205HA26

by Cde Anu

Submission date: 12-Dec-2025 01:51PM (UTC+0530)
Submission ID: 2844238010
File name: 205HA26_HEALTHCAR_LAWS,ETHICS_COUNSELING_SKILLS_Full_book.pdf (741.87K)
Word count: 22638
Character count: 138376

HEALTHCARE LAWS, ETHICS AND COUNSELLING SKILLS

MASTER OF BUSINESS ADMINISTRATION
(HOSPITAL ADMINISTRATION)

FIRST YEAR, SEMESTER-I, PAPER-V

DIRECTOR, I/c.

Prof. V. Venkateswarlu

M.A., M.P.S., M.S.W., M.Phil., Ph.D.

CENTRE FOR DISTANCE EDUCATION
ACHARYA NAGARJUNA UNIVERSITY
NAGARJUNA NAGAR 522 510

Ph: 0863-2346222, 2346208
0863- 2346259 (Study Material)
Website www.anucde.info
E-mail: anucdedirector@gmail.com

MBA (HA): Healthcare Laws, Ethics and Counselling Skills

First Edition : 2025

No. of Copies :

Published by:

Prof. V. VENKATESWARLU
Director, I/c
Centre for Distance Education,
Acharya Nagarjuna University

Printed at:

FOREWORD

Since its establishment in 1976, Acharya Nagarjuna University has been forging ahead in the path of progress and dynamism, offering a variety of courses and research contributions. I am extremely happy that by gaining 'A+' grade from the NAAC in the year 2024, Acharya Nagarjuna University is offering educational opportunities at the UG, PG levels apart from research degrees to students from over 221 affiliated colleges spread over the two districts of Guntur and Prakasam.

The University has also started the Centre for Distance Education in 2003-04 with the aim of taking higher education to the door step of all the sectors of the society. The centre will be a great help to those who cannot join in colleges, those who cannot afford the exorbitant fees as regular students, and even to housewives desirous of pursuing higher studies. Acharya Nagarjuna University has started offering B.Sc., B.A., B.B.A., and B.Com courses at the Degree level and M.A., M.Com., M.Sc., M.B.A., and L.L.M., courses at the PG level from the academic year 2003-2004 onwards.

To facilitate easier understanding by students studying through the distance mode, these self-instruction materials have been prepared by eminent and experienced teachers. The lessons have been drafted with great care and expertise in the stipulated time by these teachers. Constructive ideas and scholarly suggestions are welcome from students and teachers involved respectively. Such ideas will be incorporated for the greater efficacy of this distance mode of education. For clarification of doubts and feedback, weekly classes and contact classes will be arranged at the UG and PG levels respectively.

It is my aim that students getting higher education through the Centre for Distance Education should improve their qualification, have better employment opportunities and in turn be part of country's progress. It is my fond desire that in the years to come, the Centre for Distance Education will go from strength to strength in the form of new courses and by catering to larger number of people. My congratulations to all the Directors, Academic Coordinators, Editors and Lesson-writers of the Centre who have helped in these endeavors.

Prof. K. Gangadhara Rao
M.Tech., Ph.D.,
Vice-Chancellor I/c
Acharya Nagarjuna University.

MASTER OF BUSINESS ADMINISTRATION
(HOSPITAL ADMINISTRATION)
Programme Code: 197
PROGRAMME SYLLABUS

1st YEAR – 2nd SEMESTER SYLLABUS

205HA26: HEALTH CARE LAWS, ETHICS & COUNSELING SKILLS

Unit - I Establishment: Andhra Pradesh Private Medical Care Establishment Act 2002; Formation of a Health care Organization under Partnerships and Corporate basis (private and public); Public Private Partnerships in health care; National Medical Council; Physician Patient relationship; Duties towards patients by medical and Para-medical staff; Medical ethics & Oaths; Code of conduct.

Unit - II Hospital Services and Law: Contractual obligations in Hospital Services; Requisites of a valid contract; Contractual liability and damages; Criminal liability and defenses available to hospitals and medical staff; tortuous and vicarious liability; Legal remedies available to patients, Hospital as a bailee; CP Act, RTI.

Unit – III Hospitals and Labour Enactments: Hospital as an Industry; Unrest in Hospitals; Dispute Settlement Mechanisms; Role of Trade Unions; Unfair Labour Practices and Victimization; Disciplinary Actions– Requisitions of a valid disciplinary enquiry; Service Conditions; Retiral benefits; Social Security and Insurance

Unit - IV Legal frame work: Patient right's and responsibility; Medical malpractice; Medico legal aspects of: impotence, sterility, sterilization and artificial insemination; Medico legal aspects of psychiatric &mental health; Toxicology - laws related to toxicology; Giving evidence in police investigation; Organ transplantation; Euthanasia (mercy killing); Diagnosis, prescriptions and administration of drugs; Anesthesia and Surgery.

Unit - V Counseling skills: Introduction, growth of Counseling Services; Approaches to counseling; Process of Counseling; Attitudes of Counselors; Skill of Counseling; Problems in Counseling; Assessing and diagnosing clients' problems; Selecting counselling strategies & interventions; Changing behavior through counseling; Application of Counseling to Hospital Situations with a Focus on Performance Improvement.

Reference Books:

1. S.L. Goel, Healthcare Management and Administration, Deep & Deep Publications Pvt. Ltd. New Delhi, 2010
2. Harris, D. (2014). Contemporary Issues in Healthcare Law and Ethics. Chicago: Health Administration Press
3. Kapoor, N. D. (1983). Elements of mercantile law: Including company law and industrial law. New Delhi: Sultan Chand & Sons.
4. Kavita Singh, Counseling skills for Managers' PHI Publishing House.

CONTENTS

Unit-1

HEALTH CARE LAWS, ETHICS & COUNSELING SKILLS

There is a close relation between a medical organisation and the society in which it is established. A medical profession can be a success only if it abides by certain rules guided by the ethical and moral values of the surrounding region. These rules form the basis of all healthcare laws of any region.

The number of healthcare laws is very few when compared with the number of problems faced in the healthcare sector. So, there is a great requirement to have an extensive health care law system that gears the complete healthcare sector to its different objectives. If the hospital gets accustomed to the laws and regulations and complies with them appropriately, then it would be on right side of the law.

The Supreme Court of India has been insistent on stating that the fundamental right to life covered within its scope is the right to emergency healthcare.

In this chapter, you will study about the nature and scope of Andhra Pradesh Private Medical Care Establishment Act 2002; types of healthcare organizations under partnerships act , corporate basis under the companies act 1956 and companies act of 2013 , Public Private partnership in health care , Further, the chapter discusses about the nature of partnership and relationhip between partners according to The Indian Partnership Act, 1932.

The Andhra Pradesh Private Medical Care Establishments Act, 2002 (officially the AP Allopathic Private Medical Care Establishments (Registration and Regulation) Act, 2002) is a state law for registering and regulating private allopathic hospitals, clinics, and diagnostic centers in Andhra Pradesh, mandating registration, establishing an Authority for oversight, defining duties, and setting penalties for non-compliance, ensuring standards in private healthcare.

The Andhra Pradesh Allopathic Private Medical Care Establishments (Registration & Regulation) Act, 2002, mandates registration and sets standards for allopathic private hospitals/clinics in AP, requiring registration with a state authority, ensuring proper infrastructure (OPD, causality, ICU, OT), qualified staff, and waste management, with

penalties for non-compliance, aiming to regulate quality & accountability, though enforcement faced initial challenges.

Key Provisions

1} Mandatory Registration: No private medical establishment (hospital, clinic) can operate without being registered under this Act.

2) Authority & Committees: Establishes a State Registering Authority and District Level Advisory Committees to oversee implementation and progress of the registrations.

3} Scope: Applies to Allopathic private medical care, later clarified by amendments.

4} **Infrastructure Norms** (Examples): 1) Separate OPD, Casualty (5% beds, defibrillators, oxygen), ICCU (10% beds, specific equipment), OT, Post-Op wards (3 beds minimum).

2) Sanitation, hygiene, radiation protection, bio-medical waste disposal.

5) Staffing: Requires qualified doctors and paramedical staff.

6) Penalties: Provisions for prosecution, fines, and imprisonment for non-compliance, even for existing establishments (within 3 months of commencement).

7) Enforcement Issues: Historically, significant non-compliance (running without registration) was reported, indicating lax enforcement initially.

8) Amendments: Amended (e.g., 2006) to specifically use "Allopathic" in the title and definition.

In Simple Terms: This Act is a rulebook for private hospitals, saying "If you're an allopathic hospital in AP, you must register, have good equipment, clean facilities, qualified doctors, and follow rules, or face legal action".

Forming a healthcare organization as a partnership in India uses the Indian Partnership Act, 1932, requiring a Partnership Deed detailing roles, profit-sharing, capital, and rules, with registration optional but recommended for legal benefits (like suing third parties) under the Registrar of Firms, plus essential licenses like Drug & Shops & Establishment for operations. Latest trends show increasing Public-Private Partnerships (PPPs) for better access, like through the NHM, and discussions around mandatory registration for better accountability.

Core Requirements for Partnership Formation

The Law of Partnership is also known as The Indian Partnership Act, 1932. A partnership is a relationship between two or more people who have agreed to work together in the pursuit of a common goal and divide up the earnings from any company that they run. Changes to and definitions of partnership law are included in the Partnership Act. On October 1, 1932, this Act became law, and it applies to all of India with the exception of the state of Jammu and Kashmir.

Nature of Partnership

We know that a "partnership" exists when two or more people decide to run a company together with the intention of splitting the earnings equally, as we covered before. People working together as a "firm" are referred to as "partners" in a partnership. A similar concept applies when a company operates under a specific name; this is called the "firm name."

A partnership is not formed by social standing but rather by an agreement between two or more parties in writing. A Christian family running a company as a family is not considered a partner in such firm. The true relationship between the parties, as revealed by all relevant and relevant facts taken together, should be considered in deciding whether an individual is a partner in a business or not, or whether a collection of individuals constitutes a partnership.

The exception to this rule is the "particular partnership," in which two or more people work together on a specific project. The same holds true for "partnership at will": it denotes that the partners have not agreed upon a certain length of time for the relationship.

1) **Partnership Deed: A crucial legal document outlining:**
- Name & Nature of Business (e.g., Clinic, Hospital, Pharmacy).
- Capital Contribution, Profit/Loss Sharing Ratios.
- Duties, Rights, & Responsibilities of each Partner.
- Rules for new partners, dissolution, etc..

2) **Registration (Optional but Recommended):**

- File Form 1 with the Registrar of Firms (RoF) in your state.
- While not mandatory for existence, unregistered firms face limitations (e.g., can't sue third parties).

3) **Licenses & Compliance:**

- Drug License: Mandatory for pharmacies.
- Shop & Establishment Act License: For physical premises.
- Pharmacy Council Registration/CDSCO Norms: Specific to selling medicines.
-

Latest Trends & Considerations

Public-Private Partnerships (PPPs): Growing trend, with private entities collaborating with government (like NHM) for infrastructure, services (telemedicine), and training.

- Digital Health & Telemedicine: Integration of tech for wider reach, as seen in Ayushman Bharat initiatives.
- Mandatory Registration Push: Discussions ongoing to make partnership registration compulsory for better regulation and client trust.
- Focus on Quality & Access: Collaborations aim to improve healthcare infrastructure, preventive care, and workforce training.
-

In simple term for understanding the procedure

The hospital owner / partners should draft a Partnership Deed with a lawyer by finalizing terms and conditions of partnership and get Necessary IDs: PAN, Aadhaar, Address Proof for partners. And ensure for Registration (Optional) by filing all necessary documents and applications with Registrar of Firms (RoF) and obtain Business Licenses: Drug license, Shop & Est. license. Comply with Sector-Specific Rules: Drugs & Cosmetics Act. By following the 1932 Act framework and adhering to modern licensing & PPP models, you can form a healthcare partnership in India, with registration offering significant legal advantages.

Organizations under Corporate Basis (Private & Public)

Forming a healthcare organization involves distinct processes for private and public entities, primarily differing in funding sources, regulatory framework, and core objectives (profit vs. public welfare). Both operate under a corporate basis, but the specific legal structures and requirements vary significantly by country and type of entity.

Private Healthcare Organizations (Corporate Basis)

Private healthcare organizations are typically established as business enterprises (e.g., private limited companies, LLCs, or professional corporations) and aim for profitability.

- **Legal Structure:** The founders choose a business entity (e.g., C-corp, S-corp, LLC, or partnership) to limit personal liability. This requires registration with the appropriate government authorities, such as the Ministry of Corporate Affairs under companies act of 1956 and amended act of 2013 in India or the Secretary of State in the US.

- **Funding:** Capital is raised through private investment, business loans, or personal savings. A detailed business plan with financial projections is crucial for attracting investors or lenders.
- **Regulatory Compliance & Licensing**: Private entities must adhere to stringent healthcare regulations:

Obtain federal and state licenses to operate the medical facility. Ensure all medical professionals are licensed and registered with their respective councils (e.g., State Medical Councils like Medical Council of India , AP State Medical Council etc). Comply with specific healthcare laws like the Clinical Establishments Act, data protection regulations (e.g., HIPAA in the US), and biomedical waste management rules. Obtain various permits, including fire safety certificates, land use approvals, and pharmacy registration if applicable. Credential physicians and the organization with various payers (Medicare, Medicaid, private insurance companies) for reimbursement. The Objective and primary goal is to provide quality healthcare services while generating a return on investment for owners and shareholders.

Public Healthcare Organizations

Public healthcare organizations are government-funded and managed, focusing on providing accessible, often free or subsidized, healthcare to all citizens as a public welfare service.

- **Legal Structure:** These entities are established through legislative action and government mandate, rather than private incorporation. They are part of the government's administrative structure (e.g., national or state health departments).
- **Funding**: Funding comes primarily from taxes, government revenue, grants, and public expenditure.
- **Regulatory Compliance & Oversight:** They must adhere to government health policies, planning, and public audit procedures.

- **Compliance involves:** Operating within the national health policy framework and specific government programs. Undergoing regular government audits and performance evaluations. Ensuring services are universally accessible and address public health needs, such as preventive care and disease control.

- **Public-Private Partnerships (PPPs)**

India has a mixed economy in health services since its independence. Even though the health policies have emphasised on public delivery of services, the private sector has always existed and has grown in size and heterogeneity over the decades. The growth of the private sector was related to the underfunding of the public sector and both the sectors are not discreet. They have been interdependent on one another and there has been a history of collaborations. These collaborations became more formal with the advent of 'partnerships' in the 1990s.

PPPs gained greater legitimacy in the 1990s when multilateral organisations, bilateral organisations, pharmaceutical companies, American foundations and international non-governmental organisations partnered with global health institutions as well as governments across low-to-middle-income countries. Having said this, different forms of interactions and modes of collaboration between the public and private sectors health system capacity and sustainability, but there is a lack of conceptual clarity in the definition of PPPs .

In the health sector, the World Health Organization (WHO) describes partnership as a means to "bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles" (cited in Kickbusch and Quick 1998, p.69). In this definition, agreement on key principles is considered crucial, as well as maintaining a balance of power between the parties, to enable each to retain its core values and identities .

Public private partnerships (PPPs) have been one of the mainstays of health reforms in India and continues to be an integral part of the National Health Mission (NHM). The task force on PPP constituted in 2006 under National Rural Health Mission (NRM) had identified the role and responsibilities of the private partners and how they could be effective in implementation of different health services and programmes. It also reiterated the NRHM's framework of implementation, where the

role of NGOs was viewed as critical to the success of the Mission and made the distinction between non-profit NGO

A hybrid approach is the Public-Private Partnership (PPP), where the government collaborates with private entities to deliver healthcare services. In this model: The government typically sets the public health goals and regulatory framework. Private organizations contribute expertise, infrastructure, and potentially faster service delivery. Risks and rewards are allocated between the partners to meet defined public needs.

- **Objectives of PPPs :** The core mission is to serve the public interest, promote health equity, and ensure a basic standard of healthcare for the entire population, with profit being a secondary consideration, if at all.

The National Medical Commission (NMC) in India, replacing the MCI, is crucial for regulating medical education, professionals, and institutions to ensure high-quality, accessible healthcare, setting policies for standards, assessing healthcare needs, maintaining registers, and promoting ethics, ultimately aiming for a competent medical workforce for national health goals. Its significance lies in creating a transparent, effective system for medical standards, while its roles include policymaking, assessment, regulation, and acting as an appellate body, with duties focused on upholding ethics and ensuring equitable healthcare access.

Significance of the NMC

- Quality Assurance: Establishes high standards for medical education and practice.
- Accessibility: Aims to ensure availability of quality medical professionals across India.
- Transparency & Accountability: Provides a framework for periodic assessment and ethical enforcement.
- National Health Goals: Promotes a community health perspective to meet national health needs.

Roles and Duties of the NMC

- Policy Making: Lays down policies for medical education, institutions, research, and professionals.
- Regulation: Regulates medical institutions, research, and ethical conduct.

- Needs Assessment: Assesses healthcare infrastructure and human resource requirements.
- Coordination: Ensures coordination between the NMC, Autonomous Boards, and State Medical Councils (SMCs).
- Registration & Ethics: Maintains the National Medical Register (NMR), grants registration, and enforces ethical standards.
- Fee Regulation: Sets guidelines for fees in private medical colleges.
- Appellate Authority: Hears appeals against decisions of Autonomous Boards.
- Curriculum Development: Oversees competency-based medical education

Key Functions & Structures

- NMC is an Autonomous Boards: Works through boards like the Undergraduate Medical Education Board (UGMEB) and Postgraduate Medical Education Board (PGMEB). State Medical Councils (SMCs): Ensures SMCs function effectively and adhere to NMC guidelines.
- National Medical Register (NMR): A centralized, Aadhaar-linked database for all doctors. In essence, the NMC is the apex body for modern medicine in India, steering its growth, ensuring standards, and facilitating equitable access to healthcare services through regulation and policy.

Physician Patient Relationship:

According to sociologist William C. Cockerham, the traditional patient-physician relationship is hierarchical, where the physician (doctor) holds authority, provides instructions, and defines health/illness, while the patient follows advice, fulfilling the "sick role" (exempt from duties). This dynamic emphasizes the physician's power and knowledge, with patients often expected to be passive recipients of care, though modern views increasingly favor shared decision-making.

Key Aspects of Cockerham's Perspective:

- Hierarchy & Authority: Physicians manage the situation, display expertise, and guide treatment; patients are expected to comply.
- The "Sick Role": Patients are granted temporary exemption from normal responsibilities when legitimately ill, facilitated by the physician.
- Social Construction: Health and illness aren't just biological; they're defined by society, and physicians play a key role in this definition.

- Power Dynamics: Medicine, as a profession, has historically controlled its practice and defined social problems as medical ones, increasing physician power. Evolution Beyond Cockerham (Context):

While Cockerham highlights this traditional view, other models and views exist, including:
Mutual Participation Model: A more modern, collaborative approach where doctor and patient share decision-making, respecting each other's expertise (patient's life experience, physician's medical knowledge).
Trust as Foundational: Current emphasis on building trust through communication, empathy, competence, and shared responsibility, moving beyond purely technical interactions.
In essence, Cockerham's work provides the foundational sociological understanding of the traditional, expert-driven doctor-patient dynamic, which contrasts with newer models emphasizing shared power and partnership.

Medical and paramedical staff in India have duties to provide prompt, quality care, including accurate diagnosis, treatment, medication, monitoring vitals, personal care, and emotional support, while maintaining professionalism, confidentiality, hygiene, and respecting patient rights, ensuring continuous communication and proper documentation, all while striving for skill improvement and adhering to ethical standards like providing emergency care regardless of payment.

Key Duties of Medical Staff (Doctors, Specialists)

- Diagnosis & Treatment: Accurately assess, diagnose, and provide timely, evidence-based treatment.
- Information: Provide complete information about the patient's condition, treatment, and prognosis.
- Emergency Care: Provide immediate emergency care without demanding advance payment.
- Record Keeping: Maintain detailed case histories and records.
- Coordination: Brief colleagues and coordinate with other professionals for seamless care.

Key Duties of Paramedical Staff (Nurses, Technicians, Ward Boys, etc.)

- Direct Patient Care: Administer medications, dress wounds, assist with personal hygiene, mobility, and feeding.
- Monitoring: Continuously monitor vital signs and patient condition, reporting changes.
- Patient Education: Educate patients and families about conditions and care plans.
- Support Services: Prepare equipment, manage supplies, maintain cleanliness, and assist with investigations (ECG, X-Ray).
- Record Management: Maintain diet charts, drug registers, and other documentation.

General Professional Duties (Both Medical & Paramedical)

- Patient Rights: Treat patients with courtesy, respect, and dignity.
- Confidentiality: Uphold patient privacy.
- Professionalism: Maintain high standards of integrity, ethics, and conduct.
- Skill Development: Continuously update knowledge and skills.
- Teamwork: Collaborate effectively for holistic patient care.
- Hygiene: Ensure cleanliness and safe disposal of biomedical waste.
- Promptness: Attend to patients without undue delay.

Medical ethics in India, governed by the NMC (National Medical Commission), centers on service to humanity, patient welfare, dignity, confidentiality, and integrity, rooted in ancient Indian texts (like Charaka Samhita) and modern principles, with doctors taking a pledge (similar to Hippocratic ideals) to uphold these, prioritizing patient care, avoiding conflicts of interest, and adhering to specific conduct rules like transparency in fees and restrictions on industry endorsements, all enforced by the Medical Council.

Key Ethical Principles & Oaths

- Physician's Pledge: Doctors pledge to serve humanity, respect life from conception, maintain dignity, prioritize patient health, respect secrets, and uphold traditions, as outlined in the NMC regulations.
- Core Values: Beneficence (doing good), non-maleficence (do no harm), patient autonomy, and justice.
- Indian Roots: Draws from ancient texts like Charaka Samhita, emphasizing truth, duty, and respect for elders/teachers.

- Modern Influence: Blends with Hippocratic ideals, focusing on patient well-being and professional integrity.

Code of Conduct in India (NMC Regulations) Code of Medical Ethics Regulations, 2002 (AMENDED UPTO 8th OCTOBER 2016)

- Patient-Centric Care: Patient's health is paramount; practice with conscience and dignity, respecting autonomy.
- Professional Conduct: Maintain high standards, continuously improve skills, and share knowledge.
- Integrity & Transparency: Be honest, avoid conflicts (especially financial), announce fees upfront, and avoid "no cure, no payment" contracts.
- Restrictions: No endorsements of drugs/products, limits on accepting travel/hospitality from pharma, and restrictions on certain advertisements.
- Confidentiality: Respect patient secrets.
- Colleagues & Society: Respect colleagues, foster noble traditions, and use knowledge ethically (not against humanity).

Enforcement & Guidance

- Regulatory Body: The National Medical Commission (NMC) sets these rules applicable to all over the country .
- State Councils: Doctors must be registered with concerned State Medical Councils, which enforce these ethics.
- Legal Framework: Ethics codes operate alongside laws (like Cr. P.C / BNS/BNNS. for custody cases).

In India (2023 onwards), medical ethics are governed by the National Medical Commission (NMC) under the Registered Medical Practitioner (Professional Conduct) Regulations, 2023, replacing older rules, with key mandates including patient-centered care, strict confidentiality, informed consent, prohibition of pharma bribes/gifts, and new guidelines for social media; while the traditional Hippocratic Oath is referenced, the Physician's Pledge, based on the WMA Declaration of Geneva, serves as the core ethical commitment for new

doctors, emphasizing service to humanity, patient welfare above all, and upholding professional dignity.

Key Principles & Oaths

- Physician's Pledge (NMC Adopted): A solemn promise to serve humanity, respect life, maintain dignity, keep confidences, not discriminate, and prioritize patient health.
- Core Ethics: Patient welfare, compassion, integrity, confidentiality, competence, and respecting patient autonomy/rights are paramount.
- Charaka Shapath: While historically significant (from ancient Indian medicine), the NMC now officially adopts the Physician's Pledge.

Code of Conduct Highlights (NMC 2023 & Earlier Rules)

- Patient Care: Must provide compassionate, competent care, respect rights, ensure confidentiality, and never abandon patients in emergencies.
- Informed Consent: Mandatory written consent for procedures; specific rules for surgeries affecting sterility (requiring spousal consent).
- No Pharma Influence: Strict ban on accepting travel, gifts, hospitality, or commissions from pharma/industry representatives, with severe penalties.
- Social Media: Restrictions on sharing patient testimonials, images, or soliciting services online; focus on maintaining professional decorum.
- Integrity: Must maintain professional independence, disclose affiliations, and avoid conflicts of interest.
- Referrals: Should refer to specialists when needed, but avoid reciprocal referral arrangements (kickbacks).

Legal & Ethical Framework

- NMC Regulations: The 2023 Regulations (Registered Medical Practitioner (Professional Conduct) Regulations, 2023) update and consolidate ethical guidelines, enforced by the NMC.
- Patient Rights: Aligned with Constitutional rights (Right to Life/Dignity) and charters ensuring patient information and informed consent.

In essence, Indian medical ethics (2023) demand high standards of care, strict transparency, patient-focused practice, and zero tolerance for commercial exploitation, all guided by the Physician's Pledge.

Unit -2

HOSPITAL SERVICES AND LAW

Contractual obligations in hospital services are legally binding agreements governing relationships with payers (insurers), patients, staff, vendors, and partners, defining scope of care, payment terms (like agreed-upon rates, not balance bills), performance, data privacy (HIPAA), and compliance with laws (Stark, Anti-Kickback). These contracts ensure smooth operations by detailing everything from physician employment and equipment leases to patient consent and service level agreements (SLAs).

Key Types of Obligations

Payor Contracts (Insurers): Hospitals must provide agreed-upon services at set rates, adjust billed amounts to contract limits (Contractual Obligations/CO), and meet documentation standards.

Patient Contracts: Cover consent, risks, financial responsibility, and treatment plans, establishing the provider-patient relationship.

Staff & Physician Contracts: Define duties, compensation, benefits, and compliance with professional standards.

Vendor/Supplier Contracts: Govern IT services, equipment leases, medical supplies, and outsourced functions (billing, staffing).

Core Areas of Obligation

- Financial: Reimbursement rates, payment timelines, write-offs (COs), billing rules.
- Legal & Regulatory: Adherence to HIPAA (data privacy), Stark Law, Anti-Kickback Statute, False Claims Act.
- Operational: Service delivery standards, performance metrics, uptime guarantees, patient transfer protocols.
- Data Security: Protecting sensitive patient and business data.

Why They Matter ?

- Financial Health: To Ensure proper reimbursement and cost control.
- Compliance: To Avoid penalties for violating healthcare laws.

- Quality Care: To Standardize service delivery and patient safety.
- Risk Mitigation: To Manage risks through clear terms, dispute resolution, and termination clauses.

Requisites of a Valid Contract :

One of the most significant areas of business law is contracts. All industry relationships are shaped by contracts, which are ubiquitous. An agreement is created whenever a business hires a worker, a company purchases a product or service, or a patient seeks a healthcare provider. Contracts are structured promises. A patient commits to pay the doctor's reasonable price in exchange for the doctor using her best judgment in treating them. Beyond making promises, another way to see a contract is as a record of a relationship. The agreement outlines each party's obligations and rights. Contracts can typically be express (written or verbal), implied by fact (handshake), or implied by law. Both express and implied contracts are the product of an agreement between the contracting parties. This consensus of opinion is known as mutual assent. In an express contract, the parties formally agree to the terms of the agreement through written or verbal communication. A contract that is implied in reality is one where the actions of the parties and the environment indicate that they agree on the conditions. Voidable contracts allow one of the parties (but not the other) to escape the legal obligations of the contract. In an implied contract, the conduct of the parties and the surrounding circumstances show mutual assent to the terms. Contracts implied in law are recognized by the law on the basis of justice and equity but may not include the literal assent of both parties. These unique situations are referred to as contracts "implied in law," "quasi-contract," or "quantum meruit" (Perry & Thompson, 2017).

What is a contract?

Essentially, a contract is a legally enforceable promise. Typically, a contract is formed with two or more parties agreeing to something, and if one fails to uphold the agreement, that is considered a breach of contract. To be considered a legal contract, the following items must be present: mutual assent, consideration, legality, and capacity. The elements of a contract, whether written or verbal, include offer, consideration, and acceptance. An enforceable contract is legally binding. A breach of contract occurs when one or more of the terms of the contract are violated (Perry & Thompson, 2017).

Elements of a contract

For a contract to be legally enforceable when executed, several factors must be considered. The first is the competency of the parties. Certain classes of individuals (minors, prisoners, or mentally incompetent) are considered incompetent in a legal capacity to create a binding contract. Whether verbally or written, the following elements of a contract must exist: offer, consideration, and acceptance (Morgan, 2019).

A. Offers

An offer must be created with reasonable expectations where the offeror presents a commitment in exchange for one of the three following responses by the offeree:

1. does something (performs an act),
2. refrains from doing something (forbearance), or
3. promises to do something or to refrain from doing something.

A valid healthcare contract needs clear offer and acceptance, consideration (exchange of value like services for payment), competent parties (ability to understand), legal purpose, and free consent (no coercion). Key additions for healthcare involve ensuring informed consent, specific details on scope of care, confidentiality (HIPAA), and adherence to laws, making it a binding agreement for both provider and patient/organization.

Core Elements of Any Valid Contract

1. **Offer & Acceptance (Mutual Assent):** A clear proposal by one party (e.g., provider) and unequivocal agreement by the other (patient/insurer).
2. **Consideration:** Something of value exchanged, like medical services for payment or insurance premiums.
3. **Competent Parties (Legal Capacity):** Parties must be of sound mind, legal age, and understand the contract's terms.
4. **Lawful Purpose**: The contract's objective must be legal and not against public policy (e.g., illegal procedures).
5. **Free Consent:** Agreement must be voluntary, without fraud, duress, or undue influence.

Healthcare-Specific Requirements & Considerations

- **Informed Consent**: Patients must understand the risks, benefits, and alternatives of treatment, aligning with the "capacity" element.
- **Scope of Services:** Clearly define the medical care, treatments, and responsibilities.
- **Confidentiality & Privacy:** Must comply with laws like HIPAA, detailing data handling.
- **Payment & Terms:** Specifics on fees, insurance, billing, and termination clauses.
- **Legal Form**: May require writing or specific legal formalities for certain agreements (like clinical affiliations).

What Makes It Enforceable?

All core elements and healthcare-specific protections ensure the agreement is legally binding, creating specific rights and obligations for all involved, protecting both providers and patients.

Indian healthcare providers operate under a mix of general contract law (Indian Contract Act, 1872), specific sector laws like the Consumer Protection Act (COPRA), and specialized acts such as the MTP Act, PCPNDT Act, and Mental Healthcare Act, alongside agreements for insurance (Ayushman Bharat) and employment, all demanding clear, detailed service agreements covering roles, responsibilities, data privacy, and ethical standards.

Core Legal Frameworks

1. Indian Contract Act, 1872: Forms the foundation for all agreements (patient-provider, doctor-hospital, service contracts), ensuring lawful terms, consideration, and capacity to contract.
2. Consumer Protection Act (COPRA), 2019: Treats medical services as a "service," making providers liable for negligence or deficiency, applicable to private facilities where services are paid.
3. Indian Medical Council Act & National Medical Commission Act: Govern professional conduct and ethics, setting standards for care.

Specific Healthcare Laws

- Mental Healthcare Act, 2017: Regulates mental health services, patient rights, and confidentiality.
- Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994: Mandates registration, record-keeping, and prohibits sex determination.

- Medical Termination of Pregnancy (MTP) Act, 1971 (amended 2021): Governs abortion procedures, gestational limits, and required consents.
- Transplantation of Human Organs and Tissues Act (THOTA), 1994: Regulates organ donation and transplantation.

Contractual Liability and damages

Liability of health professionals underthe ContractAct1872 mainly depends on the express or implied terms agreed upon by the patient or his representatives and the doctor or hospital. Consentfor treatmenton payment of fees on the part of a patient can be treated as an implied contract with the doctor, who by undertaking treatment on acceptance of fees, promises to exercise proper care and skill. The Indian Contract Act, which came into force in 1872, contains detailed provisions with regard to offer, acceptance, proposal, vicarious liability etc. A detailed review and examination of the cases reveals that, though the provisions have a direct bearing on the services being provided by doctors and hospitals, it has very limited application to medical negligence.

Contractual liability for healthcare providers arises from the express or implied agreement to provide a service with reasonable care and skill. A breach of this duty can lead to claims for damages, which typically aim to compensate the patient for the loss or injury suffered.

Basis of Contractual Liability

The relationship between a healthcare provider and a patient is considered contractual in nature, even without a formal written contract.

- **Implied Contract:** When a patient seeks treatment and a doctor accepts them for a fee, an implied contract is formed where the doctor promises to use a proper degree of care and skill.
- **Express Contract:** Liability is broader if a doctor makes an explicit promise or guarantee of a specific result or a cure (which is rare), and then fails to achieve that outcome. In such cases, the patient does not need to prove negligence, only that the promised result was not achieved.
- **Healthcare Facilities:** Hospitals and clinics can also be held contractually liable for the services they provide, including the actions of their staff (vicarious liability).

Applicable Damages

When a breach of contract occurs, the injured party is entitled to receive reasonable compensation for the loss or damage caused. Damages in a medical contract case are designed to restore the patient to the financial position they would have been in had the breach not occurred.

Economic Damages: These cover direct financial losses that are a normal consequence of the breach.

- Additional medical bills and rehabilitation costs.
- Lost wages (past and future).
- Expenses for necessary aids, appliances, or travel.
- Loss of expected benefits (if explicitly part of the contract).

Non-Economic Damages: In some jurisdictions, damages for non-financial losses like pain and suffering or emotional distress may also be awarded, although this is more common under tort law (medical malpractice).

Key Differences from Tort Liability

While both contract law and tort law (medical malpractice) often apply to the same incident, there are differences in how they are pursued:

Feature	Contractual Liability	Tort Liability (Malpractice)
Basis of Claim	Breach of an agreement (express or implied duty of care).	Breach of a general legal duty of care imposed by law.
Burden of Proof	Plaintiff must show a contract existed and the obligation was unfulfilled.	Plaintiff must prove the provider was negligent (failed to meet the standard of care) and this negligence caused the harm.
Damages Scope	Typically limited to economic and direct losses.	Often covers a wider range of damages, including compensation for pain and suffering.
Statute of Limitations	Generally has a longer limitation period than tort claims.	Usually a shorter limitation period

In practice, patients in many legal systems (such as India, via the Consumer Protection Act) can pursue claims under either or both frameworks, allowing them to choose the route that offers the best remedy for their specific situation.

Criminal Liability and defenses to hospital staff and medical staff:

In India, the criminal liability of hospitals and medical staff arises from acts of gross medical negligence or recklessness under provisions of the Indian Penal Code (IPC) and the new Bharatiya Nyaya Sanhita (BNS). Key defenses include acting in good faith, providing a reasonable standard of care, and obtaining informed consent.

Criminal Liability

Medical professionals and hospitals can face criminal charges for negligence that goes beyond a mere error of judgment and demonstrates a high degree of culpability or a total disregard for the patient's safety.

- Indian Penal Code (IPC) / Bharatiya Nyaya Sanhita (BNS): The primary provisions under which liability is determined are:
- Section 304A IPC (or Section 106 BNS): Causing death by a rash or negligent act not amounting to culpable homicide. This is the most common section applied to cases of death due to gross medical negligence and carries a punishment of up to two years imprisonment and/or a fine.
- Section 337 IPC: Causing hurt by an act which endangers human life or personal safety.
- Section 338 IPC: Causing grievous hurt by an act which endangers human life or personal safety.
- Hospitals' Liability: Hospitals can be held directly liable for failing to provide a safe environment, malfunctioning equipment, or insufficient facilities. They can also be held vicariously liable for the negligent acts of their employees (doctors, nurses, etc.) committed in the course of their employment.

Defenses Available

Medical professionals and institutions have several legal defenses against criminal negligence charges, often guided by the principles established in the landmark Supreme Court case of Jacob Mathew v. State of Punjab.

- Adherence to a Reasonable Standard of Care: The key defense is that the medical professional acted in a manner considered acceptable by a responsible body of medical professionals skilled in that particular field (the modified Bolam test). A mere error of judgment or choosing one acceptable course of treatment over another is not negligence.
- Accident or Misfortune: Section 80 of the IPC provides a defense if the injury or death was caused by an accident or misfortune, done lawfully, with lawful means, and with proper care and caution, without any criminal intention or knowledge.
- Act Done in Good Faith with Consent: Section 88 of the IPC protects a medical professional from liability if the act was done in good faith for the patient's benefit, with their express or implied consent, and without the intention to cause harm, even if there was a known risk.
- Lack of Gross Negligence: Criminal liability requires a "gross" or "very high degree" of negligence or recklessness, not just simple carelessness that might attract civil liability. The prosecution must prove a "morally blameworthy" conduct.
- Procedural Safeguards: Based on the Jacob Mathew guidelines, a doctor should not be arrested routinely. Investigating officers must obtain a fair, objective, and credible opinion from another competent government doctor in the same field before initiating criminal action.
- Proper Documentation: Meticulous and accurate medical records are a doctor's strongest defense, while tampering with records can attract separate criminal charges.
- Informed Consent: Ensuring the patient (or their legal attendant) provides informed consent for procedures, including an understanding of the risks and complications involved, is a critical safeguard against liability claims.

Tortuous and vicarious Liability

In India, healthcare providers face both tortious (civil) and vicarious liability for medical negligence, which is primarily adjudicated under the Consumer Protection Act, 2019, the Law of Torts, and, in cases of gross negligence, the Indian Penal Code/BNS.

Tortious Liability

Tortious liability for medical negligence arises from a breach of a "duty of care" owed by a medical professional to their patient. This is a civil wrong for which the victim can claim monetary compensation.

The key elements a plaintiff (patient) must prove are:

- Duty of Care: A legal doctor-patient relationship existed, establishing a duty of care.
- Breach of Duty: The healthcare provider failed to meet the standard of care expected of an ordinary, reasonably competent professional in the same field (following the Bolam Test). The standard is neither the highest possible skill nor a very low degree of care.
- Causation: The breach of duty directly caused injury or damage to the patient.
- Damage: The patient suffered actual harm (physical, emotional, or financial) as a result.

In some cases, the doctrine of res ipsa loquitur (the thing speaks for itself) may apply (e.g., leaving a surgical instrument inside a patient), shifting the burden of proof to the doctor/hospital to demonstrate they were not negligent.

Vicarious Liability

Vicarious liability is the legal principle where one party is held responsible for the negligent actions of another due to a specific relationship between them, typically master-servant or employer-employee.

In the healthcare context:

- Hospitals are vicariously liable for the negligent acts of their employees (doctors, nurses, technicians, and other staff) committed during the course of their employment.
- This applies even if the hospital itself did not directly cause the harm, because the hospital benefits from the employees' services and exercises control over them.
- Courts have held that hospitals cannot escape liability by claiming a surgeon is an "independent contractor" if the hospital is the one providing the facilities and the public approaches the hospital based on its reputation.
- The State is also vicariously liable for the negligence of doctors and staff in government hospitals.

However, the hospital may not be held vicariously liable for the actions of consultants specifically selected and employed directly by the patient themselves.

Legal Recourse

Patients in India have several avenues for seeking redressal:

- Consumer Courts (most common): Medical services fall under the Consumer Protection Act, 2019, allowing patients (consumers) to seek compensation for "deficiency in service".
- Civil Courts: A civil suit based on the Law of Torts can be filed for damages.
- Criminal Courts: In cases of "gross" or "reckless" negligence, criminal proceedings can be initiated under the Indian Penal Code (e.g., Section 304A for causing death by negligence), which can result in imprisonment or fines for the individual practitioner.
- Medical Councils: Complaints can also be filed with the State Medical Council for disciplinary action, which may include suspension of the doctor's license.

Legal Remedies available to patients

Patients in India have several legal remedies available for grievances regarding hospital services, primarily through consumer courts, civil courts, criminal courts, and medical regulatory bodies. The most common recourse is under the Consumer Protection Act, 2019, which provides for compensation for "deficiency in service".

Key Legal Pathways for Redressal

- Consumer Courts (Consumer Disputes Redressal Commissions): This is often the preferred route as it is generally less expensive and faster than civil courts. Patients who pay for medical services (even partially or through insurance) are considered consumers.
- Jurisdiction tiers: Complaints are filed based on the value of the claim: District Commission (up to ₹50 lakh), State Commission (₹50 lakh to ₹2 crore), and National Commission (over ₹2 crore).
- Remedy: Compensation for loss, injury, and mental agony suffered due to negligence or deficiency in service.
- Civil Courts: A patient can file a civil suit for monetary damages under the Law of Torts.
- Remedy: Financial compensation (damages).

- Criminal Courts: In cases of gross negligence or recklessness resulting in serious harm or death, a criminal complaint can be filed with the local police under sections of the Indian Penal Code (IPC), such as Section 304A (causing death by negligence),

Section 337 (causing hurt by negligence), and Section 338 (causing grievous hurt by negligence).

- Remedy: Punishment (imprisonment and/or fine) for the guilty practitioner/hospital, not compensation for the patient.
- Medical Regulatory Bodies: Complaints about professional misconduct can be lodged with the State Medical Council or the National Medical Commission (NMC).
- Remedy: Disciplinary action against the doctor, such as suspension or cancellation of their license to practice. These bodies cannot award compensation.

- Constitutional Courts (High Court/Supreme Court): A writ petition can be filed under Article 226 or Article 32 of the Constitution of India, respectively, against a State or Government hospital if a fundamental right (such as the right to life under Article 21, which includes the right to emergency medical care) is violated.
- Remedy: The court can award compensation for the violation of constitutional rights.

Initial Steps for a Patient

- Gather Evidence: Collect all medical records, prescriptions, bills, and reports. Note that patients have a right to access these records.
- Get a Second Opinion: A second opinion from a competent doctor in the same field helps to validate the case for negligence.
- Lodge Internal Complaint: First, file a complaint with the Medical Superintendent (MS) or the internal grievance redressal mechanism of the hospital concerned.
- Send Legal Notice: If the hospital's response is unsatisfactory, a legal notice can be sent through an advocate.
- File Formal Complaint: Proceed to file a formal complaint in the appropriate forum (Consumer Court, Civil Court, or Medical Council).

Patients and their caregivers can also use the government's National Consumer Helpline portal to register grievances at a pre-litigation stage or the CPGRAMS portal for grievances against government organizations.

A hospital acts as a bailee (a temporary custodian) when a patient entrusts personal belongings (like jewelry) for safekeeping, creating a bailment relationship where the hospital (bailee) must exercise "reasonable care" (like a prudent person) for the goods, according to

Indian Contract Law. If the hospital fails to take this care and the items are lost or damaged (e.g., stolen from a locked room), it can be held liable for the loss, as seen in cases where jewelry given for safekeeping was stolen from the hospital's drug room.

Key Aspects of Hospital as a Bailee:

- Definition: Bailment (Sec 148) is the delivery of goods by one person (bailor/patient) to another (bailee/hospital) for a specific purpose (safekeeping) under a contract, with the understanding the goods will be returned.
- Duty of Care (Sec 151): The hospital must take the same care of the valuables as a person of ordinary prudence would take of their own goods of similar value, quality, and bulk.
- Liability: Failure to meet this standard of care, leading to loss, makes the hospital liable.

Examples:

- Giving jewelry to a nurse for safekeeping.
- Leaving valuables with hospital staff upon admission.
- Not Just Custody: This is different from mere custody (like a servant holding something), as bailment involves a specific purpose (safekeeping) and transfer of possession, not ownership.

In essence, when a hospital accepts your valuables for storage while you're a patient, it assumes the legal role of a bailee, responsible for their safe return.

Consumer Protection Act 2019

The Consumer Protection Act (CPA), especially the 2019 amendment, treats patients as consumers and healthcare services (paid for) as a service, enabling patients to file complaints against hospitals/doctors for negligence or "deficiency in service" (poor quality, lack of info, etc.). Key protections include rights to informed consent, explanation of bills, access to records, and speedy redressal via consumer forums (CICs, DCDRCs, NCDRC). The Act applies to private and government hospitals for paid services but excludes free charity care, focusing on fair practices and accountability for providers.

Key Aspects for Hospitals & Patients

- Applicability: Applies to paid medical services, including corporate and government hospitals, but not free care.
- "Deficiency in Service": Covers medical negligence, poor communication, inadequate consent, bad documentation, or substandard facilities/equipment.
- Patient Rights: Right to know the line of treatment, get itemized bills, explanations, and access medical records.
- Provider Duties: Must provide care with reasonable skill and care, obtain informed consent, and maintain clear records.

How Patients Can Seek Redressal

- File a Complaint: Can be done at District (DCDRC), State (SCDRC), or National (NCDRC) Consumer Disputes Redressal Commissions, depending on the service cost.
- Simple Process: CPA offers a simpler, faster, and cheaper alternative to civil suits, with provisions for e-filing and tele-hearings.
- Remedies: Can include compensation for damages, refund of fees, or correction of practices.
- What Constitutes Negligence Under CPA?
- Failure to get consent before procedures.
- Lack of transparency or disclosure of risks/side effects.
- Substandard treatment or use of defective equipment.
- Poor record-keeping or refusal to provide records.

In Essence the CPA empowers patients by holding healthcare providers accountable for service quality, transforming the doctor-patient relationship into a consumer-provider dynamic for paid services, ensuring rights and recourse against deficiencies.

RTI ACT 2005

The RTI Act 2005 empowers Indian patients to access their medical records and hospital information, as Central Information Commission (CIC) rulings mandate that hospitals (public and sometimes private) must provide details like diagnoses, treatments, doctor qualifications, and test results, upholding the patient's right to information and confidentiality under medical

ethics and law, though challenges with private hospitals persist, requiring applications to the hospital's PIO or State Information Commission for action on denied access.

How RTI Applies to Hospitals & Patients:

1. Right to Medical Records: Patients have a fundamental right to their complete medical records (treatment, tests, prescriptions, doctor details).
2. Hospital Obligations: Hospitals are obligated under MCI regulations and the RTI Act to maintain and provide these records.
3. Information Scope: You can seek details on diagnoses, treatments, doctor qualifications, hospital policies, disciplinary history, and registration status.
4. Enforcement: Decisions by CIC and State Information Commissions (SICs) confirm that even private hospitals fall under the RTI ambit for patient information.

Procedure to File an RTI for Hospital Information:

1. Write the Application: Draft a formal, written application in English or your local language.
2. Address to PIO/APIO: Send it to the Public Information Officer (PIO) or Assistant PIO (APIO) of the concerned hospital.
3. Specify Your Request: Clearly state you are seeking information under the RTI Act, requesting specific records (e.g., "My complete medical file from [Date] to [Date]").
4. Include Details: Provide your full name, address, contact info, patient ID, and dates of admission/treatment.
5. Follow Up: If no response within 30 days, file a First Appeal with the State Information Commission (SIC).

Why It's Important?

- Accountability: Holds hospitals and doctors accountable for care quality.
- Transparency: Ensures clarity on treatments and procedures.
- Legal Recourse: Provides evidence for malpractice or negligence claims.
- Key Takeaway: The RTI Act is a powerful tool for patients to access crucial healthcare information, ensuring transparency and rights within the healthcare system, even extending to private facilities.

Unit -3

HOSPITALS AND LABOUR ENACTMENTS

Hospitals are considered an "industry" under Indian labour law, particularly the Industrial Disputes Act, 1947, due to providing systematic material services (healthcare) with employee help, extending labour protections like compensation for termination, though legal interpretations have evolved via landmark cases like Hospital Mazdoor Sabha, solidifying their industrial status despite profit motive debates, making them subject to labour statutes for worker welfare.

Hospitals as an Industry in India

- Legal Recognition: Indian courts, notably the Supreme Court in cases like State of Bombay v. Hospital Mazdoor Sabha, classified hospitals (both public and private) as "industries".
- Reasoning: This classification is based on providing systematic services (healthcare) using employer-employee cooperation, akin to a trade, regardless of profit motive.
- Impact: This brings hospitals under the purview of labour laws, ensuring employees have rights regarding working conditions, dispute resolution, and retrenchment compensation.

Key Labour Laws & Enactments

- Industrial Disputes Act, 1947: Governs industrial relations, making hospitals subject to rules for closure procedures (like Section 25-O), layoffs, and compensation.
- Shops and Establishments Act: Applicable to hospitals, though sometimes requiring specific state notifications or amendments to cover medical establishments fully, as seen in Maharashtra.
- Other Laws: Hospitals must also comply with other labour laws like those related to minimum wages, gratuity, maternity benefits, and contract labour, depending on their structure and state regulations.

Evolution & Nuances

- Profit vs. Service: Early debates questioned if non-profit government hospitals were "industries," but the Hospital Mazdoor Sabha case established that systematic service provision itself defines an industry.

- Modern Healthcare: With the growth of large private hospital chains, the "industry" status is further cemented, falling under broader labour codes (like the 2020 Industrial Relations Code in India).

In essence, hospitals function as vital service industries, and this legal framework ensures labour rights for their substantial workforce.

Hospital unrest in India stems from issues like violence against healthcare workers, insurance claim disputes, and poor infrastructure. Various mechanisms exist for dispute settlement, including dedicated hospital supervisory bodies, alternative dispute resolution (ADR) methods like mediation and arbitration, and traditional courts.

Primary Causes of Unrest in Hospitals

Hospital unrest in India involves conflicts between various stakeholders, including patients, their families, doctors, hospital management, and insurance companies.

- Violence Against Healthcare Workers: This is a major issue, often fueled by staff shortages, overcrowded facilities, inadequate infrastructure, and a breakdown of public trust. Doctors and other staff have held nationwide strikes to protest unsafe working conditions and demand a central law for their protection.
- Insurance and Reimbursement Disputes: Conflicts between hospitals and health insurance companies frequently lead to the suspension of cashless services, leaving patients vulnerable and agitated. Hospitals cite delayed payments, insufficient package rates, and post-settlement deductions by insurers as core problems.
- Patient Grievances and Medical Negligence: Patients' rights awareness is increasing, leading to more complaints regarding deficiency in service, medical malpractice, overbilling, and communication gaps with doctors.
- Worker Protests: Internal issues, such as demands for regularisation of services and better working conditions by contractual staff, also lead to protests and disruption of services.

Dispute Settlement Mechanisms in India

India employs a multi-pronged approach to resolve these disputes, ranging from specialized bodies to formal legal avenues.

- Hospital Supervisory Boards (BPRS): Mandated by the Law No. 44 of 2009 on Hospitals, Provincial Hospital Supervisory Boards (BPRS) are tasked with receiving complaints and mediating dispute resolutions between patients/aggrieved parties and hospitals. Their decisions are often recommendatory and submitted to the Governor or the Provincial Health Office.
- Alternative Dispute Resolution (ADR): ADR mechanisms are increasingly encouraged to provide faster, more cost-effective, and amicable solutions compared to traditional litigation.
- Mediation and conciliation aim for win-win solutions through a neutral third party.
- Arbitration involves a third party making a binding decision (an 'Award').
- Lok Adalats (People's Courts) offer a grassroots-level, cost-free option, especially for public utility services like hospitals, and can handle medical negligence claims.
- Internal Grievance Redressal Systems: Hospitals and clinical establishments are mandated to set up internal mechanisms to handle patient and staff complaints and aim for time-bound resolution.

Legal and Judicial Channels:

- Consumer Courts allow patients to sue doctors and hospitals under the Consumer Protection Act for deficiency in service, with potential for significant compensation.
- Professional Bodies like the National Medical Commission (NMC) (formerly MCI) can handle complaints regarding professional misconduct and potentially suspend a doctor's license.
- Criminal Courts can be approached if the grievance involves a criminal offense (e.g., violence, gross negligence) under the Indian Penal Code.
- Civil Courts handle breach of contract cases and other tortious claims not covered by other specific mechanisms.

Role of Trade Unions

In India, hospital trade unions advocate for healthcare workers (doctors, nurses, staff) by ensuring better pay, job security, and working conditions through collective bargaining, fighting wrongful termination, securing social benefits (PF, Gratuity), promoting health & safety, influencing policy, and resolving disputes, thereby striving for industrial peace and

social justice for vulnerable health staff. They act as a unified voice, protecting employees from arbitrary management actions and bridging gaps in labor law implementation.

Key Roles of Hospital Trade Unions:

- Collective Bargaining: Negotiate with hospital management for fair wages, better service conditions, bonuses, and permanent employment for daily wage/contract workers.
- Job Security & Protection: Fight unfair retrenchments, wrongful terminations, and victimization by management, ensuring permanency for temporary staff.
- Welfare & Social Security: Secure benefits like Provident Fund (PF), Gratuity, healthcare access, and education for workers' families, promoting overall well-being.
- Workplace Safety & Health: Advocate for safe environments, protective gear, and health support, especially crucial during crises like pandemics.
- Dispute Resolution: Represent members in labor courts, tribunals, and handle internal grievances to maintain industrial harmony.
- Policy Advocacy: Influence health sector policies and labor laws at local, state, and national levels to protect worker rights.
- Empowerment & Training: Educate members on their rights and provide training to improve skills, benefiting both workers and the healthcare system.
- Democratization: Work towards more democratic workplaces where workers' skills and labor are fairly compensated, ultimately benefiting patient care.

Impact:

- For Workers: Improved livelihoods, rights, dignity, and a strong support system against powerful employers.
- For Hospitals/System: Can help create stable, motivated workforces, reduce disputes, and ensure better service delivery, although sometimes seen as disrupting management.
- For Patients/Society: A well-treated, motivated workforce leads to better healthcare outcomes, serving the community at large.

In essence, Indian hospital unions bridge the power gap, ensuring that healthcare workers, often facing precarious employment, receive fair treatment, security, and recognition.

Unfair labour practices (ULPs) and victimization in Indian hospitals involve denying union rights, discrimination (wage gaps, promotions), retaliation (dismissals, transfers) for activism, poor wages/conditions, ignoring natural justice, and false accusations, often seen in lack of implementation of laws like the ID Act, with victimization meaning punishing workers for union/grievance actions, all leading to exploitation despite existing legal frameworks.

Common Unfair Labour Practices (ULPs) in Hospitals

- Discrimination & Unequal Treatment: Paying less, denying promotions/training based on gender, caste, or union activity.
- Refusal to Bargain: Not negotiating in good faith with unions or denying collective bargaining.
- Interference with Unions: Banning union formation, supporting rival unions, coercing membership.
- Retaliation/Victimization: Dismissing, demoting, or harassing workers for union involvement.
- Poor Conditions: Long hours, low wages, inadequate facilities, especially for women.
- Ignoring Due Process: Dismissals without fair hearings, false implications

What is Victimization?

It's when an employer subjects a worker to detriment (harm/punishment) for lawful union activities or complaints, like unjust firing after a grievance.

Why It Happens in Hospitals

- Profit Motive: Cost-cutting often targets wages and benefits.
- Power Imbalance: Healthcare is a high-pressure sector with many temporary/contract workers, making them vulnerable.
- Weak Enforcement: Laws exist (ID Act, Prevention of ULPs Act), but implementation is poor.
- Legal Framework in India
- Industrial Disputes Act, 1947 (ID Act): Lists specific employer and union ULPs (like unfair dismissals, coercion).
- Prevention of Unfair Labour Practices Act, 1971: Aims to prevent these actions by defining them.

Impact

- Disrupts industrial peace, lowers morale, reduces productivity, and harms workers' livelihoods.

Solutions Needed

- Stronger enforcement of labour laws, better grievance redressal, and greater accountability for employers.

Disciplinary Actions , Requisitions of a valid disciplinary enquiry :

In India, disciplinary actions in hospitals, whether government or private, are governed by a combination of labor laws (like the Industrial Disputes Act, 1947, and relevant state-level Shops and Establishments Acts) and specific service rules or standing orders of the institution, all while adhering to the fundamental principles of natural justice.

Disciplinary actions against registered medical practitioners are also subject to the professional ethics and misconduct regulations of the National Medical Commission (NMC) and the relevant State Medical Councils.

Key Requisites of a Valid Disciplinary Enquiry

A valid disciplinary enquiry in an Indian hospital must follow a fair and impartial procedure to withstand legal scrutiny. The essential requisites, primarily based on principles of natural justice, are:

- Clear Information of Charges: The employee must be informed clearly, in writing, of the specific charges and allegations of misconduct against them. A formal charge sheet should include the date, time, place of occurrence, and a description of the alleged misconduct.
- Opportunity to be Heard (Audi Alteram Partem): The employee must be given a fair and reasonable opportunity to present their defense, which includes:
- Sufficient time to submit a written explanation to the charge sheet.
- The right to inspect relevant documents and records relied upon by the management to support the charges.
- T he right to cross-examine management witnesses.
- The right to present their own witnesses and evidence in their defense.
- **Impartial Inquiry Officer (Nemo Judex in Causa Sua):** The inquiry must be conducted by an impartial and unbiased officer or committee. The person who is the

complainant, a witness, or has a personal interest in the case should not be the Inquiry Officer.

- Presence During Proceedings: The inquiry should be conducted in the presence of the employee (or their defense assistant/representative, if permitted by rules).
- Evidence-Based Findings: The inquiry officer's findings must be based solely on the evidence and materials presented during the inquiry, not on external information or hearsay.
- Reasoned Report: The Inquiry Officer must record their findings on each charge, along with the reasons for their conclusions, in a report submitted to the Disciplinary Authority.
- Disciplinary Authority's Decision: The Disciplinary Authority, after considering the inquiry report and the employee's representation on it, decides the appropriate penalty. The punishment must be proportionate to the gravity of the misconduct.
- Communication of Final Order: The final order of punishment must be communicated in writing to the employee, outlining the reasons for the decision.
- Right to Appeal/Review: The employee generally has a right to appeal the disciplinary authority's decision, either internally within the hospital structure or to external judicial forums like Labour Courts or Administrative Tribunals.

Disciplinary Actions

Disciplinary actions vary based on the severity of the misconduct, which can range from minor infractions to gross misconduct. Examples include:

- Minor Actions: Verbal or written warnings, fine, or withholding of salary/privileges for a limited period.
- Major Actions: Suspension (with subsistence allowance paid during the inquiry period), reduction in rank, demotion, removal from service, or dismissal.
- Professional Misconduct (for Doctors): The State Medical Council/NMC can censure the practitioner, order a public apology, temporarily suspend their license to practice, or permanently remove their name from the medical register.
- Criminal/Civil Liability: Separate from internal disciplinary action, a doctor or staff member may face civil liability (under the Consumer Protection Act, 2019) or criminal prosecution (under the Indian Penal Code) for gross negligence, fraud, or other criminal acts.

In India, service conditions and retiral benefits for hospital employees vary significantly depending on whether the hospital is government-run (Central or State), a Public Sector Undertaking (PSU), or a private institution. Statutory benefits like the Employees' Provident Fund (EPF) and gratuity are mandatory, while access to specific medical schemes depends on the employer type.

Service Conditions

- Service conditions in hospitals generally adhere to relevant labour laws and employer-specific policies.
- Statutory Compliance: Hospitals must comply with the Employees' State Insurance (ESI) Act, 1948 and the Employees' Provident Funds and Miscellaneous Provisions Act, 1952 for eligible employees.
- Working Hours & Leave: Conditions regarding working hours, paid leave, and national holidays are defined by the Shops and Establishments Act of the respective state and internal hospital policies.
- Voluntary Retirement Scheme (VRS): Some employers may offer VRS schemes, providing financial incentives for early retirement, subject to specific conditions.
- Assured Career Progression: Government and some PSU hospitals may have schemes for career progression.

Retiral Benefits

Retiral benefits typically include financial and medical provisions after superannuation.

Financial Benefits

- Pension:
- Government Hospitals: Employees may be covered by the Central Civil Services (Pension) Rules or the National Pension System (NPS), depending on their joining date. A minimum of 10 years of qualifying service is typically required for a full pension.
- Private/PSU Hospitals: Employees often receive pension benefits through the Employees' Pension Scheme (EPS), funded by the employer's contribution to the EPF, or a specific superannuation fund managed by a trust.

- Provident Fund (PF): Mandatory contributions are made by both the employee and employer to the EPF or General Provident Fund (GPF) (for some government employees), which can be withdrawn at retirement.
- Gratuity: A lump-sum payment is provided to employees with at least **five years of** continuous service. The amount is calculated based on the last drawn basic pay plus Dearness Allowance for each completed year of service.
- Leave Encashment: Payment for accumulated unutilised leave is often provided at the time of retirement.

Medical Benefits

- Central Government Health Scheme (CGHS): Retirees from Central Government hospitals are eligible for lifelong medical facilities under CGHS by registering at a dispensary and making an annual contribution.
- Employees' State Insurance Corporation (ESIC): Insured persons (IPs) who retire after at least five years in insurable employment can receive continued medical benefits for themselves and their spouse for a nominal annual payment.
- Employer-specific Schemes: Many large PSUs and some private hospitals offer their own Post-Retirement Medical Benefit Schemes (PRMBS) or health insurance plans to retired employees and their dependents, often managed by a dedicated trust or through tie-ups with specific hospitals.
- Fixed Medical Allowance: Pensioners residing in areas not covered by a specific scheme (like CGHS) may receive a monthly medical allowance.

The specific terms are generally outlined in the employee's contract and the hospital's official policy documents.

Social Security and Insurance :

In India, social security for health involves government schemes like ESI (Employees' State Insurance) for organized workers, offering medical care via ESIC hospitals/dispensaries and tie-ups, plus large schemes like Ayushman Bharat PM-JAY for vulnerable families, while private insurance also uses extensive hospital networks (PPN) for cashless treatment, all under evolving frameworks like the Code on Social Security, 2020.

Key Social Security & Health Insurance Systems

1. Employees' State Insurance (ESI):
    - Who it's for: Employees in organized sectors earning below a certain wage.

- Benefits: Medical care (cashless at ESIC facilities/empanelled hospitals), maternity, disability, and survivor benefits.
- How it works: Contributions from employers and employees fund the scheme, managed by ESIC (Employees' State Insurance Corporation).
- Hospitals: ESIC runs its own hospitals and dispensaries, and ties up with private hospitals.

2. Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PM-JAY):

- Who it's for: Over 12 crore poor and vulnerable families (around 55 crore people).
- Benefits: Rs. 5 lakhs per family per year for secondary & tertiary hospitalization.
- How it works: Largest government health assurance scheme, covering beneficiaries through empaneled public and private hospitals.

Other Key Aspects

- Code on Social Security, 2020: Aims to consolidate laws for comprehensive protection, including health, for all workers (organized, unorganized, gig).
- Private Health Insurance: Policies from insurers like Oriental Insurance, New India Assurance, etc., use Preferred Provider Networks (PPN) for cashless hospital access, with continuous empanelment processes.
- Finding Hospitals
- ESIC: Check the ESIC website for lists of their hospitals, dispensaries, and tie-up providers by state/district.
- PM-JAY: Find empaneled hospitals via the National Health Authority website or related portals.

Private Insurance: Use insurer websites or platforms like PolicyX.com to find cashless network hospitals by insurer, city, or pin code.

Unit-4

LEGAL FRME WORK

India's hospital legal framework balances provider duties (safety, info, consent) with patient rights (dignity, privacy, informed choice, redressal) under laws like the Clinical Establishments Act and constitutional mandates (Art. 21), requiring transparency, proper consent, and ethical care, while patients must provide info, follow advice, and behave responsibly, ensuring a two-way street for quality healthcare. The Universal Declaration of Human Rights (1948) emphasizes the fundamental dignity and equality of all human beings. Based on this concept, the notion of Patient Rights has been developed across the globe in the last few decades. There is a growing consensus at international level that all patients must enjoy certain basic rights. In other words, the patient is entitled to certain amount of protection to be ensured by physicians, healthcare providers and the State, which have been codified in various societies and countries in the form of Charters of Patient's Rights. In India, there are various legal provisions related to Patient's Rights which are scattered across different legal documents e.g. The Constitution of India, Article 21, Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002; The Consumer Protection Act 1986 and amended act of 2019; Drugs and Cosmetic Act 1940, Clinical Establishment Act 2010 and rules and standards framed therein; various judgments given by Hon'ble Supreme Court of India and decisions of the National Consumer Disputes Redressal Commission.

Legal Framework for Hospitals & Providers

- Constitutional Basis: Article 21 (Right to Life & Liberty) implies a right to health, making states responsible for providing medical facilities (Paschim Banga Khet Mazdoor case).
- Clinical Establishments Act (2010): Regulates healthcare providers, setting standards for registration, regulation, and quality of services.
- Medical Council of India (MCI) Code: Mandates ethics, transparency, and patient-centric care, including access to records.
- National Patient Safety Framework: Guides improvements in patient safety, addressing workforce, infections, and reporting.

- Consent Laws: Emphasis on "prior informed consent" for treatments and research, barring emergencies.

Patient Rights in India

- Right to Health & Dignity: Access to standard care, respect, privacy, confidentiality, and freedom from discrimination.
- Right to Information: Full info on diagnosis, treatment, costs, and outcomes; right to medical records.
- Informed Decision-Making: Right to agree or refuse treatment, seek second opinions, and know consequences.
- Safety & Environment: A safe, clean hospital environment.
- Grievance Redressal: Right to complain and receive timely, written responses

Patient Responsibilities in India

- Provide Accurate Informaton: Full disclosure of health history.
- Cooperate: Follow doctor's advice, attend appointments, maintain hospital cleanliness.
- Respect Staff: Dignity of doctors/staff; avoid violence or property damage.
- Follow Rules: Adhere to hospital protocols.
- Accountability: Take responsibility for decisions, especially refusing treatment.

The framework is designed for a partnership where hospitals must provide ethical, safe, and transparent care, and patients must actively participate by being truthful and cooperative, creating a system focused on quality, safety, and mutual respect.

Medical Malpractices

Medical negligence in India is defined as the failure of a medical professional to provide the reasonable standard of care expected, which causes harm to the patient. It is a dual liability, addressed through both civil remedies, such as consumer complaints and tort claims for compensation, and criminal charges under the Indian Penal Code, particularly in cases involving death due to gross negligence. Key legal principles include the Bolam Rule (a doctor is not negligent if they act in accordance with a responsible body of medical opinion) and the need for expert opinion to prove fault.

Civil liability

- Consumer Protection Act: Patients can file complaints for compensation for deficiency in service, heard in District, State, or National Commissions based on the claim value.
- Tort Law: Lawsuits for damages can be filed based on the principles of negligence under tort law.
- Remedies: Compensation for loss of life, financial loss, or physical/mental suffering is the primary goal.

Criminal liability

- Indian Penal Code (IPC): Cases can be prosecuted under sections such as 304A (causing death by a rash or negligent act), 337 (causing hurt by a rash or negligent act), or 338 (causing grievous hurt).
- Standard of Proof: Criminal charges require a higher degree of negligence, typically known as "gross negligence".
- Consequences: Punishment can include imprisonment, fines, or both.

Key legal principles

- Standard of Care: A doctor is liable if they lacked the necessary skill or did not exercise the reasonable competence they possessed in a given situation.
- Bolam Rule: A doctor is not considered negligent if their actions or omissions are in accordance with a body of medical opinion that is responsible and respectable.
- Expert Opinion: Expert opinion is crucial for establishing whether a doctor's actions fell below the accepted medical standard of care.

Important considerations

- **Documentation: Thorough and clear documentation is essential for both medical professionals to defend themselves and for patients to prove negligence.**
- **Emergency Treatment: In emergencies, consent is often considered implicit, and a failure to provide necessary immediate treatment can be grounds for negligence.**

- **Distinguishing Civil and Criminal: Civil claims focus on compensation, while criminal proceedings focus on punishing the guilty party.**

Medico Legal Aspects

Medico-legal aspects refer to the intersection of medicine and the law, encompassing legal issues in healthcare like malpractice, consent, confidentiality, and record-keeping. They also include the documentation and examination of cases with legal implications, such as injuries from accidents, assaults, or suspected crimes, which require a medical opinion to determine responsibility. A key example is the medico-legal certificate (MLC), a report needed for patients involved in incidents that have legal implications.

Key areas of medico-legal aspects

- Medical negligence and malpractice: Issues that arise from a healthcare provider's failure to meet the expected standard of skill and care, which can lead to legal consequences.
- Informed consent: The legal requirement for patients to give permission for treatment after understanding the possible outcomes, alternatives, and risks involved.
- Patient confidentiality: The legal duty to keep patient information private, with specific exceptions for when the practitioner is required to provide evidence in court.
- Medical records: The legal importance of maintaining accurate, complete, and confidential medical records, as they are vital legal documents.
- Forensic medicine: A field that uses medical knowledge for legal purposes, such **as** determining the cause of death in suspicious cases or identifying injuries.

Medico-legal cases (MLCs)

- A medico-legal case is any medical case with legal implications. The attending doctor determines if a case is medico-legal based on the patient's history and clinical examination, and if it requires investigation by law enforcement.

Examples of MLCs:

- Injuries from accidents (vehicular, industrial, etc.) or assault
- Suspected suicide or homicide (including attempts)
- Suspected poisoning or intoxication
- Sexual assault

- Unnatural deaths
- Cases referred by courts or police for age determination
- Burns, electrical, or chemical injuries

Medico-legal certificates (MLCs)

- A medico-legal certificate is a medical record required by law for cases involving incidents like suspicious suicide attempts, trauma, or assaults.
- 7The report includes all facts observed by the medical practitioner and the opinion drawn from them, which must be based on the observations themselves, not hearsay.

Medico Legal aspects of ; Impotence

The medico-legal aspects of impotence, or erectile dysfunction, primarily involve civil and criminal law cases where a person's ability to perform sexual intercourse has legal consequences. Impotence must be distinguished from sterility, as the former is the inability to copulate, while the latter is the inability to procreate; legally, only the inability to copulate (impotence) is generally considered for certain actions like annulment of marriage.

Civil Cases

Impotence is a significant factor in several civil law matters:

- Nullity of Marriage and Divorce: Permanent, incurable impotence existing at the time of marriage is often a valid ground for an annulment, as the law presumes marriage consummation. If it causes mental cruelty, it may be grounds for divorce.
- Disputed Paternity and Legitimacy: A man may claim he is not the father of a child because he is impotent or sterile, requiring medical evaluation and proof.
- Suit for Adoption: Impotence might be raised as a defense in adoption cases.
- Claims for Damages/Compensation: A person may seek increased financial compensation for an injury or accident that has caused the loss of sexual function.

Criminal Cases

Impotence can also become relevant in criminal proceedings:

- Rape and Sexual Assault: An accused individual may plead impotence as a defense, claiming they were physically incapable of committing the offense. However, medical

evidence shows that even impotent individuals can sometimes commit rape, and the defense is often a tactic by lawyers.

- Adultery and Unnatural Sexual Offences: Impotence may be introduced as evidence or a defense in cases involving these offenses.
- Medico-Legal Examination and Opinion
- Medical professionals are frequently called upon by courts or police to examine individuals for potency.

Key aspects of the medical evaluation include:

- Informed Consent: A written informed consent is mandatory before any examination is conducted.
- Detailed History: A thorough history is taken, covering past illnesses, nervous and mental conditions, and sexual history.
- Physical and Psychological Examination: A general and systemic examination (including the genital organs) is performed, alongside a psychological assessment, as many cases of impotence are psychogenic.
- Special Investigations: Tests such as Duplex USG, hormonal profiling, and nocturnal penile tumescence monitoring (NPT) may be used to differentiate between organic and psychological causes.
- Formulating an Opinion: Due to the complexity and potential for psychological factors (e.g., impotence quod hanc - impotent with one partner but not another), doctors often provide a "double negative" opinion for male potency: "from the examination, there is nothing to suggest that the person is incapable of performing a sexual act".
- Medical Boards: For criminal cases, it is often recommended that a medical board composed of experts (urologist, psychiatrist, general surgeon, etc.) conducts the assessment.

Medico Legal aspects: Sterility

The medico-legal aspects of sterility, the inability to procreate, primarily involve civil law matters, as it does not affect the ability to engage in sexual intercourse (potency). Unlike impotence, which can be grounds for annulment, sterility alone is generally not a ground for

divorce in most jurisdictions, though it may be considered cruelty if accompanied by other factors.

Key Legal Implications

Civil Cases

- Disputed Paternity/Maternity: Sterility is a crucial plea in cases where a man denies the paternity of a child, claiming he is incapable of fathering one. Medical evidence, such as semen analysis showing azoospermia (absence of sperm), is used to support such a claim.
- Compensation Claims: Individuals who lose their reproductive capability due to an injury, accident, occupational exposure (e.g., to X-rays or certain chemicals), or surgical negligence may sue for significant financial compensation.
- Adoption Cases: A couple's sterility may be a factor considered by courts in adoption proceedings.
- Artificial Insemination and Surrogacy: The rise of assisted reproductive techniques (ART) due to sterility has created complex legal issues surrounding:

✓ Consent: Proper written consent from all parties (husband, wife, and donor/surrogate, and the donor's wife if applicable) is essential.

✓ Legitimacy and Inheritance: The legal status and inheritance rights of children born through artificial insemination by donor (AID) are subjects of legal debate.

✓ Doctor's Role and Liability: Doctors face potential litigation for negligence (e.g., using a donor with a hereditary disease).

Criminal Cases

Sterility has less relevance in criminal law than impotence, as a sterile person is physically capable of sexual acts. However, it may occasionally be raised in cases of:

- Adultery: While a sterile person can commit adultery, a husband's failure of a vasectomy might lead him to suspect his wife of adultery, initiating legal action.
- Suppositious Child: It may be relevant in cases where a sterile woman is accused of presenting a 'suppositious child' (a fake child) to claim property.

Medico-Legal Aspects of Sterilization

Sterilization (surgical procedure to induce sterility) has specific medico-legal considerations, primarily concerning consent and potential negligence:

- Voluntary Sterilization: This is the most common form, performed for contraceptive, therapeutic (to prevent a life-threatening pregnancy), or eugenic reasons (to prevent transmission of hereditary defects).
- Informed Consent: Obtaining informed, written consent from the person undergoing the procedure is paramount. Consent should be voluntary and clearly explain the permanent nature of the procedure and the small risk of failure. Spousal consent is often recommended but may not be a legal requirement in all regions.
- Medical Negligence and 'Wrongful Birth' Claims:
- Doctors can be sued if a sterilization operation fails and results in an unwanted pregnancy, especially if the patient was not adequately informed of the failure rate.

- Proper documentation of the surgical procedure and counseling is essential for the doctor's defense in malpractice lawsuits.
- Compulsory Sterilization: This is largely illegal in modern democratic countries like India, though it has historical precedent in some regions for specific cases (e.g., institutionalized mentally ill individuals). Laws like the Rights of Persons with Disabilities Act, 2016 in India specifically prohibit medical procedures leading to infertility without the individual's free and informed consent.

Medical Examination

Medico-legal examination for sterility involves:

- Obtaining informed consent.
- Taking a detailed medical and sexual history.
- In males, examining the seminal fluid for sperm count and motility.
- In females, examining the reproductive organs, hormone levels, and the patency of Fallopian tubes.
- Providing an expert opinion to the court based on clinical and laboratory findings.

Artificial Insemination (AI)

The medico-legal aspects of artificial insemination (AI) are primarily governed by the Assisted Reproductive Technology (Regulation) Act, 2021 (ART Act) and the ART Rules, 2022 in India. These laws provide a robust framework to address the complex legal, ethical, and social issues arising from the use of AI.

Key Medico-Legal Aspects

1. Regulation and Licensing of Clinics and Banks

The ART Act mandates that all ART clinics and banks must be registered with the National Registry of Banks and Clinics of India. This ensures standardized practices and prevents the operation of unlicensed facilities, with significant penalties for violations.

2. Informed Consent

Written informed consent from all parties involved (recipient couple or woman, and the donor) is a cornerstone of the legal framework. The consent process must be thorough, covering potential risks, the permanent nature of the donor's rights relinquishment, and financial implications, with proper counseling provided.

3. Donor Anonymity and Rights

Anonymity: The identity of the sperm donor must remain confidential and is not disclosed to the recipient parents or the child, except in cases of life-threatening medical conditions and with the donor's explicit consent.

No Parental Rights: Donors legally relinquish all parental rights and responsibilities over any child born from their gametes.

Donor Screening: Donors must undergo rigorous medical and genetic screening for communicable and hereditary diseases (e.g., HIV, Hepatitis B/C, syphilis). Donated sperm is often quarantined for a period (e.g., three months or more) and the donor re-tested to rule out infections.

Single Recipient Rule: Gametes from a single donor cannot be used for more than one commissioning couple or woman to prevent accidental consanguinity (incestuous relationships) between offspring later in life.

- No Commercial Transaction: The commercial sale or purchase of gametes is prohibited. Donors may receive compensation for expenses and time, but not for the gametes themselves.

4 Legal Status and Rights of the Child

- A child born through ART (including AI) is considered the biological and legitimate child of the commissioning parents and is entitled to all the rights and privileges of a naturally conceived child. The birth certificate records the names of the commissioning parents, not the donor.

5. Adultery and Divorce

Under Indian law, artificial insemination, even with a donor's sperm (AID), does not amount to adultery because it lacks the element of physical sexual intercourse. However, if a wife undergoes AID without her husband's consent, it could potentially be a ground for divorce on the basis of cruelty.

6. Prohibited Practices

- Sex Selection: Sex-selective ART procedures are strictly prohibited under the ART Act and the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, to prevent female foeticide.
- Use of Relatives as Donors: The use of sperm from a relative or friend is generally not permitted; gametes must be obtained from an anonymous source through a registered ART bank.
- Human Cloning/Research: The law prohibits research involving human embryos without proper institutional ethical committee approval and bans practices like transferring a human embryo into a male or an animal body.

Medico-Legal Risks for Physicians and Clinics

Doctors and clinics face potential legal liability for negligence in cases such as:

- Failure to perform mandatory screening, leading to the transmission of disease.
- Mixing up semen samples.
- Failure of the procedure if due to negligence.
- Improper record-keeping or breach of confidentiality.

Adherence to the Assisted Reproductive Technology (Regulation) Act, 2021 is crucial for all practitioners in India to avoid significant penalties, including fines and imprisonment.

Medico-legal aspects of Psychiatric and Mental health

The medico-legal aspects of psychiatric and mental health are primarily governed by the Mental Healthcare Act, 2017 (MHCA) in India, which adopts a rights-based approach, emphasizing patient autonomy and dignity. These aspects span both civil and criminal law and impose specific duties and liabilities on medical professionals

Key Legislative Framework

The MHCA, 2017 replaced the outdated Indian Lunacy Act, 1912 and the Mental Health Act, 1987. Key provisions include:

- Rights-Based Approach: The Act focuses on the rights of persons with mental illness (PMI) at par with the fundamental human rights, including the right to access mental healthcare, live in the community, and be protected from cruel or degrading treatment.
- Decriminalization of Suicide: A person who attempts suicide is presumed to be suffering from severe stress and is not to be punished under Section 309 of the Indian Penal Code. The government has a duty to provide care, treatment, and rehabilitation.
- Informed Consent: The Act mandates informed consent for all mental health treatments. It presumes that all PMI have the capacity to make their own decisions unless proven otherwise. If a person lacks capacity, a "nominated representative" makes decisions on their behalf, considering their past wishes and best interests.

Prohibited Procedures: The Act bans electro-convulsive therapy (ECT) without anesthesia and muscle relaxants, ECT for minors, sterilization for the purpose of treating mental illness, and chaining or solitary confinement.

Civil Law Aspects

Mental illness has significant implications in civil legal matters, where the concept of mental capacity is crucial:

- Marriage and Divorce: Under the Hindu Marriage Act, 1955, a marriage can be annulled if a person was incapable of giving valid consent due to unsoundness of mind at the time of marriage. Incurable unsoundness of mind can also be a ground for divorce.
- Testamentary Capacity (Wills): A person can make a valid will if they are of "sound mind" at the time of execution, meaning they understand their assets, beneficiaries, and the consequences of their actions. A person with mental illness can make a will during a lucid interval.
- Contracts: According to the Indian Contract Act, 1872, a contract made by a person of unsound mind is void.
- Guardianship and Property Management: Courts can appoint a guardian for a person with mental illness who is incapable of managing their own affairs or property, under the Mental Healthcare Act, 2017 and the Rights of Persons with Disabilities Act, 2016.

Criminal Law Aspects

In criminal cases, the focus is on criminal responsibility:

- Insanity Defense: Section 84 of the Indian Penal Code (based on the M'Naghten rules) states that an act is not an offense if done by a person who, at the time, was incapable of knowing the nature of the act, or that it was wrong or contrary to law, due to unsoundness of mind.
- Fitness to Stand Trial: The court assesses if an accused person has the mental capacity to understand the legal proceedings and participate in their own defense.
- Police Duties: Police officers have a duty to take a homeless or wandering person with mental illness who is at risk of harm to themselves or others to the nearest public hospital for assessment within 24 hours.

Role of the Mental Health Professional (MHP)

MHPs have a crucial medico-legal role:

- Confidentiality: Patient information is confidential, but can be disclosed in certain exceptions (e.g., in the interest of public safety and security, or to the nominated representative).

- Documentation: Detailed and accurate record-keeping is essential for legal protection in case of malpractice lawsuits.
- Forensic Reports: Psychiatrists may be called upon to provide expert opinions to the court on a person's mental capacity or criminal responsibility.
- Adherence to Standards: MHPs and mental health establishments must be registered with the Central/State Mental Health Authorities and adhere to prescribed minimum standards of care.

Toxicology :

Laws related to toxicology in India cover a wide range of areas including public health, occupational safety, environmental protection, and criminal justice, primarily to regulate and control the manufacture, sale, use, and disposal of toxic substances.

Key Laws and Regulations in India

Public Health and Criminal Justice

- The Poisons Act, 1919: This Act regulates the possession for sale, wholesale and retail sale, and import of specified poisons. State governments can create rules for licensing vendors, setting maximum sale quantities, and ensuring safe custody and labeling to prevent misuse.
- The Indian Penal Code (IPC), 1860: The IPC includes several sections dealing with poisoning as a criminal act:
- Section 284 punishes negligent conduct with respect to poisonous substances.
- Section 328 penalizes causing hurt by means of poison or any stupefying, intoxicating, or unwholesome drug with intent to commit an offense.
- Section 299 covers culpable homicide, including that caused through administration of poison.

- The Code of Criminal Procedure (CrPC), 1973 & Indian Evidence Act, 1872: These acts outline the procedures for investigating poisoning cases, the duties of doctors to report suspected homicidal poisoning cases to the police (Sec 39 CrPC), and the admissibility of expert toxicological evidence in court.
- The Drugs and Cosmetics Act, 1940: This Act regulates the import, manufacture, distribution, and sale of drugs to ensure their quality, purity, and strength. It uses

schedules (e.g., Schedule E1, H, L, X) to list poisonous substances or drugs that require strict medical supervision for sale.

- The Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985: This comprehensive law consolidates regulations on narcotic drugs and psychotropic substances, strictly prohibiting the cultivation, production, possession, and trade except for scientific or medical purposes.

Environmental and Occupational Health

- The Environment (Protection) Act, 1986: This is an umbrella legislation empowering the central government to take measures to protect and improve the environment and regulate hazardous substances. Many specific rules are framed under this Act:
- Manufacture, Storage and Import of Hazardous Chemicals (MSIHC) Rules, 1989: These rules focus on industrial safety, requiring occupiers to identify major hazards, prepare on-site emergency plans, and provide information and training to workers.
- Hazardous Wastes (Management and Handling) Rules, 1989 (replaced by 2016 rules): These govern the proper handling, collection, storage, treatment, and disposal of hazardous and other wastes.
- Bio-Medical Waste (Management and Handling) Rules, 1998: These ensure the safe disposal of medical waste from healthcare facilities to prevent public health hazards.
- The Ozone Depleting Substances (Regulation and Control) Rules, 2000: These regulate the production and consumption of ozone-depleting substances.
- The Factories Act, 1948 (now largely subsumed by the OSH Code, 2020): Historically, this Act mandated safety provisions in factories, especially for processes involving hazardous substances, including requirements for health records and maximum permissible exposure limits.
- The Occupational Safety, Health and Working Conditions (OSH) Code, 2020: This code consolidates several labor laws and requires employers to provide a workplace free from hazards, conduct free annual health examinations for employees in notified hazardous establishments, and inform authorities of serious accidents.
- The Public Liability Insurance Act, 1991: This Act makes it mandatory for owners handling hazardous substances to take out insurance policies to provide immediate relief to victims in case of accidents on a "no-fault" basis.

- The Insecticides Act, 1968: This law regulates the import, manufacture, sale, and use of insecticides to prevent risks to human health and the environment.

- The Atomic Energy Act, 1962: This Act provides strict government control and regulation over nuclear materials and radioactive substances to prevent radiation hazards.
- The Proposed Chemicals (Management and Safety) Rules (CMSR): This draft regulation, similar to the EU REACH, aims to provide a single, comprehensive framework for chemical management in India, requiring notification and registration of substances based on risk and quantity.

Giving evidences in police investigation:

In India, giving evidence to the police during an investigation is governed primarily by the Code of Criminal Procedure (CrPC) and the Indian Evidence Act. This process involves both obligations and fundamental rights for the person providing information.

Legal Obligations and Rights of a Witness

Individuals questioned by the police have certain obligations and rights.

Obligations

- Police can issue a written order (Section 160 CrPC) for anyone familiar with the case facts to attend for questioning.
- Those summoned must answer truthfully all questions related to the case.
- Anyone aware of serious offenses being committed or planned must inform the nearest magistrate or police officer (Section 39 CrPC).

Rights

- Individuals have the right to remain silent if answering would expose them to a criminal charge (Article 20(3) of the Indian Constitution and Section 161(2) CrPC).
- They can consult and be defended by a legal practitioner of their choice during questioning.
- Certain individuals, like males under 15 or over 65, women, or those with disabilities, cannot be required to attend the police station; their statements must be recorded at

their residence. Statements of women victims of sexual offenses must be recorded by a woman police officer.

- Police cannot use force, threats, or inducements to obtain a statement or confession.
- Statements made to police under Section 161 CrPC are generally not signed and cannot be used as primary evidence in court, except to contradict the witness's testimony during trial.

Consequences of Giving False Evidence

Providing false evidence or information during a police investigation is a serious offense in India.

- Intentionally making a false statement under legal obligation to tell the truth constitutes giving false evidence (Section 191 IPC/Section 227 Bhartiya Nyaya Sanhita). In judicial proceedings, this can lead to up to seven years imprisonment and a fine.
- Giving false information to protect an offender from punishment can result in imprisonment and/or a fine (Section 203 IPC).

Process of Giving Evidence

1. Attendance: You may receive a written notice to attend for questioning.
2. Recording: Police will ask questions and may write down your answers. Statements can also be recorded electronically.
3. No Signature: You are not required to sign the police-recorded statement.
4. Magistrate's Role: Confessions or formal statements for stronger evidence may be recorded by a Judicial Magistrate under Section 164 CrPC, ensuring voluntariness and legal rights, including counsel.

Organ transplantation :

Organ transplantation in India is regulated by a comprehensive legal framework to ensure ethical practices and prevent the commercial dealing of human organs and tissues. The primary legislation is the Transplantation of Human Organs and Tissues Act, 1994 (THOTA), which was amended in 2011 to include tissues and strengthen

Key Legal and Ethical Aspects

1. Regulation and Authorization

- Registration of Hospitals: Only hospitals with the required infrastructure, facilities, and skilled medical professionals are permitted to perform transplantation activities after being registered by the Appropriate Authority (AA).
- Authorization Committees (AC): For living donors who are not "near relatives" (spouse, parents, siblings, children, grandparents, grandchildren), an Authorization Committee must approve the donation to verify genuine altruism and rule out any commercial transactions. Interviews are video-recorded for accountability.
- National Network: The National Organ and Tissue Transplant Organisation (NOTTO) at the national level, along with Regional (ROTTO) and State (SOTTO) organizations, manage the organ allocation, maintain registries of donors and recipients, and coordinate the process transparently.

2. Types of Donation and Consent

- Living Donors: A living person can donate one kidney, a portion of the liver, or part of the pancreas, as these organs/tissues can regenerate or the remaining part can sustain bodily functions. Donors must be over 18 years of age and give voluntary, informed consent.
- Deceased (Cadaver) Donors: Donation after brain-stem death (BSD) or cardiac death is permitted. The Act legally recognizes BSD as a valid form of death. Consent from the deceased person during their lifetime (e.g., via an organ donor pledge) or from a near relative after death is mandatory.
- Swap Transplants: When a near-relative donor is incompatible with the recipient, the Act permits swapping donors between two incompatible pairs (paired exchange) with AC approval.
- Informed Consent: Medical professionals must explain all possible effects, complications, and hazards of the removal and transplantation procedures to both the donor and the recipient.

3. Prohibitions and Penalties

- Commercial Dealings: The buying and selling of human organs and tissues is a criminal offense. Violations can lead to imprisonment for a term of five to ten years and a fine of up to one crore rupees.

- Unauthorized Removal: Removal of organs without proper authority is punishable by imprisonment for up to ten years and a fine of up to twenty lakh rupees. Registered medical practitioners can face suspension of their medical license for such offenses.
- Transplant Tourism: The Act aims to prevent transplant tourism and generally prohibits an Indian national from donating to a foreigner unless they are a near relative.

4. **Medico-Legal Cases and Brain Death Certification**

- Brain Death: BSD must be certified by a board of four medical experts, independent of the transplant team, who perform tests twice over a period of hours to confirm the irreversible cessation of brainstem function.
- Medico-Legal Cases: Organ donation in medico-legal cases (like accident victims) is permitted, and procedures are defined in the rules to ensure the donation process does not jeopardize the determination of the cause of death during post-mortem. The cost of donor management is not borne by the donor's family.

The legal framework aims to maximize organ donation rates while strictly adhering to ethical guidelines, protecting vulnerable populations from exploitation, and ensuring fair and transparent allocation of available organs.

Ethanasia (mercy Killing) :

Euthanasia, often referred to as "mercy killing," involves intentionally ending a person's life to relieve pain and suffering. The term originates from the Greek words eu (good) and thanatos (death), implying a "good death."

Legal Status in India

Euthanasia is a complex and contentious medico-legal issue. As of late 2025, the legal position in India is as follows:

- Active Euthanasia is Illegal: Intentionally administering a lethal substance to end a patient's life (active euthanasia) remains a criminal offense in India, punishable as murder or culpable homicide under the Indian Penal Code. Medical professionals performing active euthanasia face severe legal penalties and suspension of their medical license.

- Passive Euthanasia is Legal (with strict conditions): The Supreme Court of India legalized passive euthanasia in a landmark 2018 judgment, upholding the right to die with dignity as a facet of Article 21 (Right to Life).
- Definition: Passive euthanasia involves withdrawing or withholding life-sustaining treatment (like turning off a ventilator, stopping artificial hydration or nutrition, or withholding medication) where there is no hope of recovery.
- Conditions: It can only be performed on terminally ill patients, primarily those in a permanent vegetative state (PVS), after strict adherence to guidelines:

- Living Wills/Advance Directives: The patient may have previously prepared a "living will" or advance directive outlining their desire to refuse life support if terminally ill.
- Court Approval: If no advance directive exists, the decision to withdraw life support must be approved by a high court, following rigorous medical board assessments to confirm the diagnosis and prognosis.

Types of Euthanasia

The legality often depends on the classification

Type	Description	Legal Status in India
Active Euthanasia	Directly causing death (e.g., lethal injection).	Illegal
Passive Euthanasia	Withdrawing life support or treatment.	Legal (under strict court-supervised conditions)
Voluntary Euthanasia	Performed with the patient's explicit, informed consent.	Illegal (Active) or Legal (Passive)
Non-Voluntary Euthanasia	Performed when the patient is comatose/incapable of consent; a relative decides their best interests.	Legal only for Passive Euthanasia via court order
Physician-Assisted Suicide	A doctor provides the means (e.g., medication prescription) for a patient to end their own life.	Illegal

Medico-Legal Aspects for Professionals

Medical professionals face a complex ethical and legal landscape:

- Palliative Care: Doctors have a duty to provide high-quality palliative care to manage pain and suffering.

- Confidentiality vs. Legal Duty: Doctors must balance patient confidentiality with the legal requirements for court oversight in passive euthanasia cases.
- Documentation: Meticulous documentation of the patient's condition, prognosis, consultation with family members, and adherence to legal protocols is essential for protection against legal charges.
- Conscientious Objection: Medical professionals in many jurisdictions may have the right to refuse to participate in euthanasia procedures based on personal or religious beliefs.

Diagnosis, prescriptions and administration of drugs

The diagnosis, prescription, and administration of drugs are core responsibilities within the practice of modern medicine. The legal and ethical framework governing these activities in India is primarily defined by the Drugs and Cosmetics Act, 1940, the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, and specific hospital protocols.

I. Diagnosis (Medical)

Diagnosis is the process of identifying a disease or condition through the evaluation of signs, symptoms, history, and medical tests.

- Legal Prerogative: In India, only registered medical practitioners (RMPs)—individuals holding recognized medical qualifications (MBBS, MD, etc.) and registered with the Medical Council of India or State Medical Councils—are legally permitted to diagnose medical conditions.
- Negligence: A doctor can be held liable for medical negligence if they fail to exercise "reasonable degree of care and skill" in making a diagnosis (e.g., misdiagnosis or delayed diagnosis) that a peer would typically employ, leading to patient harm.
- Informed Consent: While the diagnostic process itself usually doesn't require formal written consent beyond general consent to treat, specific invasive diagnostic procedures (like biopsies or endoscopies) require explicit informed consent.

II. Prescriptions (Dispensing Orders)

- A prescription is a written order by an RMP for a specific medication to be administered to a patient.
- Mandatory Content: Prescriptions must adhere to legal and ethical guidelines:
- Doctor's name, qualification, and registration number are mandatory.

- Patient details (name, age, sex, date).
- Generic or brand name of the drug, dosage, frequency, route of administration, and duration.
- Signature and date.
- Ethical Guidelines: The Medical Council of India (MCI) ethics regulations mandate that doctors prescribe drugs rationally, using generic names where possible, and avoid prescribing medicines solely from companies with which they have a financial link.
- Pharmacists' Role: Only licensed pharmacists can dispense medicines based on a valid RMP's prescription, adhering strictly to the conditions specified in the Drugs and Cosmetics Act (e.g., Schedule H/X drugs require a written prescription and specific record-keeping).

III. Administration of Drugs

Drug administration is the actual delivery of the medication to the patient by a qualified professional.

- Qualified Personnel: This is typically performed by RMPs or trained and registered nursing staff under the supervision and orders of an RMP. Unqualified individuals administering drugs (e.g., quacks) face severe penalties.
- The "Five Rights" of Administration: Healthcare providers must follow protocols to prevent errors, commonly known as the "five rights": Right Patient, Right Drug, Right Dose, Right Route, and Right Time.
- Informed Consent and Refusal: A patient has the right to be informed about the medication they are receiving (benefits, risks, side effects) and has the autonomous right to refuse treatment. Administering medication against a conscious, competent patient's will is a violation of rights and may constitute assault or battery.
- Documentation: Every administration of medication must be meticulously recorded in the patient's medical chart, including the time, route, and the signature of the person administering it.

Medico-Legal Implications

Across all three stages—diagnosis, prescription, and administration—healthcare providers bear significant legal liability under civil, criminal, and consumer protection laws (Consumer Protection Act, 2019):

- Medical Negligence: Any deviation from the accepted standard of care at any stage (e.g., administering the wrong dose, failing to check for allergies, incorrect diagnosis) can lead to charges of negligence.
- Malpractice Suits: Poor documentation often weakens a healthcare provider's defense in court.
- Regulatory Action: Breaches of the Drugs and Cosmetics Act or MCI regulations can lead to suspension or cancellation of medical licenses and criminal prosecution.

ANESTHESIA AND SURGERY

Anesthesia and surgery represent a major area within medico-legal jurisprudence, primarily focusing on medical negligence, informed consent, and liability. The procedures are inherently high-risk, requiring meticulous adherence to standards of care, primarily guided by the Consumer Protection Act, 2019, the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, and specific clinical guidelines.

Medico-Legal Aspects of Anesthesia

Anesthesia involves a high degree of risk, and anaesthesiologists carry significant responsibility for patient safety during, before, and after surgery.

- Informed Consent: A detailed, specific, and written informed consent is legally mandatory for the type of anesthesia (e.g., general, spinal, epidural) being used. The risks, benefits, and alternatives must be explained clearly in a language the patient understands.
- Pre-Operative Check-up: Failure to conduct a thorough pre-anaesthetic check-up (PAC) to assess fitness for surgery is a significant breach of duty of care and a common ground for negligence claims.
- Standard of Care: Anaesthesiologists are expected to follow established protocols, monitor vital signs continuously, use appropriate equipment, and be prepared for emergencies (e.g., malignant hyperthermia).
- Respondeat Superior: In a hospital setting, the hospital administration and the anaesthesiologist share liability (vicarious liability) for the actions of employed staff (like nurses).
- Specific Complications: Common medico-legal issues in anesthesia relate to nerve injuries post-regional anesthesia, dental damage during intubation, awareness during anesthesia, and adverse drug reactions.

Medico-Legal Aspects of Surgery

Surgical procedures also carry inherent risks, and surgeons are accountable for the entire process, from consultation to post-operative care.

- Informed Consent: As with anesthesia, comprehensive, written, and specific informed consent is mandatory. This must cover the diagnosis, the proposed procedure, potential outcomes, alternative treatments, and all material risks. Performing surgery beyond the scope of consent (e.g., performing a hysterectomy when only an appendectomy was consented to, unless a life-saving necessity arose) is a legal violation (battery).
- Documentation: Meticulous documentation is the surgeon's primary legal defense. This includes pre-operative notes, the signed consent form, a detailed operative note (including steps taken, findings, and any complications), and post-operative progress notes.
- Standard of Care: Surgeons must operate within the accepted standards of the medical profession. An honest error of judgment is not necessarily negligence, but a deviation from standard practice that causes harm is.

- Liability for 'Retained Foreign Bodies': One of the most indefensible forms of surgical negligence is leaving instruments, sponges, or other foreign objects inside the patient's body.
- Surgical Asepsis: Failure to maintain sterile conditions, leading to post-operative infections, can be grounds for a negligence claim.

Common Legal Themes in Anesthesia and Surgery

- **Res Ipsa Loquitur (The thing speaks for itself):** In certain outcomes that do not ordinarily occur without negligence (like operating on the wrong side of the body), the burden of proof may shift to the doctor/hospital to prove they were not negligent.
- **Criminal Negligence:** While most cases are civil negligence, gross negligence (reckless disregard for the patient's safety) can lead to criminal charges under the Indian Penal Code, such as Section 304A (causing death by negligence).

Unit– 5

COUNSELING SKILLS

Introduction, growth of counseling services

Counseling skills are foundational competencies used by professionals across various disciplines—psychologists, social workers, doctors, nurses, and even managers—to help individuals navigate personal, social, or psychological challenges. The field has evolved from informal guidance to a structured professional service, primarily in response to increasing societal complexity and mental health awareness. Counseling involves a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.

Key aspects of effective counseling skills include:

- Active Listening: Fully concentrating, understanding, responding, and remembering what is being said, both verbally and non-verbally.
- Empathy: The ability to understand and share the feelings of another person. This differs from sympathy.
- Rapport Building: Establishing a trusting, respectful relationship with the client to create a safe space for disclosure.
- Questioning: Using open-ended and closed-ended questions strategically to gather information and encourage self-exploration.
- Confidentiality: Maintaining strict ethical boundaries regarding client information, which is a cornerstone of the therapeutic relationship.
- Goal Setting: Collaborating with clients to identify their desired outcomes and develop actionable steps to achieve them.

Growth and Evolution of Counseling Services

The growth of counseling services reflects significant shifts in how society addresses human problems, moving from punitive and informal approaches to professional, evidence-based methods.

Historical Development

1. Early 20th Century Guidance: The formal movement began in the early 1900s, focusing heavily on vocational guidance in schools, particularly in the United States, to help young people adapt to the industrial workforce.
2. Post-War Focus (WWI & WWII): Both world wars highlighted the need for mental health support for soldiers returning with "shell shock" (PTSD). This spurred the development of formal counseling theories and diagnostic tools.
3. The Civil Rights Movement and Social Change: The latter half of the 20th century saw counseling expand to address social justice issues, multiculturalism, and diversity, recognizing that personal problems are often linked to systemic issues.
4. Rise of Mental Health Awareness: The development of robust diagnostic manuals (like the DSM) and the destigmatization of mental illness led to a surge in demand for professional mental healthcare outside traditional hospital settings.

Modern Expansion (India Context)

In India, the growth of counseling services has accelerated significantly in recent decades:
Legislation and Policy: The Mental Healthcare Act, 2017, and the push for better public health infrastructure have created a legal mandate and policy support for mental health services.

- Diverse Settings: Counseling is now commonplace not just in clinical settings, but also in schools (mandated by CBSE guidelines), corporate offices (Employee Assistance Programs), universities, rehabilitation centers, and private practice.
- Increased Awareness: Campaigns and media coverage have reduced stigma, leading more people to seek professional help for stress, anxiety, relationship issues, and trauma.
- Tele-counseling: The COVID-19 pandemic catalyzed the rapid growth of tele-mental health services, increasing accessibility, especially in a country with a significant treatment gap.

The field has professionalized, with clear licensing requirements, standardized training, and ethical codes of conduct, establishing counseling as a critical component of holistic health and well-being services globally.

Approaches to counselig

There are numerous approaches to counseling, each based on different theories of human behavior and change. These approaches provide a framework for the counselor's work with the client. Most professional counselors are integrative, meaning they draw techniques from several different theories tailored to the specific needs of the client.

The main approaches can be grouped into several major categories:

1. **. Psychodynamic Approaches**

These approaches are rooted in the work of Sigmund Freud and focus on how past experiences, unconscious conflicts, and defense mechanisms influence current behavior and emotions.

- Psychoanalysis: A long-term, intensive therapy that uses techniques like free association and dream analysis to bring unconscious conflicts to conscious awareness for resolution.
- Adlerian Therapy: Focuses on an individual's unique style of life, social interest, and the pursuit of goals (superiority). The counselor helps the client understand their purpose and how to interact effectively with society.

2. Behavioral Approaches

Behavioral counseling focuses on observable behaviors rather than unconscious thoughts. The premise is that all behavior is learned and can, therefore, be unlearned or modified.

- **Applied Behavior Analysis (ABA):** Uses principles like reinforcement and punishment to change specific behaviors.
- **Cognitive Behavioral Therapy (CBT):** This is one of the most widely used and evidence-based approaches. CBT posits that thoughts influence feelings and behaviors. Counselors help clients identify and challenge irrational or negative thought patterns to change their emotional responses and actions.

3 **Humanistic Approaches**

Humanistic approaches emphasize the inherent worth of the individual, the capacity for self-actualization, and the importance of personal growth.

- Person-Centered Therapy (Rogerian): Developed by Carl Rogers, this approach relies heavily on a supportive, non-judgmental therapeutic relationship. The counselor provides core conditions (empathy, unconditional positive regard, congruence) that allow the client to lead the session and find their own solutions.
- Gestalt Therapy: Focuses on the "here and now," helping clients become fully aware of their current feelings and behaviors ("gestalt" means a whole). Techniques often involve role-playing or the "empty chair" technique

4 Systemic Approaches

These approaches view individuals within the context of their relationships and social systems (family, work, community).

- Family Systems Therapy: The "client" is the entire family unit. The counselor works to change dysfunctional interaction patterns and communication styles within the family structure.

5. Other Key Approaches

Solution-Focused Brief Therapy (SFBT): A goal-oriented approach that focuses on solutions rather than problems. Counselors ask questions about the client's desired future and help them find existing resources and strengths to reach that future quickly.

Narrative Therapy: This approach views individuals as separate from their problems. The counselor helps the client "re-author" their life stories in a more positive and empowering way.

Process of Counseling :

The counseling process is a structured, dynamic, and confidential interaction between a trained counselor and a client. While specific techniques vary depending on the theoretical approach (e.g., CBT, Person-Centered), the overall process generally follows a standardized sequence of stages:

1. Stage: Initial Disclosure / Relationship Building

This initial stage is crucial for establishing rapport and a safe, confidential environment. The primary goal is to help the client feel comfortable enough to open up.

- Introduction: The counselor introduces themselves, explains their role, and clarifies the boundaries of the relationship, especially regarding confidentiality and its limits (e.g., risk of harm to self or others).

- Intake and Assessment: The counselor gathers necessary background information, including the client's demographics, presenting problem (the "why now?"), history, and goals for therapy.
- Informed Consent: The counselor discusses the process, fees, session length, and the client's rights, ensuring the client voluntarily agrees to engage in counseling.

2 . Stage: Deep Exploration / Problem Identification

Once trust is established, the process shifts to exploring the issues in depth.

- Ventilation and Exploration: The client is encouraged to share their feelings, thoughts, and experiences openly. The counselor uses core skills like active listening, empathy, and non-judgmental acceptance.
- Problem Definition: The counselor works with the client to clearly define the specific issues or challenges they are facing. This often involves uncovering the root causes or contributing factors, which may be different from the initial "presenting problem."
- Goal Setting: The counselor helps the client identify what they want to achieve. Goals should be specific, measurable, achievable, relevant, and time-bound (SMART goals).

3. Stage: Intervention / Action Planning

This stage is where therapeutic techniques are applied to facilitate change and work towards the established goals.

- Developing Strategies: Based on the agreed-upon goals and the counselor's theoretical orientation (e.g., CBT techniques, solution-focused questions), the counselor and client collaborate on specific actions or interventions.
- Applying Techniques: This might involve teaching coping mechanisms, practicing communication skills, challenging negative thought patterns, exploring alternative perspectives, or assigning "homework" (tasks outside of sessions).
- Empowerment: The focus is on empowering the client to take responsibility for their own choices and actions, utilizing their strengths and resources.

4 Stage: Termination / Conclusion

The termination stage involves bringing the therapeutic relationship to a close when goals have been met or the client chooses to end services. This is a critical stage that should not be rushed.

- Review and Consolidation: The counselor and client review the progress made, reinforce new skills and insights gained, and discuss how the client can maintain changes after therapy ends.
- Planning for the Future: A clear plan is made for ongoing support networks or potential future check-ins.
- Closure: The relationship is formally ended, allowing both the counselor and client to part ways in a healthy manner and deal with any residual feelings about the ending of the process. Follow-up sessions may be arranged if necessary.

Attitudes of Counselors, Skill of Counseling

The effectiveness of the counseling process depends fundamentally on the counselor's professional attitude and their mastery of core skills. While attitudes form the foundation of the therapeutic relationship, specific skills are the tools used to facilitate change.

Attitudes of Counselors (Core Conditions)

Carl Rogers, the founder of person-centered therapy, identified three core attitudes, or "core conditions," that are essential for a healthy counseling environment. When these attitudes are genuinely present, they allow the client to grow and change.

1. Empathy (Empathetic Understanding)

This is the ability to deeply understand the client's feelings and perspective from their frame of reference, rather than the counselor's own. It involves communicating this understanding back to the client.

Attitude: The counselor adopts a genuine curiosity and a non-judgmental stance, striving to walk in the client's shoes. It is not just about saying "I understand," but demonstrating that understanding through careful listening and reflection.

2. **Unconditional Positive Regard (UPR)**

This attitude involves accepting and valuing the client as a person, without judgment, regardless of what they say or do.

Attitude: The counselor conveys a fundamental respect for the client's humanity and autonomy. This acceptance helps the client feel safe enough to explore aspects of themselves

they might feel ashamed of. The counselor may not agree with all actions, but they accept the person.

3**. Congruence (Genuineness)**

This refers to the counselor being authentic and real in the relationship. It means the counselor's internal feelings are consistent with their external expression during the session.

Attitude: The counselor is transparent and avoids adopting a façade or a purely professional, detached persona. While professional boundaries are maintained, the counselor shares their genuine humanity with the client, fostering trust and a real connection.

Skills of Counseling

Counseling skills are the observable techniques used within the framework of these attitudes to move the process forward through its various stages.

1**. Attending and Listening**

These are foundational skills that show the client the counselor is engaged and focused.

Verbal Following: Tracking the client's story and asking questions that relate directly to what they just said.

Non-Verbal Cues: Using appropriate body language (e.g., open posture, eye contact), nodding, and minimizing distractions to show engagement.

2. Questioning

Questions are tools used to gather information, clarify understanding, and encourage the client to explore their own thoughts.

- Open-Ended Questions: (e.g., "How did you feel about that?") encourage exploration and detailed responses.
- Closed-Ended Questions: (e.g., "When did that happen?") are used for specific information or clarification.

3. Reflection and Paraphrasing

These skills involve feeding back the client's message to them, demonstrating understanding and allowing the client to hear their own thoughts echoed back, often gaining new perspective.

Paraphrasing: Restating the content of what the client said in the counselor's own words.

Reflection of Feeling: Stating the emotional tone of the client's message (e.g., "It sounds like you felt really angry when that happened").

4. Summarizing

This skill is used to tie together multiple ideas, feelings, and events discussed over a period of time (e.g., at the end of a session). It helps structure the conversation and confirm progress.

5. Confrontation/Challenge

Used gently and respectfully, this skill highlights inconsistencies in the client's thoughts, feelings, or behaviors (e.g., "You say you want to quit smoking, but you haven't managed to go a full day yet. How do those two things fit together?").

6**. Information Giving and Guidance**

Counselors may provide factual information (e.g., about local resources, mental health conditions, or techniques) but generally avoid giving direct advice, instead empowering the client to make their own informed decisions.

Problems in Counseling

- Counseling is a powerful process for change, but it is not without its challenges. Problems can arise from various sources: the client themselves, the counselor, the therapeutic relationship, or external systemic factors.
- Problems Originating from the Client

Clients bring diverse challenges into the counseling room that can hinder progress:

- Resistance and Reluctance: Clients may be reluctant to engage, fearing vulnerability or change. They might resist by being silent, forgetting appointments, diverting the topic, or challenging the counselor.
- Lack of Motivation or Commitment: If a client is attending counseling due to external pressure (e.g., family, court order) rather than personal desire, they are less likely to invest effort in the process.
- Unrealistic Expectations: Clients may expect a quick fix, simple advice, or a cure for all problems within a few sessions, leading to disappointment when sustained work is required.
- Difficulty with Emotional Expression: Some clients struggle to identify, name, or express their feelings, making deep emotional processing difficult.
- Crisis Situations: Clients presenting in acute crisis (suicidal ideation, domestic violence, psychosis) require immediate safety planning and risk assessment, which can temporarily overshadow standard counseling goals.

- Problems Originating from the Counselor

Even trained professionals can encounter challenges in their practice:

- Lack of Experience or Training: A counselor may lack sufficient experience or specialized training to effectively address complex issues like severe trauma, addiction, or specific mental health disorders.
- Countertransference: This occurs when the counselor's own unresolved personal issues, feelings, or past experiences interfere with their perception of or reaction to the client. Maintaining self-awareness is key to managing this.
- Burnout and Compassion Fatigue: Due to the emotionally demanding nature of the work, counselors can experience exhaustion, cynicism, and reduced empathy, negatively impacting client care.
- Ethical Violations: Problems arise from breaches of confidentiality, establishing dual relationships (e.g., socializing with clients), or maintaining poor professional boundaries.

Problems within the Therapeutic Relationship

The therapeutic alliance (the relationship between the counselor and client) is a strong predictor of success, and its breakdown is a major problem:

Poor Rapport/Lack of Trust: If the client does not feel safe, respected, or understood, they will be unwilling to share honestly, stalling the process.

- Mismatch in Style or Personality: Sometimes, despite the best intentions, the client and counselor's personalities or communication styles clash, making collaboration difficult.
- Cultural Misunderstanding: A lack of cultural competence can lead to misinterpretations, microaggressions, or a failure to understand the client's worldview, damaging the relationship.

Systemic and External Problems

External factors often pose significant barriers to effective counseling:

- Accessibility and Cost: Financial constraints and lack of access to affordable mental healthcare are common problems in many regions, including India.
- Stigma: The prevailing social stigma surrounding mental health issues can prevent clients from seeking help early or engaging fully when they do attend sessions.

- Lack of Support Systems: Clients may return to unsupportive or abusive environments outside the counseling office, which can quickly undo progress made in sessions.
- Policy and Legal Constraints: Complex legal reporting mandates (e.g., child abuse, immediate risk of harm) can conflict with the principle of absolute confidentiality, creating difficult ethical dilemmas for the counselor.

Assessing and diagnosing clinets' problems

Assessing and diagnosing clients' problems is a critical, multi-faceted process that forms the foundation of effective treatment planning in counseling and clinical psychology. This process is governed by professional standards, structured methodologies, and ethical considerations.

- The Purpose of Assessment and Diagnosis

Assessment: The ongoing process of gathering information about a client using multiple methods and sources. The goal is to understand the client's unique context, strengths, challenges, and overall functioning.

- Diagnosis: A specific classification of a problem using standardized criteria (such as those found in the DSM-5-TR or ICD-11). Diagnosis helps standardize communication among professionals, guides treatment selection, and is often required for insurance purposes.
- The Process of Assessment

Assessment is typically comprehensive and involves several components:

1. Clinical Interview: The primary tool for gathering information. Counselors use structured or semi-structured interviews to cover the client's presenting problem, history of symptoms, medical background, family history, social context, strengths, and goals.
2. Observation: Observing the client's behavior, affect (emotional expression), mood, cognitive functioning, and non-verbal cues during sessions provides valuable qualitative data.
3. Standardized Testing and Inventories: Counselors may use valid and reliable psychometric tools to measure specific areas:

- Symptom Checklists: (e.g., PHQ-9 for depression, GAD-7 for anxiety).

- Personality Assessments: (e.g., MMPI, NEO-PI).
- Intelligence and Cognitive Testing: (e.g., WAIS, specific cognitive screens).
- Specific Disorder Measures: Scales for trauma, addiction, or eating disorders.

4. Review of Records: With the client's signed consent, reviewing previous medical, educational, or therapeutic records provides a fuller picture and context.
5. Collateral Information: Gathering information from family members or significant others (with the client's consent) can provide essential perspectives on behavior that the client may not be aware of or may minimize.

The Process of Diagnosis

Diagnosis involves synthesizing the assessment data and matching the client's pattern of symptoms to established criteria.

- Using Standardized Manuals: Clinicians refer to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-5-TR) or the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11). These manuals provide specific criteria and duration requirements for various mental health conditions.
- Differential Diagnosis: The process of distinguishing the client's condition from other disorders that share similar symptoms. This requires careful consideration and often ongoing assessment.
- Multiaxial/Multidimensional Approach: Modern diagnosis usually looks beyond just the single disorder label. It assesses multiple factors: the clinical disorder itself, relevant personality traits, medical conditions, social stressors, and the client's overall functioning.

Key Medico-Legal and Ethical Considerations

The processes of assessment and diagnosis carry significant ethical and legal responsibilities:

- Informed Consent: Clients must be informed about the purpose of assessment and diagnosis, how the information will be used, and their right to refuse testing.
- Cultural Competence: Assessments and diagnoses must be culturally sensitive. What is considered a symptom in one culture may be a normative behavior in another.
- Confidentiality: All assessment data is confidential. Limits to confidentiality (e.g., risk of harm to self or others, child abuse reporting) must be clearly communicated.
- Competence and Validity: Counselors must only use assessment tools for which they are trained and competent to administer and interpret.

- Avoiding Misdiagnosis and Stigma: Diagnosis can be stigmatizing. Clinicians must strive for accuracy and use the diagnosis primarily as a tool for treatment planning and communication, not to label the individual.

Selecting Counseling Strategies and Interventions

Selecting effective counseling strategies and interventions is a highly individualized process that involves a collaborative effort between the counselor and the client. The selection process is guided by the data gathered during assessment, the established goals, the counselor's theoretical orientation, and the client's preferences.

The process involves several key steps:

1. Synthesizing Assessment Data

The first step is to thoroughly analyze all the information gathered during the assessment phase (diagnosis, symptoms, strengths, history, cultural context, and support systems).

- Understanding the Problem: A clear picture of the problem allows the counselor to identify which interventions are empirically proven to be effective for that specific issue (e.g., CBT for anxiety disorders, EMDR for trauma).
- Identifying Client Strengths: Strategies should leverage the client's existing strengths and resources. A "strengths-based approach" helps build resilience and engagement.
- Considering Diversity and Culture: Interventions must be culturally sensitive. A strategy effective in one cultural context might be inappropriate or ineffective in another.

2. Formulating and Prioritizing Goals

Strategies are selected to meet the specific goals established in collaboration with the client.

- SMART Goals: Goals should be Specific, Measurable, Achievable, Relevant, and Time-bound.
- Prioritization: The counselor and client decide which goals are most urgent or foundational, and select interventions to address those first (e.g., stabilizing a crisis before working on long-term trauma).

3. **Choosing the Approach and Interventions**

The selection of interventions is generally guided by the counselor's primary theoretical orientation, though most counselors use an integrative approach.

- Evidence-Based Practices (EBPs): Counselors prioritize interventions that have strong empirical support for treating the client’s specific condition.
- Matching Client to Technique:

A client who prefers structure and clear instructions might respond well to Cognitive Behavioral Therapy (CBT) techniques, such as thought records, behavioral activation, and exposure therapy.

A client seeking self-exploration and a deeper understanding of their identity might benefit from Person-Centered or Psychodynamic interventions that focus on empathy, reflection, and exploring past patterns.

A client focused purely on the future may benefit from Solution-Focused Brief Therapy interventions like the "miracle question" or scaling questions.

4. Collaboration and Client Buy-In

Interventions should never be imposed on a client. The selection process is collaborative to ensure the client is engaged and motivated.

- **Sharing the Rationale:** The counselor explains why a particular strategy is being suggested (e.g., "Research shows that practicing relaxation techniques like this helps reduce physical anxiety symptoms").
- Seeking Feedback: The counselor checks if the client is comfortable with the suggested approach and willing to try it. If the client resists, an alternative strategy must be selected.
- Informed Consent: The client provides informed consent to the treatment plan and proposed interventions.

5. Implementation, Review, and Adjustment

The process does not end with selecting the strategy. Interventions are continuously monitored for effectiveness.

- Tracking Progress: The counselor and client regularly review progress toward the SMART goals.
- Flexibility: If an intervention is not working, the counselor must be flexible and willing to adjust the approach, try a different technique, or refer the client to another professional better suited to their needs.
- Patience: Implementing strategies takes time and practice, and patience is essential for both the counselor and the client.

Changing Behavior through counseling

Changing behavior through counseling is a primary goal of the therapeutic process. It is not about forcing someone to change but rather empowering them to make intentional,

sustainable modifications in their thoughts, feelings, and actions to improve their well-being. This process typically utilizes a combination of theoretical approaches, primarily Cognitive Behavioral Therapy (CBT) and the Stages of Change Model, to facilitate lasting behavioral shifts.

The Mechanism of Change: How Counseling Works

Counseling facilitates behavior change by:

- Increasing Self-Awareness: The confidential, non-judgmental space of counseling helps clients explore the root causes of their behaviors, understanding why they do what they do and how those actions connect to their thoughts and feelings.
- Challenging Core Beliefs: Many behaviors are driven by ingrained beliefs (e.g., "I'm not good enough"). Counselors help clients identify and restructure these limiting beliefs into more realistic and positive self-perceptions.
- Developing Coping Skills: Clients learn new, healthier coping mechanisms to replace old, maladaptive behaviors (e.g., managing stress through mindfulness instead of substance use).
- Providing Support and Accountability: The therapeutic relationship offers a supportive environment where clients feel safe to take risks, try new behaviors, and receive structured feedback and encouragement.

The Stages of Change Model

A useful framework for understanding how clients change is Prochaska and DiClemente's Stages of Change Model (Transtheoretical Model). Counselors adapt their approach based on the client's current stage:

- Precontemplation: The client is unaware of a problem or has no intention of changing (e.g., an alcoholic who sees no issue with their drinking).
- Counseling Role: Raise awareness, provide information, and gently challenge denial.
- Contemplation: The client is aware of the problem and thinking about changing but not committed to action (e.g., "I know my anger is an issue, but I'm not ready to go to therapy yet").
- Counseling Role: Help explore pros and cons of changing, reduce anxiety about change, and build motivation.
- Preparation: The client intends to take action soon (within the next month) and may have already started small steps (e.g., buying a self-help book, making a counseling appointment).

- Counseling Role: Develop a concrete action plan and set small, achievable goals.
- Action: The client actively modifies their behavior, thoughts, and environment (e.g., attending support group meetings, practicing new communication skills).
- Counseling Role: Provide support, teach new skills, and reinforce positive changes.
- Maintenance: The client works to prevent relapse and consolidate the gains made during the action stage.
- Counseling Role: Develop relapse prevention plans, encourage ongoing self-care, and fade out therapy sessions gradually.
- Termination/Relapse: While termination is the goal, relapse is a common part of the change process.
- Counseling Role: Normalize relapse as a learning opportunity and help the client re-engage with the process without shame.

Key Counseling Interventions for Behavior Change

Counselors use specific techniques to facilitate movement through these stages:

- Cognitive Restructuring: Identifying and changing distorted thinking patterns that drive unwanted behaviors.
- Behavioral Experiments: Working with the client to test new behaviors in real-world scenarios (e.g., trying a different way of communicating a need to a partner).
- Exposure Therapy: Gradually exposing clients to feared situations (in anxiety disorders) to reduce avoidance behaviors.
- Motivational Interviewing (MI): A collaborative, goal-oriented style of counseling used specifically for reluctant clients to strengthen their own motivation for change.
- Skill Training: Teaching specific skills like assertiveness training, time management, or relaxation techniques.

Application of Counseling to Hospital Situations with a Focus on Performance Improvement :

Counseling skills are vital in hospital situations not only for direct patient care but also for performance improvement within interdisciplinary teams. The application of these skills enhances communication, resolves conflicts, improves patient outcomes, and fosters a more supportive work environment.

Application of Counseling Skills in Clinical Settings

Counseling is used in hospitals for both patients/families and staff/teams.

A. Patient and Family Counseling

Coping with Illness and Trauma: Counselors help patients and families deal with shock, grief, denial, and anxiety associated with sudden diagnoses, chronic illness, or traumatic injuries.
Informed Decision Making: Using counseling skills like active listening and empathy allows medical staff to better understand patient preferences and values. This ensures that informed consent is truly a shared decision-making process, leading to better compliance with treatment plans.

- End-of-Life Discussions: Palliative care teams use advanced counseling skills to facilitate difficult discussions about prognosis, goals of care, and end-of-life choices, improving the quality of death and grieving process for families.
- Adherence to Treatment: By identifying and addressing psychological barriers to adherence (e.g., fear, misunderstanding), counseling improves patient follow-through with medication schedules, diet changes, and rehabilitation programs.

B. Staff and Team Counseling

Managing Stress and Burnout: Hospital staff face high stress and compassion fatigue. Peer support programs and formal counseling services help staff process difficult cases, manage emotional distress, and prevent burnout.

- Conflict Resolution: Counseling approaches provide frameworks for mediating conflicts between staff members, departments, or even between staff and administration, creating a more cohesive work environment.

Focus on Performance Improvement

Performance Area	Counseling Application	Improvement Metrics
Communication	Active Listening: Improves clarity during shift handovers and team meetings.	Reduced medical errors; fewer patient complaints.
Teamwork	Empathy & Collaboration: Fosters better working relationships among diverse teams (doctors, nurses, technicians).	Increased staff satisfaction; better coordinated care.
Patient Satisfaction	Person-Centered Approach: Makes patients feel heard, respected, and involved in their care.	Higher HCAHPS scores (patient experience scores); positive reviews.
Ethical Climate	Values Clarification: Helps navigate complex ethical dilemmas (e.g., resource allocation, end-of-life care).	Improved ethical decision-making processes; better staff retention.
Quality of Care	Behavioral Strategies:	Reduced readmission rates;

	Supports patient lifestyle changes (e.g., managing diabetes, quitting smoking).	better long-term health outcomes

In essence, counseling skills move hospitals from a purely transactional (task-focused) model of care to a relational (person-focused) model, which inherently drives performance improvement across clinical, operational, and human resource metrics.

205HA26

ORIGINALITY REPORT

16%	13%	7%	7%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	www.coursehero.com Internet Source	2%
2	Submitted to Purdue University Student Paper	2%
3	nhsrcindia.org Internet Source	1%
4	iimtu.edu.in Internet Source	1%
5	Sharma, K., and S. Zodpey. "Demand and Supply Analysis of Human Resource Capacity for Hospital Management in India", Journal of Health Management, 2011. Publication	1%
6	main.mohfw.gov.in Internet Source	1%
7	pressbooks.uwf.edu Internet Source	<1%
8	Ambika Prasad Patra, Kusa Kumar Shaha. "Medical Jurisprudence & Clinical Forensic Medicine - An Indian Perspective", CRC Press, 2023 Publication	<1%
9	www.int-jecse.net Internet Source	<1%
10	Submitted to Uttaranchal University, Dehradun Student Paper	<1%

11	Mary H. Guindon. "A Counseling Primer - An Introduction to the Profession", Routledge, 2019 Publication	<1%
12	ijlsi.com Internet Source	<1%
13	K., Laxmisha Rai. "A Critical Study of Law Relating to Medico-Legal Litigations in India", Alliance University (India) Publication	<1%
14	David Capuzzi, Douglas R. Gross. "Introduction to the Counseling Profession", Routledge, 2019 Publication	<1%
15	Gary Chaimowitz, Mini Mamak, Heather Moulden, Drew Kingston. "Global Perspectives in Forensic Psychiatry - International Approaches to Practice, Policies, and the Law", Routledge, 2025 Publication	<1%
16	Ahmed, Raheel. "The Explicit and Implicit Influence of Reasonableness on the Elements of Delictual Liability", University of South Africa (South Africa) Publication	<1%
17	Submitted to Symbiosis International University Student Paper	<1%
18	www.buzznewslive.com Internet Source	<1%
19	Submitted to International Islamic University Malaysia Student Paper	<1%

20	dest.hp.gov.in Internet Source	<1%
21	"NAMS task force report on Organ donation and transplantation", Annals of the National Academy of Medical Sciences (India), 2024 Publication	<1%
22	www.civilsdaily.com Internet Source	<1%
23	Pragya Mishra. "Neurolaw and Criminal Jurisprudence in India", Routledge, 2024 Publication	<1%
24	Submitted to Republic Polytechnic Student Paper	<1%
25	investmentbank.kotak.com Internet Source	<1%
26	narendrapur.rkmvu.ac.in Internet Source	<1%
27	sdmlc.ac.in Internet Source	<1%
28	www.bhu.ac.in Internet Source	<1%
29	Submitted to Amity University Student Paper	<1%
30	www.123articleonline.com Internet Source	<1%
31	Madhav Madhusudan Singh, Uma Shankar Garg. "Laws Applicable to Medical Practice and Hospitals in India", International Journal of Research Foundation of Hospital and Healthcare Administration, 2013 Publication	<1%

32	Submitted to San Joaquin Valley College Online Student Paper	<1%
33	counseling.sfsu.edu Internet Source	<1%
34	scales.arabpsychology.com Internet Source	<1%
35	www.dnpindia.in Internet Source	<1%
36	Submitted to S.P. Jain Institute of Management and Research, Mumbai Student Paper	<1%
37	www.ensureias.com Internet Source	<1%
38	www.pilc.law Internet Source	<1%
39	Submitted to Gujarat National Law University Student Paper	<1%
40	www.lupin.com Internet Source	<1%
41	www.nmc.org.in Internet Source	<1%
42	www.slideshare.net Internet Source	<1%
43	www.sssutms.co.in Internet Source	<1%
44	dayofdifference.org.au Internet Source	<1%
45	www.drishtiias.com Internet Source	<1%
	Submitted to Bennett University	

46	Student Paper	<1%
47	Lloyd, Ryan Kent. "A Comparison of Several Family Therapy Models on the Clients' Experience of Family Therapy and the Impact of the Therapeutic Relationship on Therapeutic Process: A Group Dissertation.", Texas Wesleyan University Publication	<1%
48	Submitted to University of Sussex Student Paper	<1%
49	Herman Wheeler. "Law, Ethics and Professional Issues for Nursing - A reflective and portfolio-building approach", Routledge, 2013 Publication	<1%
50	Solanki, Namrata. "A study of the laws relating to right to health: A human rights perspective.", Proquest, 2016. Publication	<1%
51	blog.scientific-selfdiscovery.com Internet Source	<1%
52	edurev.in Internet Source	<1%
53	ia802206.us.archive.org Internet Source	<1%
54	track2training.com Internet Source	<1%
55	www.nursa.org Internet Source	<1%
56	Edward Premdas Pinto. "Health Justice in India", Springer Science and Business Media LLC, 2021	<1%

	Publication	
57	Submitted to Lead College Pty Ltd Student Paper	<1 %
58	Morgan, Steven A.. "A Systematic Review of Certified Peer Support Prevention and Preventative Protocols to Treat Prisoners Living With Serious Mental Illnesses", University of Arizona Global Campus Publication	<1 %
59	Submitted to South Lanarkshire College Student Paper	<1 %
60	atlantafi.com Internet Source	<1 %
61	chasingtales.blog Internet Source	<1 %
62	journals.lww.com Internet Source	<1 %
63	nativetribe.info Internet Source	<1 %
64	w3assets.angelone.in Internet Source	<1 %
65	Submitted to Sandwell College Student Paper	<1 %
66	Submitted to TAFE Queensland Brisbane Student Paper	<1 %
67	baadalsg.inflibnet.ac.in Internet Source	<1 %
68	cdn.cocodoc.com Internet Source	<1 %
69	diversedaily.com Internet Source	<1 %

70	hicas.ac.in Internet Source	<1 %
71	latestlaws.com Internet Source	<1 %
72	mumbaimirror.indiatimes.com Internet Source	<1 %
73	www.hilarispublisher.com Internet Source	<1 %
74	Submitted to Academy of Family Physicians of Malaysia (AFPM) Student Paper	<1 %
75	Submitted to Macquarie University Student Paper	<1 %
76	www.ejcl.org Internet Source	<1 %
77	3fdef50c-add3-4615-a675-a91741bcb5c0.usrfiles.com Internet Source	<1 %
78	Submitted to B.S.Abdur Rahman Crescent Institute of Science & Technology Student Paper	<1 %
79	Submitted to National Law University New Delhi Student Paper	<1 %
80	Submitted to O. P. Jindal Global University Student Paper	<1 %
81	Submitted to Southern New Hampshire University - Continuing Education Student Paper	<1 %
82	ijmsrr.com Internet Source	<1 %
	ngji.in	

83	Internet Source	<1%

Exclude quotes	On	Exclude matches	< 14 words
Exclude bibliography	On		

205HA26

GRADEMARK REPORT

FINAL GRADE

/0

GENERAL COMMENTS

PAGE 1

PAGE 2

PAGE 3

PAGE 4

PAGE 5

PAGE 6

PAGE 7

PAGE 8

PAGE 9

PAGE 10

PAGE 11

PAGE 12

PAGE 13

PAGE 14

PAGE 15

PAGE 16

PAGE 17

PAGE 18

PAGE 19

PAGE 20

PAGE 21

PAGE 22

PAGE 23

PAGE 24

PAGE 25

PAGE 26

PAGE 27

PAGE 28

PAGE 29

PAGE 30

PAGE 31

PAGE 32

PAGE 33

PAGE 34

PAGE 35

PAGE 36

PAGE 37

PAGE 38

PAGE 39

PAGE 40

PAGE 41

PAGE 42

PAGE 43

PAGE 44

PAGE 45

PAGE 46

PAGE 47

PAGE 48

PAGE 49

PAGE 50

PAGE 51

PAGE 52

PAGE 53

PAGE 54

PAGE 55

PAGE 56

PAGE 57

PAGE 58

PAGE 59

PAGE 60

PAGE 61

PAGE 62

PAGE 63

PAGE 64

PAGE 65

PAGE 66

PAGE 67

PAGE 68

PAGE 69

PAGE 70

PAGE 71

PAGE 72

PAGE 73

PAGE 74

PAGE 75

PAGE 76

PAGE 77

PAGE 78

PAGE 79

PAGE 80

PAGE 81