened before shifting the patient to the higher center so he did not give any referral letter, but he gave death summary.”

The Commission noted that the Case sheet lacked the necessary details such as identification column, the details of the patient's condition (blockage of the valves and the percentage of the blockage). The case sheet had been written in the form of a story and it hadn't contained visiting time or the details of the treatment given. The Opposite Party accepted all these flaws in the case sheet. The Commission also found contradictions in the statements of the Opposite Party, as the Discharge Summary stated that "referred to higher centre for Coronary Angiogram", but the Opposite Party, during his cross-examination, had stated that "there is no need of angiogram facility to this injection."

Further, after verifying the documents, the Commission referred to the previous judgment by the Supreme Court reported in IV (2004) CPJ 40 (SC). It mentions, "the doctrine of res ipsa loquitur apply the onus lay on the hospital authority to prove that there had been no negligence on its part or on the part of anyone for whose acts or omissions it was liable and that onus has not been discharged. Once an allegation is made by the patient was admitted in a particular hospital and the evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, the hospital which is in better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service."

The apex court judgment further mentioned, "In the opinion of this court before forming an opinion that expert opinion is necessary, the Fora under the Act must come to a conclusion that the case is complicated enough to require an opinion of the expert or that the facts of the case as such that it cannot be resolved by the Members of the Fora without the assistance of an expert opinion."

The Commission further referred that in the decision reported in I (2020) CPJ 3 (SC) between Maharaja Agrasen Hospitals and others Vs. Master Rishabh Sharma and others, it had been observed that "Medical Negligence – Expert evidence – Court is not bound by evidence of an expert, which is advisory nature – Court must derive its own conclusions after carefully sifting through medical records, and whether the standard protocol was followed in the treatment of the patient."

The Commission observed, "Though the Opposite Party knew that the patient was suffering from a serious heart attack had failed to refer the patient to higher center for better treatment with the equipment available. The Opposite Party failed to perform his professional duty in treating the patient due to his negligence and carelessness."

It added, "The deceased is 56 years old woman, the Complainant lost his wife's love and affection due to the untimely death in the hospital of the Opposite Party who would have survived if the Opposite Party would have given proper treatment, i.e. administering the Reteplese injection within 30 minutes which has been admitted by the Cardiologist."

Subsequently, the Commission noted; "There is negligence and deficiency in service on the part of the Opposite Party in giving treatment to the Complainant's wife and her fundamental right to life has been curtailed due to the negligent treatment given to the patient. The Opposite Party has failed to prove a valid informed consent obtained from the Complainant before subjecting his wife for the treatment. The Opposite Party had himself admitted that there was a delay of two hours in administering

Reteplace injection to the patient who was in serious condition of heart attack and delayed the treatment which caused the death of the patient, as the principal of res ipsa loquitor applies."

On the basis of these findings, the Commission directed the Cardiologist to pay "An amount of Rs.6,00,000/- [Rupees Six Lakhs only] towards compensation, Rs.1,00,000/- [Rupees One Lakh only] towards mental agony, Rs.47,300/- [Rupees Forty-Seven Thousand and Three Hundred only] towards medical expenses with interest @ 9% p.a. from the date of filing of the complaint till realization along with costs of Rs.10,000/- [Rupees Ten Thousand only] within 45 days from the date of receipt of this order."

Ref.: *Delay In Administering Reteplase Injection: Cardiologist Told To Pay Rs 6 Lakh Compensation For Patient Death. Accessed on 14/02/2021*

Complications Due To Accidental Nerve Cut During Surgery: Gynaecologist, Hospital Told To Pay Rs 6 Lakh Compensation

West Bengal: The District Consumer Court of South Dinajpur has directed a Bengal-based gynecologist and a private hospital to pay a compensation of rupees 6 lakhs to a patient after a pregnant woman approached the consumer court alleging medical negligence on part of the hospital and the doctor.

The petitioner alleged that her condition kept on deteriorating after her delivery due to the negligence of the doctor and the hospital. The petitioner also mentioned the report of the medical board which indicated that a nerve in the patient's abdomen was mistakenly cut by a doctor, leading to her health complication.

According to a Millenium Post, the counsel for the petitioner submitted that the petitioner was pregnant and she was admitted to a District Hospital in 2016. After examining the patient, the gynecologist advised her to get admitted to another private facility. Following the advice of the doctor, she took admission at the private facility on October 13th and the same gynecologist conducted surgery on her and delivered her baby girl.

However, after the operation, the health of the mother started declining rapidly. The doctor suggested that she should be referred back to the district hospital for better treatment.

But her condition did not show any improvement after which she had to be referred to RG Kar hospital in Kolkata. She was under treatment in the very facility for 47 days after which her condition improved and finally, she was released from her hospital.

Millennium Post reported that the medical board comprising experts in R G Kar Hospital informed her husband that a nerve in her abdomen was mistakenly cut by the doctor, leading to the complication. After returning to Balurghat, the patient lodged a written complaint against the doctor and the hospital for medical negligence on March 13, 2018, before the District Consumer Court.

After considering the submission of both the parties, the consumer forum found that the allegations were not groundless and held the doctor and the hospital guilty of medical negligence.

A 3-member justice bench comprising judges Shyam Prakash Rajak, Rumki Samajdar and Ashok Kanti Sarkar pronounced the verdict and instructed the accused doctor to pay Rs 5 lakh and the private facility to pay Rs 1 lakh as compensation to the patient for their negligence in providing treatment. "In addition to this, the private facility will have to pay Rs10,000 as litigation cost to be paid within 45 days from the verdict,"added the court.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/complications-due-to-accidental-nerve-cut-during-surgery-gynaecologist-hospital-told-to-pay-rs-6 Accessed on 16/02/2021*

Child Dies After MR Vaccine Shot At Chennai Hospital: Rs 2 Lakh Compensation Ordered

Chennai: Tamil Nadu Government has been directed by the State Human Rights Commission

(SHRC) to pay Rs 2 lakh as compensation to the father of a pediatric patient who died soon after being administrated with the Measles and Rubella (MR) vaccine.

The case goes back to 2018, wherein, the vaccine administrated by doctors at a Chennai Hospital had allegedly caused the death of the 5-year-old girl.

Based on a newspaper report published on May 5, 2018, D. Jayachandran, a member of SHRC took suo motu cognizance of the incident. This step by the commission was followed by the submission of a proof affidavit against the hospital before the commission by the deceased's father.

As per the latest media report by the Times of India, the child was administrated with the vaccine around 11 am on May 2, 2018. Claiming that before taking the vaccine the girl had no health issues, the father alleged that only 15 minutes after taking the vaccine, the patient started complaining about breathlessness and severe burning in the eyes. Soon, the child fainted and was taken to the emergency ward by the hospital staff. The parents allegedly got no permission to visit their daughter and the next day the child was pronounced dead.

Following a complaint with the Flower Bazaar Police Station, the father claimed that the reason for his daughter's death was medical negligence on part of the assistant professor and other hospital staff. Along with a demand for suitable action against the hospital and the doctor, the complainant had asked for a compensation of Rs 10 lakh.

The hospital, however, denied all these allegations. TOI adds that assistant professor at the Institute of Social Paediatrics, the dean and the head of the department at the institute denied charges of medical negligence and irregularities.

Claiming that the child had developed only anaphylaxis (a severe allergic reaction), which had been treated immediately, the hospital and the doctor further mentioned that the MR vaccine was a multi-dose vial. They further contended that 20 other children had been administrated the vaccine from the same vial on that day and there had been no other complications. The respondents denied the charges of not letting the parents see their daughter.

After taking note of all the arguments of both the parties and examining their documents including the report of the Director of Medical Education (DME), Chennai, the Commission observed that the materials on record clearly had shown that the child died due to an adverse event that followed the MR vaccination at the Government Hospital.

The Hindu quotes the statement of the Commission noting, "However, it is not in dispute that the child died due to pulmonary edema with pneumonitis and acute tubular injury of the kidneys. But the respondent has not produced any document to show that the child died due to an individual immune response to the vaccine. Further, the respondent has not produced any document to show the records pertaining from January 2018 to December 2018, though they have vaccinated 428 children with MR vaccine, except of the deceased child D.G. Tanishka."

It further pronounced, "Therefore, the death of the deceased child D.G. Thanishka caused irreparable loss and much mental agony to the complainant on this aspect. Therefore, considering the pathetic situation and also on humanitarian grounds, on behalf of the respondents, the Government of Tamil Nadu is vicariously liable to pay compensation to the victim child's father/complainant. Therefore, this Commission is of the opinion that a sum of ₹2 lakh to the victim's father should be awarded to him."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/child-dies-after-mr-vaccine-shot-at-chennai-hospital-rs-2-lakh-compensation-ordered-Accessed on 16/02/2021*

Indian Medico- Legal Ethics Association
Professional Assistance / Welfare Scheme

1) The scheme shall be known as PAS **"Professional Assistance Scheme".**
2) **ONLY the life member of IMLEA, IAP& PAI** shall be the beneficiary of this scheme on yearly basis. The member can renew to remain continuous beneficiary of this scheme by paying renewal fees every year. The scheme shall assist the member ONLY as far as the medical negligence is concerned.
3) This scheme shall be **assisting the members** by:
   - **i) Medico-legal guidance** in hours of crisis. A committee of subject experts shall be formed which will guide the members in the hours of crisis.
   - **ii) Expert opinion** if there are cases in court of law.
   - **iii) Guidance of legal experts.** A team of Legal & med-legal experts shall be formed which will help in guiding the involved members in the hours of crisis.
   - **iv) Support of crisis management committee** at the city / district level.
   - **v) Financial assistance** as per the terms of agreement.
4) The fund contribution towards the scheme shall be decided in consultation with the indemnity experts. The same will depend on the type & extent of practice, number of bed in case of indoor facilities & depending upon the other liabilities.
5) The financial contribution towards the scheme shall be as follows:

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

S. no	Qualification/ Specialty	Ten Lakhs	Twenty Lakhs	Fifty Lakhs	One Crore	One Crore
1	Physician / doctors with Bachelor degree and/or OPD Practice	**400 (625)**	**800 (1250)**	**1700 (3125)**	**3200 (6250)**	**6000 (12500)**
2	Physician / doctors with PG degree &/ or Indoor Practice	**800 (1250)**	**1400 (2500)**	**3200 (6250)**	**6000 (12500)**	**11000 (25000)**
3	Physician / doctors with Practice of Surgery	**1400 (2500)**	**2600 (5000)**	**6000 (12500)**	**11000 (25000)**	**21000 (50000)**
4	Plastic Surgeons, Anesthetist etc	**2000 (3750)**	**3800 (7500)**	**9000 (18625)**	**16000 (37250)**	**30000 (75000)**

Figure in brackets indicates amount if you directly do through Insurance Company

- The amount includes the charges of New India Assurance company charges as well as the charges of Human Medico-Legal Consultants Company.
- This scheme is for **AOY** (Any one year Limit); amount shall be calculated on individual to individual basis for extra **AOA** (Any one Accident limit) assistance.
- **5% concession on payment for three years & 10% concession for payment for five years** on individual to individual basis.
- Physician / doctors visiting other hospitals shall have to pay 5% extra
- The additional charges 15 % for those working with radioactive treatment.
- The a dditional charges can be included for other benefits like OPD/ indoor attendance, instruments, fire, personnel injuries etc

PAS for Hospital Establishments:

Annual Fee for Hospitals Establishment
Rs/- 300 per lakh + 1 rupee/OPD P atient (total OPD in one calendar year) + 5 rupee per IPD patient (total admissions in one calendar year) + GST 18 %+ 7.5 % of basic premium for Unqualified Staff.
The exact calculations will depend upon number of OPD & Indoor patients as per the actual number given by the hospital. Medical colleges/ Corporate hospitals after discussing with hospital administration.
This scheme is for**AOY** (Any one year Limit); amount shall be calculated on individual to individual basis for extra**AOA** (Any one Accident limit) assistance.
5% concession on payment for three years & 10% concession for payment for five years on individual to individual basis.

6) The hospital can become the member of this scheme only if all the members associated with the hospital have their personal professional indemnity under the scheme.
7) A trust / committee / company/ society shall look after the management of the collected fund. The scheme shall initially be run in collaboration with the New India Assurance or National Insurance Company.
8) The Financial assistance will be like Medical Indemnity welfare scheme, where indemnity part shall be covered by government / IRDA approved companies or any other private company.
9) The amount shall be deposited in the Central Indemnity Reserve Fund (CIRF) of the association. The association shall be responsible only for the financial assistance. Any compensation/cost/damages awarded by judicial trial shall be looked after by government / IRDA approved insurance companies or any other similar private company.
10) Experts will be involved so that we have better vision & outcome of the scheme.
11) The payment to the experts, Legal & med-legal experts shall be done as per the pre-decided remuneration. Payment issues discussed, agreed and processes shall be laid down by the members of these scheme.
12) If legal notice / case are received by member he should forward the necessary documents to the concerned person.
13) Reply to the notice/case should be made only after discussing with the expert committee.
14) A discontinued member if he wants to join the scheme again will be treated as a new member.
15) Most of the negligence litigations related to medical practice EXCEPT the criminal negligence cases shall be covered under this scheme. The scheme will also NOT COVER the damages arising out of fire, malicious intension, natural calamity or similar incidences.
16) All the doctors working in the hospital (Junior, Senior, Temporary, Permanent etc) shall be the members of the IMLEA, if the hospital wants to avail the benefits of this scheme.
17) The scheme can cover untrained hospital staff by paying extra amount as per the decision of expert committee.
18) A district/ State/ Regional level committee can be established for the scheme.
19) There will be involvement of electronic group of IMLEA for electronic data protection.
20) Flow Chart shall be established on what happens when a member approaches with a complaint made against him or her [Doctors in Distress (DnD) processes].
21) Telephone Help Line: setting up and manning will be done.
22) Planning will be done to start the **Certificate / Diploma / Fellowship Course on med-leg issues** to create a pool of experts.
23) Efforts will be made to spread preventive medico-legal aspects with respect to **record keeping, consent and patient communication** and this shall be integral and continuous process under taken for beneficiary of scheme by suitable medium.

□■□

INDIAN MEDICO-LEGAL & ETHICS ASSOCIATION

[Reg. No. - E - 598 (Amravati)]
Website - www.imlea-india.org , e mail - drsatishtiwari@gmail.com

LIFE MEMBERSHIP FORM

Name of the applicant : _____
(Surname) (First name) (Middle name)

Date of Birth : _____ Sex : _____

Address for Correspondence: _____

_____

Telephone No.s : Resi. : _____ Hosp. : _____ Other : _____

Mobile : _____ Fax : _____ E-mail : _____

Name of the Council (MCI/Dental/Homeopathy/Ayurved /Other) : _____

Registration No.: _____ Date of Reg. : _____

Medical / Legal Qualification	University	Year of Passing

_____ _____

Name, membership No. & signature of proposer Name, membership No. & signature of seconder :

A) Experience in legal field (if any) : _____

B) Was / Is there any med-legal case against you /your Hospital : (Yes / No) : _____
If, Yes (Give details) _____ (Attach separate sheet if required)

C) Do you have a Professional Indemnity Policy (Yes / No) : _____
Name of the Company: _____ Amount : _____

D) Do you have Hospital Insurance (Yes / No) : _____
Name of the Company: _____ Amount : _____

E) Do you have Risk Management Policy (Yes / No) : _____
Name of the Company: _____ Amount : _____

F) Is your relative / friend practicing Law (Yes / No) : _____
If Yes, Name : _____
Qualification : _____ Place of Practice : _____
Specialized field of practice (Civil/ Criminal/ Consumer / I-Tax, etc) : _____

G) Any other information you would like to share (Yes / No) _____ If Yes, please attach the details
_____

I hereby declare that above information is correct. I shall be responsible for any incorrect / fraudulent declarations.

Place: _____ _____

Date: _____ (signature of applicant)

Enclosures: True Copy of Degree, Council Registration Certificate & photograph.

Life Membership fee (individual Rs.3500/-, couple Rs.6000/-) by CBS (At Par, Multicity Cheque) in the name of Indian Medico-legal & Ethics Association (IMLEA) payable at Amravati. Send to Dr.Satish Tiwari, Yashodanagar No.2, Amravati-444606, Maharashtra. Ph. No. 0721-2952851, 8483987566

INDIAN MEDICO-LEGAL & ETHICS ASSOCIATION

[Reg. No. - E - 598 (Amravati)]
Website - www.imlea-india.org , e mail - drsatishtiwari@gmail.com

LIFE MEMBERSHIP FORM (ADVOCATES)

Name of the applicant : _____
(Surname) (First name) (Middle name)

Date of Birth : _____ Sex : _____

Address for Correspondence: _____

_____

Telephone No.s : Resi. : _____ Hosp. : _____ Other : _____

Mobile : _____ Fax : _____ E-mail :_____

Name of the BAR Council : _____

Registration No.: _____ Date of Reg. : _____

Medical / Legal Qualification	University	Year of Passing

_____ _____
Name, membership No. & signature of proposer Name, membership No. & signature of seconder :

A) Experience in legal field (if any) : _____

B) Did you defend any med-legal case against Doctor / Hospital : (Yes / No) : _____
If, Yes (Give details) _____ (Attach separate sheet if required)

C) Is your relative / friend practicing Medicine (Yes / No) : _____
If Yes, Name: _____
Qualification: _____Place of Practice: _____
Specialized field of practice (Medicine, Surgical etc) : _____

D) Any other information you would like to share (Yes / No) _____ If Yes, please attach the details

_____

I hereby declare that above information is correct. I shall be responsible for any incorrect / fraudulent declarations.

Place: _____

Date: _____

_____
(signature of applicant)

Enclosures: True Copy of Degree, Council Registration Certificate & photograph.

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The Members of Professional Assistance Scheme

S.N	Name	Place	Speciality
1	Dr. Sunil Agrawal	Satna	Surgeon
2	Dr. Rashmi Agrawal	Satna	Ob & Gyn
3	Dr. Dinesh B Thakare	Amravati	Pathologist
4	Dr. Neelima M Ardak	Amravati	Ob.&Gyn.
5	Dr. Rajendra W. Baitule	Amravati	Orthopedic
6	Dr. Ramawatar R. Soni	Amravati	Pathologist
7	Dr. Rajendra R. Borkar	Wardha	Pediatrician
8	Dr. Satish K Tiwari	Amravati	Pediatrician
9	Dr. Usha S Tiwari	Amravati	Hospi/ N Home
10	Dr. Vinita B Yadav	Gurgaon	Ob.&Gyn.
11	Dr. Balraj Yadav	Gurgaon	Pediatrician
12	Dr. Dinakara P	Bengaluru	Pediatrician
13	Dr. Shriniket Tidke	Amravati	Pediatrician
14	Dr. Gajanan Patil	Morshi	Pediatrician
15	Dr. Madhuri Patil	Morshi	Obs & Gyn
16	Dr. Vijay M Kuthe	Amravati	Orthopedic
17	Dr. Alka V. Kuthe	Amravati	Ob.&Gyn.
18	Dr. Anita Chandna	Secunderabad	Pediatrician
19	Dr. Sanket Pandey	Amravati	Pediatrician
20	Dr. Ashwani Sharma	Ludhiana	Pediatrician
21	Dr. Jagdish Sahoo	Bhubneshwar	Pediatrician
22	Dr. Menka Jha (Sahoo)	Bhubneshwar	Neurology
23	Dr. B. B Sahani	Bhubneshwar	Pediatrician
24	Dr. Poonam Belokar(Kherde)	Amravati	Obs & Gyn
25	Dr. Rakesh Tripathi	Satna	Pediatrician
26	Dr. Sandeep Dankhade	Amravati	Pediatrician
27	Dr. Ashish Dagwar	Amravati	Surgeon
28	Dr. Chinthalapalli Gowari	Bengaluru	Family Medicine
29	Dr. Ishita Majumdar	Asansol(W.B)	Cardiologist
30	Dr. Ashish Narwade	Mehkar	Pediatrician
31	Dr. Mallikarjun H B	Bengaluru	Pediatrician
32	Dr. Premchand Jain	Karjat	Pediatrician
33	Dr. Virendra Roda	Dhule	Opthalmologist
34	Dr. Sandhya Mandal	Medinipur(W.B)	Pediatrician
35	Dr. Sunita Wadhwani	Ratlam	Ob & Gyn
36	Dr. Sagar Idhol	Akola	Physician
37	Dr. Ashish Varma	Wardha	Pediatrician
38	Dr. Anuj Varma	Wardha	Physician
39	Dr. Neha Varma	Wardha	Ob & Gyn
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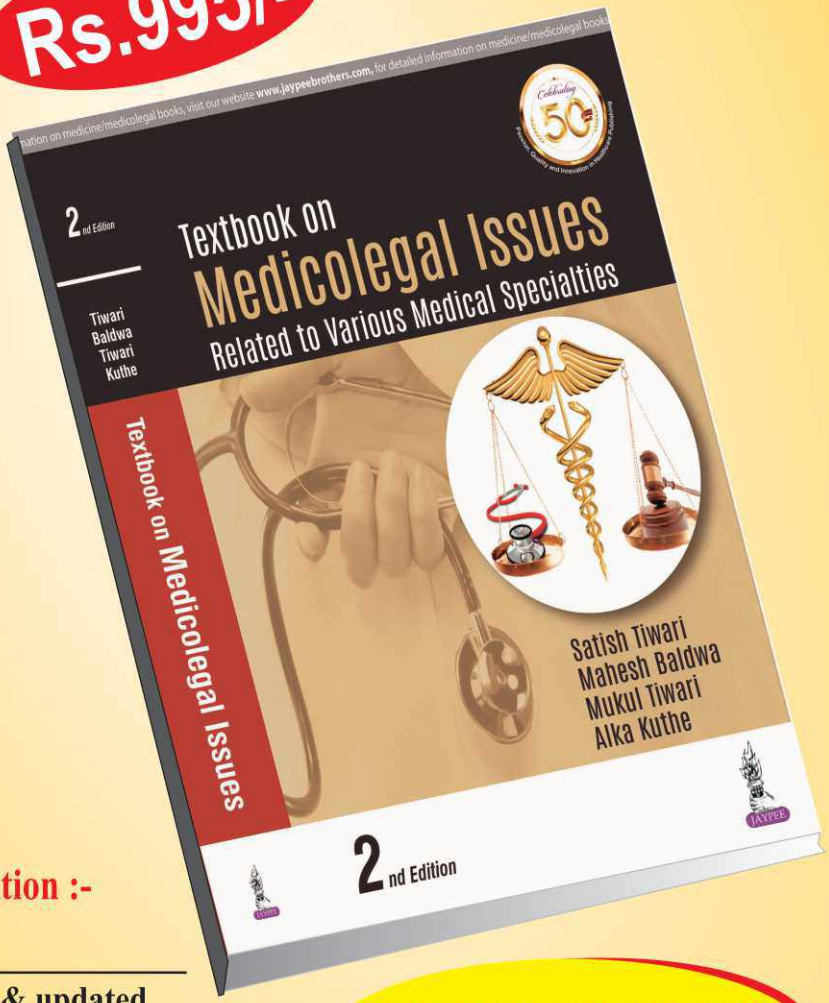

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