



The Grasp

Association of Medical Consultants, Mumbai



Cover Page by Dr. Rakhi Rajeev Agarwal

Association With Mission & Commitment

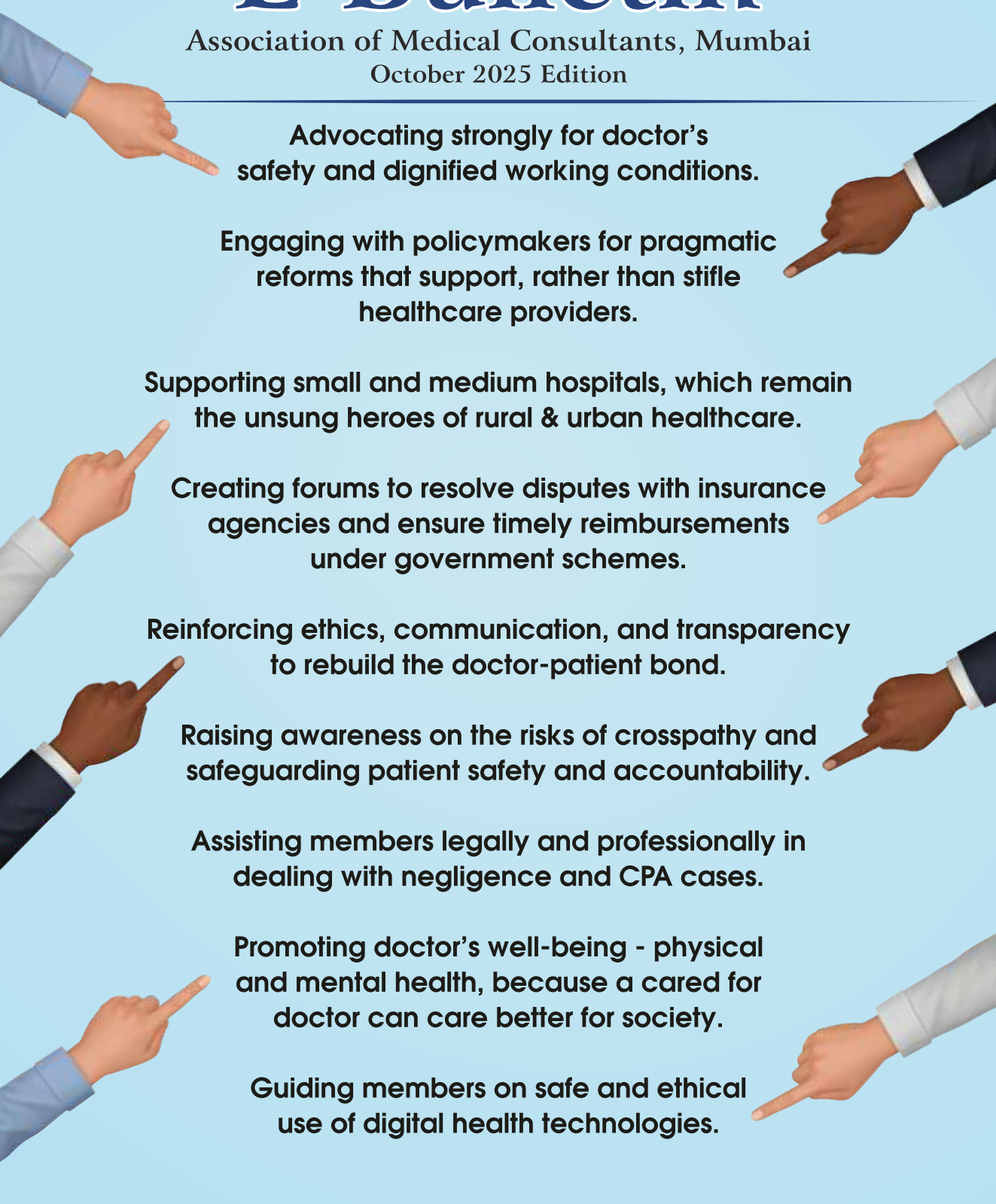
Together Towards Excellence In Healthcare

Issue No. 3 | October 2025 Edition

Official Publication of the Association of Medical Consultants, Mumbai

E-Bulletin

Association of Medical Consultants, Mumbai
October 2025 Edition

An illustration featuring several hands of different skin tones (light, medium, and dark) pointing towards the central text blocks. The hands are positioned around the perimeter of the page, with some pointing directly at the text and others slightly offset. The background is a solid light blue.

Advocating strongly for doctor's safety and dignified working conditions.

Engaging with policymakers for pragmatic reforms that support, rather than stifle healthcare providers.

Supporting small and medium hospitals, which remain the unsung heroes of rural & urban healthcare.

Creating forums to resolve disputes with insurance agencies and ensure timely reimbursements under government schemes.

Reinforcing ethics, communication, and transparency to rebuild the doctor-patient bond.

Raising awareness on the risks of crosspathy and safeguarding patient safety and accountability.

Assisting members legally and professionally in dealing with negligence and CPA cases.

Promoting doctor's well-being - physical and mental health, because a cared for doctor can care better for society.

Guiding members on safe and ethical use of digital health technologies.



Editor Speaks - Dr. Ashok Shukla	6
President Precept - Dr. Rajeev Agarwal	7
Secretary Report - Dr. Prashant Kerkar	10
Obituaries	12
Program Committee Report - Dr. Navneet Desai	13
Doctors Day Program	22
Medical Ethics & Law- Complementary Or Conflicting? - Dr. Lalit Kapoor	30
IPC- Legal Ramifications For Medical Practitioners By - Dr. Sujay Kantawala	33
Security Settings For Phones And Social Media. - Dr. Aashish Mody	38
Future Of Healthcare: The Smart Hospital Revolution - Dr. Rakhi Rajeev Agarwal	40
Impact Of Ai In Medico-legal - Dr. Harold D'costa	44
Low-Cost Transcranial Magnetic, Electrical, & Ultrasound Therapies - Dr. Sagar A. Jawale	48
Hospital Fires In India - Mr. M.V Desmukh	51
Finnovate Debt Detox	57
Redevelopment Guidelines for Doctor's Clinic & Hospitals - Adv. Anilkumar Marlecha	63
AMC & Tata AIG: Your Journey, Our Assurance - Manish Singhania	69
From Paper to Precision: Why Digitization Is Now a Clinical Imperative	71
Umbrella Package policy for your Medical Establishment	73
Cyber Security Compliance In Indian Hospitals - Shinee D'Costa	76
Navigating the Complex Landscape of Medical Facility Setup in India - Dr. Mayur Sarode	80
Medication Errors - liability Of Hospital - Dr. Suganthi Iyer	89
Should Non-allopathic Doctors Be Allowed To Practice Allopathy? - Jehangir B. Gai	95
Chronic Foot and Ankle Pain - Dr. Raj K Singh	98
What Happens to Hospital Waste After You Leave - Dr. Lata Ghanshamnani	101
Health Benefits of a Whole-Food, Plant-Based Diet - Dr. Rupa Shah	108
A Holistic Way To Manage Mental Health And Stress In Life By - Dr. Anil Garg	113

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Association With A Mission And Commitment



From the Editor's Desk

Dr. Ashok Shukla

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It gives me immense pleasure to present the third edition of The Grasp — the flagship quarterly bulletin of the Association of Medical Consultants (AMC) Mumbai). Each issue of The Grasp is more than just a publication; it is a reflection of our association's vibrant journey — showcasing our shared achievements, collective wisdom, and unwavering commitment to the medical fraternity.

AMC Mumbai continues to play a pivotal role in safeguarding the interests of doctors and enhancing the standards of healthcare delivery. Under the visionary leadership of our President Dr. Rajeev Agarwal and the dedicated team of Office Bearers and Executive Committee members, the association has expanded its horizons through impactful academic programs, medicolegal awareness drives, welfare initiatives, and strong advocacy for medical professionals.

This edition encapsulates the breadth of AMC's activities — from our academic and policy initiatives to welfare schemes like the Umbrella Insurance Policy and professional indemnity support. It also features insightful articles and member contributions that stimulate thought and celebrate the spirit of togetherness within our fraternity.

As Editor, I express my sincere gratitude to all our contributors, readers, and members whose energy and enthusiasm keep The Grasp alive and thriving. Your participation and feedback are the true driving forces behind its continued success.

Let us move forward with renewed purpose - informed, united, and inspired - as we continue to strengthen AMC Mumbai and uplift the stature of the medical profession.

With warm regards,
Dr. Ashok Shukla
Editor, The Grasp
Association of Medical Consultants – Mumbai



President's Perspective

Dr. Rajeev Agarwal

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Dear AMC Members & Doctors

It gives me great privilege to address you through this edition of Grasp, our quarterly bulletin. As we step into another quarter, I wish to share with you both the challenges confronting the medical profession today and the opportunities that lie ahead. Medicine remains a noble calling, but the environment in which we practice is becoming increasingly complex.

One of the gravest concerns is the rising incidence of violence against doctors and healthcare staff, often triggered by unrealistic expectations and misinformation. No profession can function under fear, and it is our collective duty to pursue stronger protective legislation, while simultaneously creating public awareness to restore trust and safety in healthcare spaces.

Alongside this, stricter government norms and compliance requirements are making survival difficult for small and medium-sized hospitals, which form the backbone of affordable healthcare in India. Their closure would create a dangerous imbalance in service delivery. At the same time, delayed reimbursements under

government health schemes and arbitrary practices by insurance companies are eroding the financial viability and autonomy of institutions, forcing doctors into administrative battles instead of patient care.

The delay in Maharashtra Medical Council (MMC) elections has further denied doctors their rightful democratic voice, weakening our representation in policy-making at a critical time.

Equally concerning is the erosion of the doctor-patient relationship. Increasing corporatization and takeover of hospitals by non-medico business houses have shifted focus from service to commerce. The essence of our practice—trust, compassion, and continuity of care—risks being replaced by profit-driven targets.

Other issues demand our urgent attention: the unresolved crosspathy and homeopathy encroachment, the rising number of medical negligence and Consumer Protection Act (CPA) cases—many of them frivolous—and the growing burnout and mental health challenges among doctors. All these factors contribute to an

atmosphere of defensive medicine, which is detrimental both to doctors and patients.

In parallel, new realities are emerging. Telemedicine, AI, and digital health records are transforming our work. While these technologies offer great opportunities, they also raise medico-legal, ethical, and data privacy concerns that we must prepare for. Medical education and continuous professional development—especially in communication, ethics, and legal awareness—must be strengthened to equip our younger colleagues for these challenges.

We must also engage constructively with the media and the public to counter negative portrayals of the profession and highlight the value doctors bring to society.

Way Forward

As an association, AMC Mumbai remains committed to:

Advocating strongly for doctors' safety and dignified working conditions. Engaging with policymakers for pragmatic reforms that support, rather than stifle, healthcare providers. Supporting small and medium hospitals, which remain the unsung heroes of rural & urban healthcare. Creating forums to resolve disputes with insurance agencies and ensure timely reimbursements under government schemes.

Reinforcing ethics, communication, and transparency to rebuild the

doctor–patient bond.

Raising awareness on the risks of crosspathy and safeguarding patient safety and accountability.

Assisting members legally and professionally in dealing with negligence and CPA cases.

Promoting doctors' well-being - physical and mental health, because a cared-for doctor can care better for society.

Guiding members on safe and ethical use of digital health technologies.

Strengthening CME, training, and mentorship to prepare the next generation of doctors.

Despite the many hurdles before us, let us not forget that medicine is more than a profession—it is a mission of service. Our collective voice carries immense strength. By remaining united, proactive, and resilient, we can transform these challenges into opportunities and secure a healthier, more ethical future for our profession and for society.

Together, let us uphold the dignity of medicine with pride, integrity, and compassion.

The AMC Umbrella Insurance Policy, launched on Doctors' Day, has already begun making a meaningful difference for our members. By insuring hospitals and clinics under this comprehensive plan—covering fire and several other critical aspects—many of you have saved substantial costs while ensuring robust protection for your

establishments. I encourage all members who have not yet explored this opportunity to connect with our team for detailed guidance and benefits.

Continuing our commitment to address pressing issues faced by the medical community, we are pleased to announce MLCON with NOAHCON, our upcoming medicolegal conference, scheduled for Sunday, 2nd November 2025, at The Club, Andheri (8:30 am–5:00 pm). This conference will focus on hospital related issues , insurance challenges, and medicolegal issues that impact our daily practice. A galaxy of distinguished speakers will share their expertise—full details will follow shortly.

Looking ahead, mark your calendars for AMCON with FAMCICON, to be held on Sunday, 11th January 2026, at The ITC Grand Maratha, Andheri. This flagship event will bring together renowned experts from diverse fields to inspire, educate, and empower us with fresh perspectives and actionable insights.

As we navigate an evolving healthcare landscape, AMC Mumbai remains steadfast in championing the interests of our fraternity, fostering knowledge-sharing, and ensuring our members are well-prepared for future challenges. Your participation and engagement are what make our initiatives impactful—together, we continue to strengthen our collective voice and vision.

Warm regards & Always available
for Doctors

Truly Yours

Dr. Rajeev Agarwal
President,
AMC Mumbai



A Message from the Secretary's Desk

Dr. Prashant Kerkar

Hon. Secretary,
Association Of Medical Consultants, Mumbai
Oncosurgeon
Secretary@amcmumbai.org

Warm greetings as we enter the festive season! Welcome to the Third edition of our newsletter, The Grasp.

As I reflect on the past six months, it's remarkable how quickly time has passed amidst a flurry of activities. Our term is at the halfway mark, and we have accomplished a great deal, with much more still to come. We have successfully held zonal conferences and a series of unique online webinars, including our insightful AI Webinar and a Financial Wisdom Webinar in partnership with Finnovate.

A significant achievement was the launch of the Umbrella Policy, a comprehensive insurance solution for nursing homes and clinics. This all-inclusive policy, developed through the tireless efforts of our President, Dr. Rajeev Agarwal, covers the full spectrum of a hospital owner's needs at an incredibly low rate. We have also remained committed to assisting every member who has reached out

for help, standing by our mission and commitment to support our members through thick and thin.

Our association has now grown to over 16,600 members, and we continue to expand, including our student membership. The number of affiliate bodies in various cities is also increasing, thanks to the dedicated work of our affiliate cell.

We are always looking for ways to better serve you. I encourage all members to reach out to me or any member of our team with suggestions. We are actively working to address various member needs, including professional indemnity, health and accident coverage, and the Consultants Benevolent Scheme, which I urge more members to utilize. We have also recently partnered with the Art of Living foundation to host sessions aimed at improving the mental well-being of our members.

Finally, I invite you to two upcoming flagship events:

MLCON with NOAHCON on November 2nd, a program dedicated to addressing medicolegal queries.

The AMCON, our annual flagship conference, on January 11, 2026, at the ITC Grand Maratha.

We look forward to your active participation and more fruitful interactions.

Sincerely,

Dr. Prashant Balvant Kerkar

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14-Jul-2025
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29-Jun-2025
DR. RAMESH B. PANDIT
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09-Aug-2025
DR. KAMLAHARI HARI VELANKAR
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CHEMBUR



18-Sep-2025
DR. ANITA MARIA BORGES
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MUMBAI



15-Sep-2025
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CHEMBUR



07-Sep-2025
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PCCs Report Seven Months of Dynamic Leadership

Dr. Navneet Desai

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Gynaecologist & Obstetrician**

The AMC has experienced a truly remarkable seven months under the stewardship of Dr. Rajeev Agarwal as President and Dr. Prashant Kerkar as Secretary. Since the committee's induction, the team has successfully conducted 51 diverse programs, reflecting an unwavering commitment to professional excellence and community welfare. The synergy and dedication of each committee member, guided by a highly motivated leadership duo, have been central to this success. A Brief of all programs is mentioned in the table below

The report will be incomplete if I don't make a special mention of the Doctors Day Celebration this year

A significant highlight of this period was the "Doctors Day JALLOSH," hosted on June 29, 2025, at Rangsharda Auditorium, Bandra. The event was conceived to honor the tireless service and compassion of medical professionals. With a theme of

"Entertainment, Entertainment, Entertainment," it showcased spirited participation from doctors throughout AMC. The day featured a competitive dance contest among nine zonal teams, alongside four non-competitive performances, with distinguished judges from the arts and cultural fields. Prizes were awarded to outstanding teams, and all participants received certificates of appreciation.

The day was celebrated by honoring Real Life Heroes
Cdr Vijay Vadhera and
Brg Hemant Mahajan

The Sanjeevani Distinguished Service Award was presented to Dr. Shrikant Badwe for exemplary service to members of AMC

Past presidents were acknowledged via a unique fashion walk, celebrating their lasting impact on the organization. The event also included stand-up comedy and poetry, further strengthening camaraderie among attendees.

Throughout this period, AMC has conducted educational events totaling 19 credit points, underscoring its dedication to continual learning.

Other impactful initiatives included blood donation drives, thalassemia awareness campaigns, academic conferences, and webinars, each reinforcing AMC's role as a unifying force within the medical community. These efforts have both fostered collaboration among professionals and yielded tangible benefits for society at large.

For smooth and meticulous conduction of all these events we have had 27 office bearer meetings and 4 Managing committee meeting so far

AMC remains steadfast in its mission to expand its reach, elevate standards of medical practice, and serve the community with care and knowledge. The past seven months demonstrate the association's spirit of teamwork, excellence, and meaningful impact in public health and professional advancement.

Regards,
Dr. Navneet Desai
PCC

NO	PROGRAM	DETAILS	HIGHLIGHTS
1	NURSES TRAINING PROGRAM	6/4/2025 RIDDHIVINAYAK HOSPITAL NALLASPORA PROGRAM CONVENOR: DR S N AGARWAL	VERY WELL CRAFTED PROGRAM ATTENDED BY MORE THAN 500 NURSES PROGRAM FOCUSED ON SKILL ENHANCEMENT AND ETHICAL PRACTICE IN NURSING CARE
2	NURSES TRAINING PROGRAM AT ANH	19/4/2025	
3	NURSES TRAINING PROGRAM AT ANH	23/4/2025	
4	LEH LADAKH TOUR	25/4/2025	SCENIC TOUR TO LEH LADAKH WITH ALL INCLUSIVE PACKAGE OF RS 69999/- WAS SUCCESSFULLY COMPLETED
5	BLOOD DONATION DRIVE	6/5/2025 WAS ORGANISED IN PALGHAR WITH MAHARASHTRA BLOOD CENTRE.	PRE DONATION COUNSELLING AND HEALTH CHECK WERE PROVIDED
6	THALASSEMIA AWARENESS DRIVE	7/5/2025 DIGNITARIES : DR RAJEEV AGARWAL (PRES AMC) DR RAMDAS MARAD (CIVIL SURGEON PALGHAR) DR BAL INAMDAR (PDG ROTARY DIST 3141) DR NEELIMA INAMDAR (AVENUE CHAIR ROTARY DIST3141)	EXPERT TALKS AND INTERACTIVE SESSIONS WITH THALASEEMIA KIDS FREE SCREENING CAMPS FOR YOUNG ADULTS AND COUPLES FREE BLOOD WAS GIVEN TO CHILDREN SUFFERING FROM THALASSEMIA
7	MOTHERS DAY CELEBRATION	10/5/2025	
8	DOCTORS DAY CELEBRATION	29/6/2025 RANG SHARDA AUDITORIUM, BANDRA DOCTORS DAY JALLOSH	DETAILS GIVEN SEPERATELY

9	ZONAL PROGRAM AT MIRABHAYANDER IN ASSOCIATION WITH OBSTETRICS AND GYNAECOLOGICAL SOCIETY MIRABHAYANDER	1/6/2025 GCC HOTEL MIRA BHAYANDER	OBGY CONCLAVE WITH EXPERT TALKS BY DR S N AGARWAL DR NAVNEET DESAI DR RITU HINDUJA DR DHARAM SHAH DR VAIDEHI THIS WAS FOLLOWED BY PANEL ON CRITICAL OBSTETRIC CARE MODERATED BY DR ASHOK SHUKLA AND DR RAJENDRA NAGARKATTI
10	MEDICOLEGAL WEBINAR WITH MUMBAI OBSTETRIC AND GYNAECOLOGY SOCIETY	25/6/2025 ONLINE PLATFORM PROGRAM CONVENOR: DR ASHOK SHUKLA	WITH THIS MEDICOLEGAL WEBINAR SERIES WAS LAUNCHED SURROGACY LAWS , MTP ACT & ART REGULATIONS WERE BEAUTIFULLY ELABORATED BY EXPERTS IN FIELD DR DILIP WALKER, DR VAISHALI CHANDANSHIVE, DR SUGANTHI IYER, DR SUDHIR NAIK , DR RAJENDRA NAGARKATTI AND DR RAJEEV AGARWAL MORE THAN 350 PEOPLE HAD LOGGED IN
11	YOGA DAY	21/6/2025 WOCKHARDT HOSPITAL MIRAROAD	WELL ATTENDED EVENT
12	BLOOD DONATION DRIVE	14/6/2025	PALGHAR
13	BLOOD DONATION DRIVE	1/5/2025 MIRABHAYANDER BLOOD BANK PROGRAM CONVENOR:DR NAVNEET DESAI	MORETHAN 70 PEOPLE REGISTERED AND 40 UNITS OF BLOOD WAS COLLECTED
14	BLOOD DONATION DRIVE	15/5/2025 POSSA HOSPITAL UTTAN PROGRAM CONVENOR: DR RAJEEV AGARWAL, DR POSSA	27 TH BLOOD DONATION DRIVE MORE THAN 581PEOPLE REGISTERED AND 529 UNITS OF BLOOD WAS COLLECTED
15	WEALTH RX ONLINE COURSE ORGANISED WITH FINNOVATE	22/6/2025 MODULE 1: ALL ABOUT FINANCIAL PLANNING FOR ACHIEVING YOUR GOALS	7 MODULE ONLINE CERTIFICATE COURSE IN FINANCIAL PLANNING & INVESTMENT STRATEGIES FOR DOCTORS
16	WEALTH RX ONLINE COURSE ORGANISED WITH FINNOVATE	6/7/2025 MODULE 2: HOW TO GROW YOUR WEALTH SAVING TAXES	

17	WEALTH RX ONLINE COURSE ORGANISED WITH FINNOVATE	20/7/2025 MODULE 3: OVERVIEW OF ALL ASSET CLASSES AND BASICS OF INVESTING IN MUTUAL FUNDS	
18	WEALTH RX ONLINE COURSE ORGANISED WITH FINNOVATE	3/8/2025 MODULE 4: BASICS OF INVESTING IN MUTUAL FUNDS	
19	WEALTH RX ONLINE COURSE ORGANISED WITH FINNOVATE	24/8/2025 MODULE 5: BASICS OF FUNDAMENTAL & TECHNICAL ANALYSIS	
20	WEALTH RX ONLINE COURSE ORGANISED WITH FINNOVATE	7/9/25 LOANS INSURANCE LEGACY : MANAGING RISKS & WEALTH TRANSFER	
21	WEALTH RX ONLINE COURSE ORGANISED WITH FINNOVATE	21/9/2025 MODULE 7: INSTILLING THE RIGHT FINANCIAL HABITS	
22	ASHTAVINAYAK TOUR		A RELIGIOUS YATRA FOR 2 NIGHTS 3 DAYS WAS ORGANISED BY AMC IT WAS VERY WELL APPRECIATED
23	BMD CAMP WITH ANH	5/7/2025	MORE THAN 77 PATIENTS WERE BENEFITED
24	AI AND MOBILE TRAINING WORKSHOP	17/7/2025 ONLINE PROGRAM CONVENOR : DR ALOK MODI	EXCELLENT INTERACTIVE WELL ATTENDED EVENT WITH EXPERT TALKS BY DR RAKHI AGARWAL, DR BHARAT SABOO, DR AASHISH MODY, DR S V KULKARNI, DR ALOK MODI
25	TOUR TO GEORGIA & ARMANIA	EXCELLENT TOUR LAUNCHED BETWEEN 4TH OCT - 12TH OCT	WITH SMART TRAVEL SOLUTIONS
26	TRIP TO ANDAMAN	13 TO 19 OCT 2025 BY ONE PLUS HOLIDAYS	

27	MEDICOLEGAL WEBINAR WITH ISA	30/7/2025 KEY MEDICOLEGAL CHALLENGES IN ANAESTHESIA PRACTICE PROGRAM CONVENOR : DR ASHOK SHUKLA	THIS WAS ORGANISED WITH ISA WITH EXPERT TALKS BY DR RAJESH RAO, DR RAJEEV AGARWAL, DR AMOLA PARIKH, DR AMIT NABAR, DR SHIVKUMAR KUMBAR, DR NILESH NAPHADE, DR PRATIBHA KANE, DR ASHOK SHUKLA FOLLOWED BY PANEL DISCUSSION ON MEDICOLEGAL CHALLENGES FACED IN DAY TO DAY PRACTICE BY ANAESTHESIST
28	NURSING TRAINING PROGRAM	24/8/25 RIDDHIVINAYAK HOSPITALNALASOPAR A PROGRAM CONVENOR : DR S N AGARWAL	
29	ZONAL PROGRAM AT MIRABHAYANDER IN ASSOCIATION WITH OBSTETRICS AND GYNAECOLOGICAL SOCIETY MIRABHAYANDER	2/7/2025 GCC CLUB MIRABHAYANDER PROGRAM CONVENOR: DR NAVNEET DESAI	EXCELLENT GYNAEC CONCLAVE WITH EXPERT TALKS BY DR NOZIER SHERIAR, DR BELA BHATT, DR PRIYA GANESHKUMAR, DR RAJENDRA NAGARKATTI, DR SHEETAL PANDEY FOLLOWED BY EXPERT PANEL BY DR ASHOK SHUKLA & DR SUPRIYA ALWARI
30	MEDICAL CHECKUP CAMP	8/7/2025 CONDUCTED BY DR S N AGARWAL	GORAI
31	E FINCON WEBINAR	20/7/2025 PROGRAM CONVENOR :DR VIKRANT DESAI	PRACTICAL ASPECTS OF INCOME TAX FOR DOCTORS WITH EXPERT SPEAKER C.A. JAYANT FURIA
32	ZONAL PROGRAM AT MIRABHAYANDER IN ASSOCIATION WITH OBSTETRICS AND GYNAECOLOGICAL SOCIETY MIRABHAYANDER	24/7/2025 GCC CLUB MIRABHAYANDER PROGRAM CONVENORS : DR ASHOK SHUKLA , DR NAVNEET DESAI	WELL ATTENDED CME WITH EXPERT TALKS ON INFERTILITY BY DR SHEETAL PANDEY, DR MUKESH GUPTA, DR SHRUTIKA THAKKAR, DR MOHIT SARAOGI FOLLOWED BY REVERSE PANEL WITH DR RAJEEV AGARWAL ON UMBRELLA POLICY OF AMC
33	WORLD BREAST FEEDING WEEK CELEBRATION	PROGRAM WAS KEPT ON 7/8/2025 BY DR S N AGARWAL AT WOCKARHT HOSPITAL MIRAROAD	PUBLIC AWARENESS WAS DONE WITH MOTHERS TO BE , POST DELIVERY MOTHERS AND THEIR FAMILIES PARTICIPATING IN VARIOUS ACTIVITIES

34	ZONAL PROGRAM AT MIRABHAYANDER IN ASSOCIATION WITH OBSTETRICS AND GYNAECOLOGICAL SOCIETY MIRABHAYANDER	19/8/2025 MASTERCHEF DAHISAR PROGRAM CONVENOR: DR NAVNEET DESAI, DR KIRAN SHINDE	KEY ISSUES IN OBGY WERE ADDRESSED BY EXPERT SPEAKERS DR MUKESH AGARWAL, DR SIDDHESH IYER, DR MUKESH GUPTA FOLLWED BY TALK ON FINANCIAL HEALTH BY NEHAL MOTA , AMC PI POLICY UPDATE BY DR ASHOK SHUKLA AND UMBRELLA POLICY BY DR RAJEEV AGARWAL.
35	ZONAL PROGRAM AT NALLASOPARA IN ASSOCIATION WITH IMA NALLASOPARA & IMA VIRAR	7/9/2025 PROGRAM CONVENOR: DR RAJEEV AGARWAL, DR RAJENDRA CHAWHAN	WELL APPRECIATED PROGRAM WITH EXPERT TALKS ON PROBLEMS FACED IN DAY TO DAY PRACTICE BY DR SANJAY MANJALKAR, DR NITIN BAYAS, DR ASHOK SHUKLA, DR VENKAT GOAYAL, DR ANAMIKA SAMANT AND DR VIKRANT DESAI ON AMC UMBRELLA POLICY AND MS REKHA MOHNOT ON FINANCIAL HABITS OF INDIA'S WEALTHIEST FAMILIES
36	ZONAL PROGRAM AT BOMBAY HOSPITAL	27/8/2025 PROGRAM CO ORDINATOR : DR PRASHANT KERKAR , DR VAIBHAV SOMANI, DR ASHOK SHUKLA	EXPERT TALKS BY DR VAIBHAV SOMANI, DR DHAVAL GOSALIA, DR ROHIT PAI, WITH DETAILED DISCUSSION ON UMBRELLA POLICY BY DR RAJEEV AGARWAL AND VARIOUS SCHEMES OF AMC BY DR ASHOK SHUKLA AND FINANCIAL HEALTH BY MS NEHAL MOTA
37	ZONAL PROGRAM AT GODREJ HOSPITAL	7/9/2025 PROGRAM CONVENOR: DR BIPIN PANDIT, DR SANJAY SONAR	HERNIA UPDATES WERE DISCUSSED BY EXPERTS DR VISPI JOKHI, DR MANOJ GANDHI, DR MANDAR GADGIL, DR SHALAKA INDAP, DR SANJAY SONAR, DR RAMEN GOEL
38	MEDICOLEGAL WEBINAR WITH IAP	13/8/2025 PROGRAM CONVENOR : DR ASHOK SHUKLA	MEDICOLEGAL TIGHTROPE FOR PAEDIATRICIANS WAS DISCUSSED DR SAMEER SADAWARTE, DR VINKY RUGHWANI, DR JAYANT NAVRANGE, DR RAJEEV AGARWAL FOLLWED BY EXPERT PANEL ON MEDICOLEGAL ISSUES FACED IN DAY TO DAY PRACTICE

39	AI AND MOBILE TRAINING WORKSHOP	21/8/2025 PROGRAM CONVENOR :DR ALOK MODI	EXPERT TALKS BY DR BHARAT SABOO, DR NEERAJ BIJLANI, DR HARESH HIRANI, DR ALOK MODI
40	ART OF LIVING ONLINE WORKSHOP	31/8/2025 ORGANISED BY ART OF LIVING ORGANISATION	A HOLISTIC WAY TO MANAGE MENTAL HEALTH AND STRESS IN LIFE WAS DISCUSSED
41	ZONAL PROGRAM AT MMR CHILDRENS HOSPITAL	14/9/2025 PROGRAM CONVENOR: DR KRITIKA DOSHI, DR SUPRIYA ARWARI, DR UJWALA BARDAPURKAR	EXPERT DISCUSSION BY DR G B KULKARNI, DR SANDEEP KELKAR, DR VINOD DUBEY, DR PRASHANT KERKAR, DR RAJEEV AGARWAL, DR HARSHAL AGARWAL, DR ASHOK SHUKLA, MS NEHAL MOTA, DR KIRAN TAMKHANE, DR DEEPAK JUMANI FOLLOWED BY PANEL ON ROLE OF AMC IN DAY TO DAY PRACTICE PROBLEMS FACED
42	MEDICOLEGAL WEBINAR WITH ASI	24/9/2025 BEYOND THE SCALPEL: MASTERING MEDICOLEGAL RISK PROGRAM CONVENOR :DR ASHOK SHUKLA	IN ASSOCIATION WITH SURGICAL SOCIETY OF INDIA MAHARASHTRA CHAPTER EXPERT TALKS BY DR SAMEER REGE, DR SACHIN NAIK, DR SHAILESH MOHITE, DR NIRANJAN AGARWAL, DR SURESH VASISTHA, FOLLOWED BY PANEL ON MEDICOLEGAL RISK IN DAY TO DAY PRACTICE MODERATED BY DR SANDEEP REGE, DR RAJENDRA TIWARI.
43	AI AND MOBILE TRAINING WORKSHOP	25/9/2025 PROGRAM CONVENOR: DR ALOK MODI	EXPERT TALKS BY DR RAJEEV AGARWAL, DR SHAMBA SAMAJDAR, DR RAJESH KESARI, DR HARSH HIRANI, DR ALOK MODI
44	ZONAL PROGRAM AT BOISAR IN ASSOCIATION WITH OBSTETRICS AND GYNAECOLOGICAL SOCIETY MIRABHAYANDER	27/9/2025 PROGRAM CONEVENOR: DR RAJENDRA CHAWHAN, DR RAJENDRA TIWARI	EXPERT TALKS IN GYNAEC BY DR VIDHA SANGAR, DR PRASHANT KOTI, DR RAJENDRA TIWARI, DR RAJEEV AGARWAL, DR RAMDAS MARAD FOLLOWED BY PANEL IN CRITICAL CARE IN OBS BY DR RAJENDRA CHAWHAN , DR RAJESH SINGH, DR ASHOK SHUKLA

45	ZONAL PROGRAM AT JUHU	28/9/25 PROGRAM CONVENOR: DR MANOJ PATEL	EXPERT TALKS BY DR GAURAV CHAUBAL, DR RAJEEV AGARWAL, DR PRADYUMMA OAK, DR GEORGE K, DR ASHOK SHUKLA, MS REKHA MOHNOT, DR MUZAMMIL SHAIKH, DR RAJ ATTUR, DR SUSHANT PATIL, DR JATIN KOTHARI
46	Medical camp at Suraj plaza	29/8/2025 During Ganesh chaturthi	included Thyroid, ECG, BMD, Blood sugar, and Eye checkup More than 100 people took benefit
47	MENSTRUAL CUP DISTRIBUTION TO HEALTHCARE WORKERS	9/9/2025 AT MIRABHAYANDER MBMC WITH SAKHI PROJECT INITIATIVE OF NGO Rnisarg	
48	Medical checkup camps	•08/09/2025-Anemia camp at Agarwal Nursing Hospital •13/09/2025- Anemia camp at Water Kingdom where 78 strips of Iron tab given to anemic pt.	
49	AI WORKSHOP	16/10/2025 ONLINE PROGRAM CONVENOR : DR ALOK MODI	EXCELLENT INTERACTIVE WELL ATTENDED EVENT WITH EXPERT TALKS BY DR MILIND GUNE ,DR NEELESH KAPOOR, MR RAJ ATUR, , DR ALOK MODI FOLLOWED BY INTERACTIVE PANEL DISCUSSION
50	WEBINAR WITH PSYCHIATRIC ASSOCIATION	MENTAL HEALTH ISSUES	
51	TRIP TO ANDAMAN	24 TH OCT 2025	

Doctors Day



Doctors Day



Doctors Day



Doctors Day





Doctors Day



Doctors Day



Doctor's Day

Musings –From the Heart of a Gynecologist

Today is Doctor's Day.
And with Google and ChatGPT having
their say,
It often feels like I've been sidelined
halfway —
But somehow, I've still found my way.

Today, I may be put on a pedestal,
But I will aim to stay humble,

My journey began with a dream
And today, in society, I stand among
those called “cream”
My eyes always gleam,
hen people hold me high esteem

I'm happy to welcome babies with
cheer,
To celebrate life when it draws near.
The first cry, a moment so dear
It makes my career

I'm happy to soothe hormonal storms,
Navigate menopause and all its moans
I'm happy to manage sonography and
mammography
I'm happy to deal with pap smears and
cancer fears

At times, I'm bugged, at times, I'm
hugged,
But always happy to be in my scrubs
With all the blood and the mess
And despite all the stress,
There's a quiet joy, in simply being
here,
I am happy to be a doctor, that is clear.





MEDICAL ETHICS AND LAW- COMPLEMENTARY OR CONFLICTING?

Dr. Lalit Kapoor

Since the evolution of mankind, efforts have been made to regulate the behavior of individuals and groups of individuals in society by voluntarily enunciating a code of ethics for their respective members. Ethics has been defined as a science of moral principles. In fact, ethics is something that has to do with your conscience. It is a code of conduct, a way of behavior, almost a way of life. For all practical purposes, the words "ethical" and "moral" are interchangeable. At one time, it was like advice from a father to a son. There are some who believe that ethics cannot be taught, it can only be inculcated, especially by example. The oldest code of ethics for medical practitioners was the Hippocrates oath which formed the basis for a self-inflicted code of conduct.

We have to understand the relationship between Medical Ethics and Law before we try to answer the question – Are the two complementary or conflicting? The link between Ethics and Law has been very neatly summed up thus- “Law cannot reach where enforcement cannot follow. Hence, ethics begins where the law ends or cannot reach.”

The fact of the matter is that Ethics cannot be considered in isolation of Law or vice versa. Ethics and Law are

cognate i.e. "related to or descended from a common ancestor." Hence, there is considerable overlap between Ethics and Law. They cannot be taught separately, and undoubtedly, they are complementary. Historically, as we said earlier, the code of conduct was self-inflicted. However, with the passage of time, evolution of society, with the tremendous scientific progress and rapid industrialization there was a sea change in the social and cultural behavior of the people. The number of physicians increased greatly and the relations between physicians were wedged by several interacting forces –politics, government, law, media, etc. It became necessary to frame statutory measures enforcing the principles laid down in the code of ethics and that is how Medical Councils were born.

The mind-boggling advances in Medicine and Technology keep aggravating the dilemmas of doctors and society and the margins between Ethics and Law become more and more hazy and the common lineage between the both becomes more evident. How does one determine where Law ends and Ethics begins It is true that Law is lagging hopelessly behind, the advances in Medicine-not having kept pace with progress in Medicine.

Genetics, Prenatal testing, organ

donation, stem cell applications, abortions, end of life issues, surrogacy are all areas which have thrown up numerous challenges which are unaddressed by law and have created painful predicaments for doctors. It must also be recognized that though Medical Ethics and Law can be considered complementary, there are areas of dissonance and conflict. For example, under the Code of Ethics, a medical practitioner gives a solemn declaration: "I will maintain the utmost respect for human life from the time of conception". And yet, every day doctors are terminating human life by way of abortions since they have the force of Law with them. Thus, terminating a life-in the making could be Legal, though unethical. This could of course vary from geographical region to region. The same act could be both illegal and unethical in a country like, say, Ireland but not so in India. In other words, an act could be illegal but ethical and yet on the other hand, an act could be legal yet unethical.

An example of the latter pertains to dichotomy of professional fees. There is no Law or Statute in India, not even an Income Tax law, which is violated in case of fee-splitting. However, what can be invoked is the violation of the Code of Ethics which specifically prohibits such an act. Hence, fee-splitting is not illegal but it is unethical!

There is another area of conflict, which is worthy of note. The Medical Code of Ethics states unequivocally: "In an operation which may result in sterility, the consent of both husband and wife is needed. "This is in direct conflict of the

Law which emphasizes that, for a sterilization operation, consent of the spouse is not essential! Where does this leave the poor doctor? Does he follow his Code of Ethics or should he follow the Law? And consider this from the Code: "6.6. Human Rights: The Physician shall not aid or abet torture nor shall be a party to either the infliction of mental or physical trauma or concealment of torture inflicted by some person or agency in clear violation of human rights" Where does this leave the jail doctors and the doctors being part of a team executing a capital punishment?

It is hence amply clear that though Medical Ethics and Law are supposed to be complementary: there are areas of conflict which need to be resolved. Also, with the rapidly changing healthcare scenario in this country, the relevance and applicability of the Code of Ethics needs to be re-looked into and made modern and more in sync with the times. Undoubtedly, the principles enshrined in the code of ethics are extremely noble and the spirit of these should never become irrelevant. However we need to re-visit this Code. I am afraid, if this is not done, it might soon become anachronistic and a historical document. Apart from the unprecedented advances in Medicine, our Society itself has undergone a tremendous metamorphosis. Materialism, greed and self-centeredness is the order of the day and our sense of right and wrong is totally blurred. Exemplary, unselfish behavior is no longer looked upon as a model to be followed but on the contrary, has

become a target of ridicule and derision.

Industrialization and rapid urbanization have led to the depersonalization of human relationships in all walks of life—whether between students and teachers, children and parents, employees and employers. In such a milieu is it realistic to expect the doctor-patient relationship to remain an exception and to remain insulated from the changing equations all around?

Healthcare is now a multi-billion dollar "industry" and growing by the day. Healthcare is now a marketable commodity. The mind-boggling advances in Medicine and Technology keep aggravating the dilemmas of doctors and society and the margins between Ethics and Law become more and more hazy and the common lineage between the both becomes more evident. How does one determine where Law ends and Ethics begins. It is true that Law is lagging hopelessly behind, the advances in Medicine-not having kept pace with progress in Medicine.

In such a milieu, the elaborate prescribed code of medical ethics is bound to take a back-seat. Whereas in earlier days, medical students were exhorted to master the art and science of Medicine, it is now inevitable that they master the art, science and commerce of Medicine!

However, it is precisely in such

circumstances that there is heightened need for auto-regulation so that Medical Ethics can truly complement the Law. But this can only happen, if the provisions in the present Code of Ethics are re-visited. We may need to delete, revise, modify, modernize, and even rationalize some of the provisions. The Medical Council Act is flawed piece of legislation and needs re-crafting. The Medical Councils need to get greater autonomy and freed from the interference of politicians. When a wealthy philanthropist in the USA made efforts to have endowed in his name a Chair of business ethics at the Harvard Business School, his offer was politely refused by the Dean of the institute on the ground that there was no such thing as ethics in business! This is precisely what happens when there is an awesome mushrooming of the various kinds of peddlers of the medical commodity resulting in unabashed and virulent marketing.

To sum up, we have a situation in which there is blatant Commodification of healthcare, Commercialization of medical education, Consumerisation of the patient and Corporatization of hospitals -----and the picture is complete!

In such a scenario, ethics, complementary to Law or otherwise, can easily be relegated to the back burner and ethics will then truly become a matter of your conscience!



SCALPEL, SUCTION, SENTENCE: BNS vs. IPC- legal ramifications for Medical Practitioners By

Dr. Sujay Kantawala
Advocate

Let the Doctors enjoy the romance of practice in an environment which would allow them to save lives for all its beauty and not for the fear of arrest

INTRODUCTION

Medical practice always operates with dual responsibility: to heal patients with due compliance of Legal Duties and Ethics. In India, the Criminal Law Governing Medical Negligence has long been a source of anxiety for Doctors. In the recent legislative overhaul replacing the outdated Colonial Era Criminal Laws, marks a significant shift in India's Criminal Justice Architecture, especially, qua the subject of this Article. This historic overhaul has implications not only on criminal jurisprudence broadly but also for sector-specific concerns, notably causing death by negligence, where legal ambiguities have long exposed Healthcare Professionals to the risk of criminal prosecution and fine. This is in addition to the disciplinary proceedings and the Consumer Court litigation.

implement the technology-based provisions. Victim participation has also been highly emphasized in the new laws.

This Article reviews the key differences, what remains from earlier precedents, and how landmark judgments, particularly, Jacob Mathews Vs. State of Punjab etc., have shaped the evolving landscape vis-a-vis the aspect of any Rash or Negligent act not amounting to Culpable Homicide by a Registered Medical Practitioner while performing Medical Procedures.

JACOB MATHEW VS. STATE OF PUNJAB1

Patient admitted with breathing difficulty died. The Hospital was found lacking in oxygen supply (an empty cylinder used), etc. An FIR was filed under Section 304A IPC (death by negligence). The Supreme Court, inter-alia, held that for a Doctor to be criminally liable under Section 304A IPC, negligence must be gross or reckless, not a mere error of judgment, not a simple accident. Also, there must be prima facie evidence of such negligence, often supported by Expert Medical Opinion. It provided guidelines to prevent unjust prosecution of Medical Professionals, thus, preserving a balance between patient rights and protecting Doctors from unnecessary harassment. The importance of an independent opinion

before any action is taken was also emphasized. The question is, does the new avatar of Section 304A which is Section 106 of BNS, 2023 wish away such a critical component? Essentially, a disgruntled Patient's complaint can still trigger a FIR faster than you can say "Appendicitis".

If intentionally, the Patient's Rights are violated only then, it is to be considered as malpractice as a result of a Rash and Negligent Act, as mentioned under the new Section 106 of the BNS Act, 2023. There is a fine distinction between "Negligence" Vs. "Malpractice". The aspect of intent also assumes great

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1. Jacob Mathew Vs. State of Punjab And Another (2005) 6 Supreme Court Cases 1

significance, as no sane Medical Professional ever even dreams of causing harm to any Patient. I know of many Doctors, who immediately tell the Patient that they are not capable of performing or advising a particular medical procedure or otherwise. The aspects of Informed Consent and the

risks associated with any particular procedure also are falling within the realm of the Code of Ethics, which are well-known.

2. Lalita Kumari

The Constitution Bench of the Supreme Court of India inter-alia clarified that, in a medical negligence case, allowing preliminary inquiry is a sine-qua-non, preventing the abuse of process. The Judgement strikes a critical balance between protecting individual liberties and ensuring prompt Criminal Justice delivery, laying down clear timelines and categories where such inquiry may be justified.

The judges must have realized and understood the difference between Patent cause of negligence i.e., a clear and obvious error made by a professional such as a foreign object left in a patient's body during surgery, etc., and Latent cause of negligence which are issues which are virtually never anticipated by any reasonable man in a particular situation. Recently, there was a news article on a Pakistani Surgeon in England, where, during an on-going surgery, he left the O.T. and went to have sex with a nurse in some other room in the Hospital. Many such shocking incidents are noticed from time to time.

3. Praful B. Desai Case

The Supreme Court in 2013 acquitted Dr. Desai of criminal negligence under Criminal Law, inter-alia, holding that though there was negligence, it was

not of such a degree to be criminal. Even where serious medical errors or omissions are noticed, foisting of criminal liability demands a higher threshold: degree of

2 Lalita Kumari Vs. Government of Uttar Pradesh And Others (2014)

2 Supreme Court Cases 1

3 The State of Maharashtra Vs. Dr. Praful B. Desai 2003 (4) SCC 601

negligence, direct involvement, foreseeability, lack of standard of care, expert opinion, etc. It underscores that negative outcomes, even painful ones, do not automatically translate to criminal wrongdoing. Patients do die. This key lesson being utterly clear, has ended up putting the medical profession on a chopping block. The attempt to codify and structure criminal negligence laws is commendable in theory but lacks implementation and procedural safeguards and zero judicial discretion in medical cases are a dangerous prescription for disaster. Traces make cases.

The IPC, though exhaustive, was often criticized for being punitive rather than reformatory and for failing to distinguish between unintentional errors by Medical Professionals and gross negligence amounting to criminal liability. The BNS, under its freshly minted Section 106 prescribes a maximum of 5 years for general negligence and adds a special clause for Medical Professionals, table of which, for easy reference, is as under:-

Aspect	IPC Provision(s)	New BNS Provision(s)	Major Changes / Clarifications
Section dealing with death by negligence	IPC Section 304A – causing death by rash or negligent act not amounting to culpable homicide. The prescribed punishment irrespective of category was imprisonment which was liable to extend up to 2 years, or with fine or with both.	BNS Section 106 – Causing death by negligence	Punishment increased (up to 5 years). For registered medical practitioners, while performing medical procedure, the term may extend up to 2 years and shall also be liable to fine.

CHALLENGES

The implementation of Jacob Mathew safeguards under BNS remains uncertain especially, with no mandatory provision for an Expert Medical Board before prosecuting Doctors. This gap, is seen to lead to misuse unless, law enforcement follows judicial guidelines, which is a completely different ground reality. The omission could potentially expose doctors to frivolous litigation and harassment and hence, the Medical Professionals are well advised to record each and every interaction, so as to insulate themselves of any hearsay or rumor or allegation of any commission or omission which has caused death by negligence. Any conduct, not in conformity, which amounts to a malpractice and thereby, leading to any unfortunate incident would cause serious problems. But does the Doctor, therefore, have to conveniently deflect urgent medical interventions and does the Doctor have to leave the patient helpless? We certainly do not intend that our Medical Professionals, who are highly respected should ever work under a shadow of any sort of doubt. I have personally witnessed a Doctor, on Board an Aircraft, 30,000 feet above ground saving a life.

On the other hand, we all are aware about the complete commercialization of hospitals due to the Corporate Structure and is largely seen and top-class medical care remains the luxury of only those who can afford the highly expensive hospitals. It is common

knowledge that targets have to be met which also must be stressful. Social Media regales in the so-called sting operations and exposing malpractices, which may not always be incorrect, as like in every profession, we have Black Sheep, similarly, even in the most honorable profession, we see Black Sheep. The gladiatorial instinct of watching a professional suffer is now embedded in our genes. Due to the super expensive medical costs, millions of Indians, therefore, resort to "Jhola Chaap" or Self-appointed doctors, hakims, vaid, etc., with fake MBBS Degrees and hence, Section 106 clearly uses the word "Registered". I wish that the Legislature would have also considered and discussed the attacks on Doctors as invariably, the Doctor is blamed for any death or complication and the mob violence and fury needs to be severely condemned and punished, which is sadly not seen, and on one hand, the Doctor has to attend a Patient, who is wheeled in, most often in an environment of an emergency situation, keep his presence of mind and also attempt to save him. A decent ambient atmosphere while performing his/her duty and not under a spectre of fear is sometimes an illusory pipe-dream. During the hearing of the PILs in the Bombay High Court in respect of severe beating of doctors at various Government Hospitals, I also appeared and espoused the cause of our Doctor Brothers and Sisters.

Raising awareness and ensuring transparency, amongst doctors and

their patients is crucial to avoid undue fear of litigation. Communication is the key. The shift in legal standards may also affect Insurance and Indemnity Coverage for Medical Professionals. Ultimately, judicial interpretation plays a key role in defining the scope and application of these provisions over time. These provisions under the BNS reflect a more structured and stringent approach to medical negligence prosecution, balanced by judicial insistence, if followed, on clear evidence of breach, expertise, and causation before criminal liability is imposed.

To safeguard against legal liability, it is imperative for medical professionals to ensure that the path of Informed Consent is duly followed and documented, and that comprehensive medical records are maintained at all times. Close supervision, during critical interventions is essential, and practitioners must act in good faith, especially during emergencies. In high-risk or complex cases, obtaining a quick opinion from a Senior Colleague is always advisable in case of even a minute doubt. Additionally, yearly Medico Legal Conferences are a great help in keeping updated with the latest trend of case law which is developing on a daily basis.

CONCLUSION

In conclusion, while the full impact of the BNS will unfold with judicial interpretation and practical enforcement, the changes, whereby, a

separate category has been created for the Medical Professional with lesser imprisonment is a welcome feature. The shift from IPC to BNS represents an important evolution in Indian criminal law. While the new law introduces stricter penalties and wider coverage, it also brings clarifications and specific provisions for medical practitioners.

Doctors are not infallible; they are human beings, not gods, and despite their best intentions, errors can occur in the course of treatment. Expecting perfection in high-pressure, life-and-death situations, where decisions must often be made in a matter of seconds, is both unrealistic and unjust. Subjecting medical professionals to criminal prosecution every time an adverse outcome occurs, not only undermines their morale but also imposes immense mental stress, potentially impairing their judgment and willingness to take bold, lifesaving decisions in critical moments. While the Supreme Court in Jacob Mathew offered critical safeguards to protect doctors acting in good faith, the Bharatiya Nyaya Sanhita (BNS) in its current form lacks explicit statutory protections, making it vulnerable to misuse against the medical fraternity. Unless suitably interpreted, on a ground level, the BNS may unintentionally expose doctors to unwarranted prosecution, deterring them from exercising independent medical judgment in emergencies, which is a lifesaver on most occasions. sujay.kantawala@yahoo.com



Be Aware, Be Safe, Be Alert. Security Settings For Phones And Social Media.

Tech info by
Dr. Aashish Mody

1. Do not dial any number beginning with #or*. These are codes which allow access of your phone to cyber frauds.
2. Do not give OTP even for cancelation of an order that you have not placed.
3. Do not download any suspicious links from unknown source.
4. Do not fill forms asking for support the petition on whats app. The data can be used for malicious purposes.
5. Before shopping on unknown websites from advertisements on facebook or instagram, check authenticity and reviews and ratings of the site. These sites usually allow only credit card payments and no email or number for refunds.
6. Do not download unnecessary videos or photos on any social media app in the phone which you are using for banking.
7. Do not download apps which are not from certified play stores. If you want to download apk do so in an other spare phone first which does not have banking apps.
8. Do not leave your phone unattended at any function or hotel or anywhere you are surrounded by unknown people.
9. Use social media to follow sites that teach something or educate rather than wasting time in forwarding news and gossip which is not authenticated especially on whatsapp. Bugs are usually found in material that has been forwarded many times
10. Be careful when you give team viewer or anydesk control of your laptop to anyone.
11. Keep truecaller off if possible. Can be used just when u want to search as to who has called.
12. Download ES file explorer app. With this you can encrypt and lock important documents on the phone with a password. Also you will get a recycle bin for recovering accidentally deleted items.
1. Put a pinlock on individual apps rather than on the mainscreen. If someone wants to return a lost phone he may not be able to do so. OR write down IN CASE OF EMERGENCY DIAL.... on the lock screen message.
2. Lock apps like gmail, hotmail, yahoo, facebook, instagram, gallery, all bank apps and others which are important.

FACEBOOK

1. Go to settings, account settings, security and login and start 2 factor authentication with sms on phone number.
2. Go to privacy settings, privacy check up and manage who can see your profile and posts. Change to friends instead of public. 3. Go to apps and websites and manage apps which can share your data where u have registered with facebook.

4. Go to news feed settings and explore and do the necessary changes.
5. Also in ads preferences you can select the kind of ads u want to see. Depending upon what u have searched in chrome, shopping apps, etc.

G MAIL, HOTMAIL, YAHOO.

1. go to accounts, click on mail account, settings, security and start 2 step authentication.
2. In security review security events and log out of devices which do not belong to you. Manage devices and manage apps which have full access to your google accounts.
3. Go to password manager and manage saved passwords.
4. Go to poeple and sharing and upload latest contact list from phone. Before take a backup of contacts as a .Csv file on the phone.

Do the same 2 factor authentication in all email accounts as well as instagram settings.

Instagram

1. Go to settings, account privacy and select private.
Security, start two factor authentication.
2. In login activity check all activities and if doubtful activity seen change password.

CHROME

1. go to settings, privacy, switch DO NOT TRACK to On.
 2. Go to Site settings, microphone Block, pop ups Block, ads Block.
- Lot of increase in cyberfrauds. Be safe.
Do not click on any link which promises

free content or at unbelievable rates. Do not give OTP to anyone. There have been cases where

1. Your apple id is blocked. To restart kindly click on link and follow the steps
2. Your hotmail account is compromised. Click on link to change password.
3. From airtel. We give you dth at half price then what you are paying for the channels. Please tell me the code that we have sent as sms on your phone number. BEWARE. IT IS NOT ACTIVATION CODE, IT IS OTP. Your credit card data is compromised.

For credit card

1. Keep a credit card with low amount for online shopping.
2. Switch off international use of credit card in bank app as no OTP is required for international use of credit card
3. preferable to have a paypal account for shopping on international sites.
4. Read a review about the safety of a new site at www.cutestats.com before entering credit card info in new sites that you use.
5. Money lost by credit card can be recovered if complained within 24 hrs but not possible most of the times for debit cards.

Techinfo by
Dr. Aashish Mody.



Future of Healthcare: The SMART HOSPITAL Revolution

Dr. Rakhi Rajeev Agarwal,

M.S. (Gen. Surgery), FAIS, FICS

Medical Director, Shree Kkasturi Medicare Pvt. Ltd.

Keynote

Healthcare is undergoing a paradigm shift. From the urgency of a Code Blue to the empowerment of a Code Cloud, hospitals are moving from reactive emergency response systems to proactive, integrated digital ecosystems. The future belongs to the **SMART HOSPITAL** - where technology, strategy, and patient-centered care converge to deliver safer, faster, and smarter healthcare

1. From Code Blue to Code Cloud

Traditionally, “Code Blue” triggered a high-stress, manual emergency response. But today, with digital alert systems, cloud-based dashboards, and real-time communication tools, hospitals can respond faster and with greater accuracy. The journey from Code Blue to Code Cloud symbolizes not just a technological upgrade, but a complete operational transformation.

2. What is a SMART HOSPITAL?

A SMART HOSPITAL is one that seamlessly integrates technology into every layer of operations.

Here’s what SMART stands for:

- **S-Secure Systems:** Data protection, cybersecurity, compliance with

national digital health frameworks.

- **M -Mobile Integration:** Apps for doctors, nurses, and patients to access information on the go.
- **A-AI-Powered Analytics:** Predictive insights, automated diagnostics, and clinical decision support.
- **R-Remote Monitoring:** IoT devices enabling continuous patient monitoring beyond hospital walls.
- **T -Telemedicine:** Virtual consultations ensuring care without boundaries.

Together with H.O.S.P.I.T.A.L.- Health Information Exchange, Operational Automation, Smart Infrastructure, Patient-Centric Design, Interoperable Platforms, Technology-Driven Training, Advanced Alert Systems, and Lean Management—this forms a **comprehensive framework for the future of healthcare delivery.**

3. Real-World Transformations

At Shree Kkasturi Medicare Pvt. Ltd., we have already begun implementing these principles:

- **Digital Code Blue Alerts** on WhatsApp and internal systems.
- **Electronic Medical Records (EMR)** with cloud backup and encryption.
- **Automated HR, Finance, and Inventory Systems** for transparency and efficiency.
- **AI-powered dashboards** for real-time decision-making.
- **Barcode-based pharmacy management** and RFID-based equipment tracking

These innovations reduce errors, improve patient safety, and ease the burden on healthcare workers.

4. Benefits & Challenges

Benefits:

- Faster emergency response
- Improved patient experience
- Greater compliance (NABH/NDHM)
- Cost savings through efficiency
- Data-driven decision-making

Challenges:

- High cost of implementation
- Training and resistance to change
- Cybersecurity threats
- Need for continuous upgrades

5. The Road Ahead

The hospital of tomorrow will be a **learning, adaptive ecosystem**. Emerging technologies like AI, IoT-enabled ICUs, blockchain-secured records, and predictive analytics will shape care delivery. But the essence will remain unchanged—**human compassion, amplified by technology**.

Take-Home Message

Digital transformation in healthcare is not optional—it is inevitable. Hospitals that embrace the SMART model will not only survive but thrive in the future. As we shift from Code Blue to Code Cloud, let us remember:

Technology does not replace doctors. It empowers them to save lives smarter, faster, and better.

ASSOCIATION OF MEDICAL CONSULTANTS MEMBERSHIP

Total Membership of the Association	: 15693
Members under professional Indemnity Scheme of AMC	: 11120
Persons (Members & Family) under H & A Scheme	: 4840
Members under CBS Scheme	: 1576



S.M.A.R.T. H.O.S.P.I.T.A.L.

S.M.A.R.T..



S – Secure Systems

Data Protection,
Cybersecurity, DISHA
Proposed Act for Data
Security



M – Mobile Integration

Apps for Doctors,
Nurses and Patients



A – AI-Powered Analytics

Predictive Insights &
Diagnostics



R – Remote Monitoring

IoT Devices, RPM –
Remote Patient
Monitoring



T – Telemedicine

Virtual Consults,
Seamless Access

H.O.S.P.I.T.A.L



H – Health Information Exchange

Cloud-Based EMR/EHR Access



O – Operational Automation

Workflow Digitization – HR, Billing,
Pharmacy, etc.



S – Smart Infrastructure

Sensor-Based Rooms, Energy-
Efficient Tech



P – Patient-Centric Design

Experience-Focused, Outcome-
Driven



I – Interoperable Platforms

Systems That 'Talk' to each other



T – Technology-Driven Training

Simulations, VR, Continuous
Learning



A – Advanced Alert Systems

Digital Code Blue, Alarms, Real-
time Alerts



L – Lean Management

Minimized Waste, Optimized
Resources Continuously
improves through Data,
Feedback, and Outcomes
Tracking.

Poster by Dr. Rakhi Agarwal

Guru Purnima

On this occasion of **Guru Purnima**
I pause, To thank all my Gurus who
showed me the way,
Who shaped my journey, day by day.

First and foremost, my father so dear,
My God, my guide,
Always by my side
A mentor so true,
The very first Guru I ever knew.

Then come my teachers — so many, so
wise,

Dr. Kumud Ingle, with a smile so
bright,
She filled my mind with learning's
light.
In those early years, through doubts
and fears,
She held my hand and calmed my
tears.

Dr. Shirish Sheth,
A vaginal surgeon of world repute
He shaped my surgical skills for which
I salute
A Rotarian at heart, that's what sets
him apart
He taught me what true service means,
And now stands tall like a father figure
in my life's scenes

Dr. Usha Saraiya,
Always so calm and composed
To her all my troubles I disclosed
In my darkest hours, she held the
flame,
And helped me play life's game
Even today, through thick and thin,
Her steady support gives me strength
within.

Dr. Duru Shah,
Her vision so sharp, and a mind so
strong,
She always knew where I can go
wrong
But nevertheless, took me along
To reach where I belong.

To every teacher, both **named and
unnamed**,
You gave me roots, you gave me wings,
You taught me life's most sacred
things.
So on this day, with heart so true,
Dear Gurus — I salute you.





IMPACT OF AI IN MEDICO-LEGAL

Dr. Harold D'Costa

President – Cyber Security Corporation

Sr. Advisor – Law Enforcement Agencies

International Trainer – Judges & Public Prosecutors

In the era of cyber security and the evolving landscape, I have witnessed first-hand how technology has reshaped traditional domains, and the medico-legal field is no exception. The integration of Artificial Intelligence (AI) into medico-legal processes has been both revolutionary and disruptive, offering immense potential while simultaneously raising new challenges in the realms of complexity, confidentiality, data integrity, security, accountability, and ethics. The intersection of medicine, law, and technology is now evolving at an unprecedented pace, and AI sits at the very centre of this transformation. In just a few decades, what was once limited to human reasoning, manual evaluation of forensic evidence, and courtroom debates has been transformed by machines capable of processing terabytes of data in seconds, detecting patterns invisible to the human eye, and providing outcomes that influence justice itself.

Historically, medico-legal work relied heavily on human expertise medical practitioners providing clinical judgment, forensic experts interpreting evidence, and legal professionals drawing conclusions from both. This human-driven

process, while deeply respected and often highly skilled, has always been constrained by subjectivity, delays, and the risk of human error. Fatigue, workload, personal bias, and incomplete access to data have often coloured medico-legal evaluations. For centuries, this reliance on manual expertise meant that justice sometimes moved slowly, and occasionally, incorrectly. For instance, a cause of death in a suspicious case could take weeks to establish, with pathologists depending solely on physical autopsy and basic toxicology. In accident or negligence cases, disputes would drag on for months because of the time required for handwriting verification, injury analysis, or radiological comparisons. Such delays meant that victims and their families often suffered extended uncertainty, while the accused remained in limbo.

Artificial Intelligence has begun to address these shortcomings by enabling faster, data-driven, and more consistent decision-making. Algorithms can now analyse massive datasets, ranging from electronic health records to toxicology reports, far more efficiently than humans. A radiological scan that might take a human radiologist an hour to examine can be processed by AI in seconds,

with anomalies automatically highlighted. In medico-legal disputes, such efficiency translates to timely, evidence-backed inputs that directly influence judicial outcomes. For courts already overburdened with cases, the difference is profound—justice can be expedited without compromising accuracy.

The applications of AI in this space are remarkably diverse. In forensic pathology, AI is being deployed to conduct virtual autopsies, where CT or MRI scans are analysed to identify fractures, haemorrhages, or concealed injuries without a single incision. In toxicology, predictive AI models help establish the metabolism rates of poisons or drugs, making it easier to determine the timeline of ingestion and cause of death. In cases of suspected forgery, AI is used to compare handwriting, signatures, or even voice samples with far greater precision than manual methods, providing courts with near-certain conclusions. Similarly, in accident reconstruction, AI combines CCTV footage, vehicle telemetry, and injury patterns to recreate events that clarify liability in both criminal and insurance disputes. These technologies are not replacing human expertise but amplifying it, ensuring that medico-legal opinions are backed by layers of computational certainty.

In India, real-world examples demonstrate the tangible impact of AI in justice delivery. AI-powered diagnostic tools were instrumental in

exposing insurance fraud by revealing that alleged accident injuries were actually pre-existing fractures. AI-assisted DNA sequencing reduced the processing time for forensic laboratories from months to mere days, and in one sensitive sexual assault case, AI-enabled DNA comparison established a statistically certain link between the accused and the victim. AI analysis of hospital records in a medical negligence case revealed that delayed administration of antibiotics had worsened a patient's condition, strengthening the claim of malpractice. These cases highlight that AI is no longer a futuristic concept but an indispensable part of the medico-legal ecosystem.

Yet with its immense promise comes equally immense responsibility. AI thrives on data, and the lifeblood of its functioning lies in medical records, biometric identifiers, prescriptions, imaging archives, and forensic databases. The very digitization that enables AI's potential simultaneously increases vulnerability to cyber threats. A single tampered medical record, a falsified radiological image, or a manipulated DNA sequence has the power to derail justice. Deepfake technology is already advanced enough to simulate medical scans or even alter autopsy photographs. Without robust verification mechanisms, such fabricated data could easily be introduced as evidence, misleading courts and resulting in miscarriages of justice.

The risks are not theoretical. In India, several hospitals have faced ransomware attacks in which patient data—including medico-legal case files—was encrypted and held hostage. Globally, the UK's National Health Service and multiple American healthcare facilities have also been victims of cyberattacks that disrupted medical and legal processes. Such breaches are not mere privacy violations but direct obstructions of justice. Imagine a criminal case hinging on digital pathology slides that suddenly become inaccessible due to ransomware; the trial stalls, victims are denied closure, and perpetrators exploit the gaps. To counter this, chain of custody for digital medical records must be upheld with the same rigor as for physical evidence. Cryptographic hashing, blockchain-based storage, and tamper-evident audit trails are no longer luxuries but essentials if AI-assisted medico-legal conclusions are to withstand judicial scrutiny.

The ethical dilemmas introduced by AI are equally pressing. Should an AI system's inference carry the same weight as the testimony of a seasoned medical expert? If AI misinterprets evidence, who bears responsibility—the developer, the doctor who relied on it, or the judge who admitted it as evidence? Bias in AI models is another danger. Algorithms trained predominantly on Western medical data may misinterpret conditions specific to Indian patients, leading to flawed

conclusions. For example, skin-tone related inaccuracies in AI dermatology tools or racial disparities in pulse oximeter readings already reveal the dangers of biased datasets. Unless addressed, such biases can distort medico-legal outcomes. The solution lies in ensuring AI complements, not replaces, human expertise. Courts must recognize AI as a valuable assistant, while human judgment remains the gold standard.

Regulation is beginning to address these challenges. Indian courts are not open to AI-generated evidence. Globally, the European Union's AI Act has categorized medical and legal AI systems as “high risk,” demanding rigorous oversight. In the United States, the FDA has established guidelines for AI-based medical devices that emphasize transparency and continuous monitoring. As these frameworks mature, trust in AI-driven evidence will grow, making its integration smoother and more reliable.

AI is also transforming education and training in the medico-legal field. Medical students now learn through AI-simulated autopsies and forensic reconstructions, providing exposure to cases they might never encounter in real life. Law students interact with AI-generated virtual witnesses or analyse AI-curated case precedents, sharpening their analytical skills.

Looking ahead, the future promises even greater transformations. Virtual

autopsies, already in limited use, may become mainstream, particularly in culturally sensitive cases where invasive procedures are unwelcome. AI-generated forensic reports could one day serve as expert witnesses themselves, provided validation mechanisms are rigorous. Predictive justice tools may allow lawyers and judges to foresee likely outcomes of medico-legal disputes, encouraging early settlements. Blockchain integration with AI may create tamper-proof medical evidence repositories, eliminating the possibility of falsification.

When comparing AI-driven medico-legal systems with traditional methods, the differences are striking. Where conventional processes take weeks or months, AI can deliver results within hours. Accuracy, while dependent on human expertise in traditional systems, is enhanced by data-driven analysis in AI-assisted systems. Costs, though high in initial setup for AI, eventually reduce because of efficiency gains. Bias, while possible in both approaches, is at least measurable and correctable in AI systems.

The integration of AI into the medico-legal ecosystem is thus irreversible. Its impact is profound, promising faster, more accurate outcomes, but also presenting new vulnerabilities. To harness its full potential, three pillars are essential: robust regulation to ensure accountability, cybersecurity by design to safeguard digital

evidence, and human oversight to preserve the centrality of judgment. AI is not a threat but an inevitability, and its influence will be determined by how responsibly it is wielded.

The medico-legal field has always stood at the intersection of life, law, and truth. With AI in the mix, that responsibility is amplified. We are no longer merely custodians of evidence but guardians of the integrity of digital justice. The future demands that we embrace technology not blindly but responsibly, ensuring it serves the cause of justice rather than distorts it.

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Innovations in Neuromodulation: Low-Cost Transcranial Magnetic, Electrical, and Ultrasound Therapies

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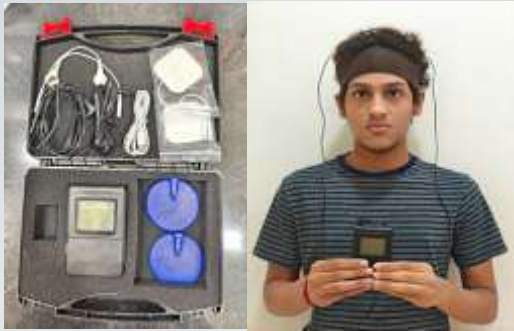
India has millions of neurological patients who are poor and not ambulatory to come to a hospital. I did research to make various modalities of brain stimulation very cheap and safe, to be used by patients at home, thus making the therapy patient friendly instead of doctor or corporation friendly. Brain stimulation produces Nerve growth factor (NGF) and Brain derived neurotrophic factor (BDNF) along with Dopamine and other neurotransmitters. They are released in CSF and they travel all across the CNS repairing it. The therapies are as follows.

1. The Transcranial magnetic stimulation of the brain by a permanent magnet (TMS PM therapy) involves stimulating various parts of the brain by massaging a very powerful Neodymium magnet on brain. It has received a patent from the Indian government. TMS PM therapy is useful for Cerebral Palsy, ADHD, Autism, Speech disorder, stroke, senile dementia and even spinal cord disorders. It can also be used to increase intelligence of normal children by brain stimulation. The therapy is already tried by more than 100 patients with good results and without any significant side effects. The device only costs Rs10,500. It is a

replacement of rTMS machine which costs Rs.50 lakhs. For more info contact <http://www.tmspm.com/>



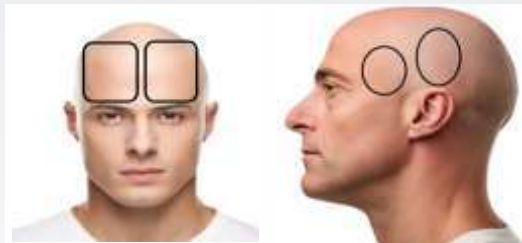
2. Transcranial electrical stimulation of the brain (tES): The tES therapy has received a patent from Indian government. It involves stimulating various parts of the brain by electrical current passed through carbon electrodes. The therapy has a unique ability to synchronise both brain hemispheres which is not possible with any other therapy like TMS-PM. The therapy is useful for Autism, Cerebral Palsy, ADHD, Speech disorder, stroke, senile dementia, Alzheimer's disease, migraine, depression and even spinal cord disorders. The same device can be used for non-invasive vagal stimulation therapy for Epilepsy, depression, migraine, paralytic ileus etc. The device only costs Rs. 21,000 compared to Rs.3-5 Lakhs devices in the market. For more details contact <http://www.tdcs.online/>



Parameter	Transcranial magnetic stimulation of the brain by permanent magnet TMS-PM	Transcranial electrical stimulation of brain tES	Transcranial ultrasound stimulation of brain TUS
Brain stimulation	Mild 5 Hz	Moderate to intense 2-50 Hz	Moderate to intense
Brain inhibition	Not possible	Possible	Not possible
Depth of brain stimulation	Up to 1 cm	Up to 1 cm	Up to 5 cm
Brain synchronisation	Not possible	Possible	Not possible
Mechanism of action	Creates electrical impulses, new synapse formation	Creates electrical impulses, new synapse formation	Cavitation, increasing neuronal activity
Ease of operation	Best	Medium	Medium
Safety	Best	Best	Best
Durability	Maximum	Medium	Medium
Cost (Rs)	10,500	21,000	26,000
Vagal stimulation	Not possible	Possible	Not possible
TENS, EMS	Not possible	Possible	Not possible
Website	http://www.tmspm.com	http://www.tdcs.online	nil

3. Transcranial ultrasound stimulation of the brain (TUS): Transcranial ultrasonic brain stimulation (TUS) is an exciting and rapidly evolving non-invasive neuromodulation technique that utilizes focused sound waves to precisely influence brain activity. Unlike traditional methods that rely on electrical currents or magnetic fields, TUS offers unique advantages in terms of spatial resolution and the ability to target deep brain structures with unprecedented accuracy. The machine costs only Rs.26,000 compared to Rs.10 Lakhs in the market. For more details contact <https://tdcs.online/transcranial-ultrasound-stimulation-of-brain-tus>

The brain stimulation is done on following areas as per the disease type and location



Frontal lobes

Brock's and Wernick's speech areas



Motor Cortex



Temporoparietal areas



Cerebellum



Visual Cortex



Nursing Training



Ashtavinayak Trip





Hospital fire accidents in India - write-up, case studies & law

Mr. M.V Desmukh

Former Director & Fire Advisor - Govt of Maharashtra.

Presently President of National Association Of Fire Officers (NAFO),

Director (Govt Affairs) Fire Safe India Foundation.

Overview

Hospital fires in India repeatedly expose the same failures: lack of valid **Fire NOC**, illegal/unsafe use of basements and service areas (storage of combustible material or oxygen cylinders), absent/defective fire-detection & suppression systems, locked/insufficient exits, poor evacuation drills and inadequate coordination with fire services. When lives are lost, responses include criminal prosecutions (charges ranging up to culpable homicide), regulatory action (revocation of licenses, FIRs), civil/consumer claims for compensation and public interest PILs seeking systemic reforms. Some case studies are cited for lessons learned as mentioned in brief

Case study 1 - AMRI Hospital, Dhakuria (Kolkata), 9 Dec 2011 - India's worst recent hospital fire

Facts: A fire in the hospital's basement/upper-basement spread quickly (early hours) and caused large smoke inhalation deaths among ICU/ward patients; reported death toll ~89–92. Investigations pointed to illegal storage of combustible material in the basement and non-functional firefighting/egress measures.

Legal action & outcome (high level):

- Several hospital directors and officials were arrested and later criminally charged; courts framed charges under serious offences including culpable homicide (IPC §304) and Section 338/304A for causing grievous hurt by negligence in different permutations as the trial proceeded. The Calcutta High Court and trial courts were active during prosecution, and the matter has seen years of litigation and supervision by courts for speedy trial.

Legal lessons from AMRI:

- Criminal culpability can attach to hospital management for systemic safety failures.
- Courts have emphasized the need for speedy trials and state oversight when large numbers of civilians die. (Source The Indian Express)

Case study 2 - New Life Hospital, Jabalpur (Madhya Pradesh), Aug 2022 (follow-on litigation 2024–25)

Facts: A fatal fire at New Life Hospital in Aug 2022 killed several people (reports recorded eight deaths). A high-level committee found local

permitting/health officials responsible for allowing the hospital to operate without requisite safety infrastructure.

Judicial/regulatory follow-up: The Madhya Pradesh High Court has queried the State about action taken against private hospitals and officials; the HC demanded the probe report and information about remedial steps and accountability. This shows courts actively pushing executive bodies to produce investigation results and take action.

Lesson: Post-incident probes often implicate not only hospital management but also local health/municipal permitting authorities that issued permissions while relaxing norms (notably during/after the pandemic). Courts expect the state to produce action taken reports and to hold officials to account.

Case study 3 - Baby Care New Born Hospital (Delhi), May 2024 - neonatal deaths and HC oversight

Facts & judicial reaction: A fire led to multiple newborn deaths at a neonatal facility. The Delhi High Court directed the State to file an Action Taken Report and highlighted that only a small fraction of registered hospitals had valid fire NOCs (news reporting: ~20% in one account), underlining systemic non-compliance across many hospitals.

Lesson: Even small/specialized

facilities (neonatal units) can be vulnerable; courts use public interest petitions and judicial review to compel executive audits and reforms where many hospitals lack valid fire certifications.

(Other recent patterns & incidents)

- Multiple smaller incidents (Noida, Delhi, other metro areas) show fires commonly originate from short circuits or records/utility rooms; many incidents are contained with evacuation, but they reveal widespread lapses (expired/absent NOCs, missing drills).

Legal & regulatory framework — what governs fire safety for hospitals in India

1. National Building Code (NBC) 2016 - Part 4 (Fire & Life Safety)

The NBC (Part 4) contains occupancy-wise fire & life safety standards (egress widths, staircases, basements, fire zones, fire-resistant construction, smoke control, alarms and sprinklers where required). Hospitals are separately classified and face specific egress and fire-protection requirements. State/local authorities adopt/implement these norms through building permits, occupancy certificates and fire department inspections.

2. Fire No Objection Certificate (NOC) / Fire clearance

Local fire authorities issue Fire NOCs after inspection. Operating without a valid NOC is a recurring legal and

regulatory cause of action after incidents (and a ground for administrative penalties and court directives).

3. Central guidelines & DGCD advisories

The Directorate General, Fire Services / Ministry advisories (e.g., standardized fire safety audit checklists and advisories for hospitals/nursing homes) were issued to standardize audits and encourage state governments to perform periodic checks. Recent central advisories (2024–2025) push standardized audits for hospitals.

4. Judicial interventions — Supreme Court guidance during COVID (Dec 2020) & subsequent orders

The Supreme Court in 2020 issued strong directions about Covid-care hospitals obtaining Fire NOCs and instituting monthly fire audits / state committees to audit fire safety; courts have used PILs to push states to ensure compliance of hospitals with basic life-safety norms. These decisions provide a template for enforcing compliance across the country.

Selected case-law & court actions (representative — for legal research)

1. Criminal prosecution in AMRI case (Kolkata) - trial courts and High Court actions; charges framed under IPC including culpable homicide and negligence-related sections. (See news and Calcutta HC supervision; prosecution continues across criminal and appellate stages.)

2. Dr. Mani Kumar Chhetri v. State of West Bengal (Calcutta/related proceedings) - judicial documents relating to AMRI prosecutions and departmental accountability appear in reported orders; see judgements and orders on custody, trials and framing of charges. (Example judgment entry: Mani Kumar Chhetri vs State of West Bengal, 2017 recorded on public law databases.)

3. Supreme Court — Covid hospital fire safety directions (Dec 18, 2020) - Court directed that hospitals without NOC should apply immediately, constituted state committees to audit Covid hospitals monthly and report deficiencies; this order has been relied upon in subsequent PILs to demand stricter fire safety compliance for hospitals. The order is frequently cited in later court actions requiring NOC and audits.

4. High Court interventions after recent incidents (MP HC, Delhi HC, Calcutta HC) - courts have demanded action taken reports, probe reports, and disciplinary action against officials who granted permission or failed to enforce safety norms (examples: MP HC on New Life Jabalpur; Delhi HC after neonatal deaths; Calcutta HC supervision in AMRI matter). These are examples of courts exercising supervisory jurisdiction to compel executive accountability.

5. Consumer/ civil judgments involving hospitals (e.g., Sir Ganga Ram matters) - where deaths or negligence are alleged, consumer fora and civil tribunals award damages and find hospitals liable for deficient services; such decisions complement criminal remedies by providing monetary remediation to victims' families. (See recent consumer commission and High Court filings concerning Sir Ganga Ram Hospital matters.)

Note for practitioners / researchers: use the public legal databases (e.g., Indian kanoon, SCC Online, official court websites) to pull the latest full judgments and charge-sheets—many criminal matters are ongoing in trial courts and appeals.

Legal principles that typically come into play

- **Duty of care & negligence (tort/consumer law):** Hospitals owe a non-delegable duty to patients. Systemic safety lapses (locked exits, lack of NOC, no fire drills) form the matrix for negligence claims and consumer-forum compensation.
- **Criminal liability:** Where negligence is gross or there is reckless disregard for human life, prosecutions under IPC such as 304A/304 (culpable homicide not amounting to murder) and provisos relating to causing hurt by negligence are invoked. Corporate officers, hospital directors and responsible officials may be prosecuted. (AMRI is a prime example.)

- **Regulatory liability & administrative action:** Granting of licenses /permissions without fire clearances can lead to license suspension, FIRs against municipal officials, and departmental disciplinary proceedings. Courts demand action taken reports from executive authorities.(The Times Of India)

- **Public law / PILs:** Courts will entertain PILs to direct systemic reforms (mandatory audits, inspection regimes, central checklists). The Supreme Court's COVID-era directions show the court's willingness to impose structured compliance regimes when public health is at risk. (SCI API)

Practical recommendations / best practices (legal + operational)

- 1.Mandatory and current Fire NOC:** Every hospital building (including temporary Covid facilities or special wings) must possess a valid Fire NOC prior to operation — and renewals must be tracked. Fire Dept inspections should be documented. (Legal risk mitigation.)
- 2.Adopt NBC (Part 4) compliance at design & operations stage:** Egress sizing, smoke control, compartmentation, automatic alarms & sprinklers where mandated for the occupancy class, and special attention to basement storage rules.
- 3.Internal fire audits & mock evacuation drills:** Quarterly/bi-

annual drills, staff training for evacuation of immobile/ICU patients, and third-party fire audits (many municipal corporations are empaneling independent auditors). Keep records for legal defense.

4.No combustible storage in basements & oxygen safety controls: Strict prohibition and monitoring of flammable storage near plant rooms, basements and patient areas—oxygen cylinders require special handling and storage protocols. (A repeated causal factor in major accidents.)

5.Documented liaison with local fire services & clear route for emergency access: Permit conditions commonly require unblocked external access and a 6-metre clearance for fire tenders; ensure municipal conditions are satisfied to avoid license risk.

6.Legal readiness: Maintain a compliance file (NOCs, inspection reports, drill logs, maintenance invoices) to produce quickly in the event of legal or regulatory scrutiny; early legal counsel in case of incident for coordination with police/investigators reduces procedural pitfalls.

How courts typically remedy failures (what victims get / what enforcement looks like)

- **Criminal prosecution** against hospital management/officers when evidence shows gross negligence. (e.g., AMRI arrests & charges.)

- **Compensation orders** in consumer forums and civil courts for families.
- **Court directions** for state/regulatory action: directed audits, framing of rules, or formation of monitoring committees (seen in Supreme Court Covid-era directions).

Quick bibliography / primary sources cited (for follow-up)

2011 AMRI hospital fire - incident reports and longform news coverage.

- Calcutta High Court & trial reporting on AMRI prosecutions.
- Supreme Court directions re: fire safety in Covid hospitals (Dec 18, 2020)—judgment/order.
- MP High Court queries and reporting about New Life Hospital (Jabalpur) probe and court supervision.
- Delhi High Court/ news on Baby Care New Born incident and ATR directions.
- National Building Code of India, Part 4 (Fire & Life Safety) - official text / PDFs.(Bureau of Indian Standard)
- Directorate General Fire safety audit checklist (DGCD advisory 2024) - central advisory for hospitals/nursing homes.

Final practical note for a legal brief or litigation file

If you are preparing a PIL, FIR petition, charge-sheet review, or expert affidavit:

1. Gather: (a) Fire NOC(s); (b) building plan approvals and occupancy certificates; (c) maintenance and service records of fire detection/suppression systems; (d) staff attendance & drill logs; (e) any third-party fire audit reports.
2. Frame reliefs that courts can grant: immediate audit & remedial action; interim closure until NOC; directions for state committees and timelines (as in the SC Covid order); compensation framework for victims; criminal investigation / departmental action against permitting officials.

If you wish, I can now:

- prepare a draft PIL (with prayers & suggested interim reliefs) based on one of the incidents above (tell me which one), or
- create a short litigation chronology + pleadings checklist for a victim/family or for a regulatory petition, or
- pull and assemble the full text of the key judgments (AMRI-related orders, the Dec 18, 2020 Supreme Court order) into a single downloadable file.

Which of these would you like next?

ASSOCIATION OF MEDICAL CONSULTANTS MEMBERSHIP

Total Membership of the Association	: 15693
Members under professional Indemnity Scheme of AMC	: 11120
Persons (Members & Family) under H & A Scheme	: 4840
Members under CBS Scheme	: 1576





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Debt Detox:

A Doctor's Prescription for Loan Freedom

For most doctors, financial journeys don't start with surplus, they start with debt. Years of expensive medical education are often funded through loans. As soon as those repayments begin to ease, another round of borrowing begins: to set up a clinic, expand a practice, or buy costly diagnostic equipment. Add in home loans, car loans, or even personal borrowings for lifestyle needs, and debt can quickly become the centre of all financial decisions.

The challenge is not just to clear loans- it is to create room for long-term wealth while handling repayments sensibly.

GOOD LOANS VS. BAD LOANS



Not every loan is harmful. Borrowings for education, clinic expansion, or equipment purchases can be considered productive- these build skills, create income streams, and even come with tax benefits. They're "good loans" when structured well.

But credit card rollovers, personal loans for holidays, or luxury expenses are different. These "bad loans" don't add future value, only interest burdens. Clearing them quickly is essential.

Follow this thumb rule in life: your total EMIs should never exceed 30-40% of your monthly take-home pay. If you exceed this,

you compromise your ability to save, invest, or handle emergencies. If repayments cross this limit, revisit which loans are essential and which can be closed early.

WHICH LOANS TO TACKLE FIRST?

Prioritise high-cost debt in this order:

1. **Credit Cards:** highest interest, no value.
2. **Personal Loans:** 12-18% rates, short tenure.
3. **Education Loans:** repay gradually, but aim to close within 5-7 years of stable practice.
4. **Home Loans:** only prepay after essentials and emergency fund are covered.

Even during residency, start small repayments on education loans. This reduces compounding interest later.

HABITS TO FOLLOW:

- Keep EMIs below 35-40% of income.
- Maintain a 6-month emergency fund before aggressive prepayments.
- Avoid lifestyle loans for luxury cars, gadgets, or weddings.
- Always clear credit cards in full- no rollovers.
- Monitor your CIBIL score quarterly.
- Never borrow to invest.

- Use bonuses, windfalls, or second income to cut debt, not inflate lifestyle.

TECHNIQUES TO PREPAY LOANS:

- Annual Top-Ups: Use bonuses or yearly income surges to reduce loan principal.
- Quarterly Targets: Every 3 months, prepay a small chunk (Rs. 25,000–50,000).
- Redirect SIPs: Once a goal is achieved, divert SIPs to reduce debt.
- Windfall Gains: Maturity of FDs, gifts, second income, etc.

ALIGN DEBT WITH LIFE GOALS:

Debt decisions should match your broader financial plan. For example, if you have a 10-year practice loan but plan to retire in 15 years, accelerate repayments so you are debt-free by retirement. Similarly, don't let heavy EMIs crowd out your ability to save for your child's education or build your retirement corpus. Understand how much to borrow, and how to repay it with a strategy. Working with an experienced financial advisory team is helpful here.

Loans, if used wisely, are tools for growth. But unmanaged debt can block financial progress for years. For doctors who spend so much time and energy serving others: building clarity, discipline, and a structured debt strategy is the first step toward true financial freedom.

FINNOVATE CLIENT CASE STUDY:

How we helped a young couple to pay their 20 years home loan in just 10 years.

A young doctor couple from Mumbai bought their dream home for ₹1.2 Cr and took a ₹1 Cr home loan, paying a ₹20 Lakh down payment. Their EMI was ₹86,000/month at 8.5% interest.

THE CHALLENGE:

They didn't want to stretch the loan for 20 years and pay ₹1.08 Cr in interest, which would make their total payout ₹2.08 Cr for a ₹1 Cr loan! This created anxiety for the couple. Therefore we advised to pre-pay the home loan.

FINNOVATE HELPED THEM WITH THE STRATEGY:

Instead of rushing to prepay the loan, we advised them to:

1. Start an SIP of ₹30,000/month to nullify the loan
2. Let compounding work while continuing regular EMIs
3. Stay invested with a structured financial roadmap

After 10 years, their SIP corpus grew to ₹70 Lakh, matching their outstanding loan amount. They used this corpus to clear the home loan early.



Mumbai Metro Aqua Line

On Sunday I decided to do a joy ride in
the recently started metro from
Prabhadevi

Few steps down and I got a ticket.
That minute I knew I will love it

I stepped on the escalator, and the
depth did not matter
Down I went, such a smooth slide, Into
the metro's belly - what a fabulous ride!

The platform was clean and shining
No chaos, and paan staining I was
waiting for the metro with pride
beaming

The train so fabulous and sleek Getting
in was so chic.

I zoomed past Dadar, BKC, T1 and T2,
and Santacruz And honestly, it felt like
I am just gliding through.

No sweat, no bad smell threat, No
traffic lights, Not a pothole in sight,
No rash drivers overtaking,
No honking, Just smooth sails and
commuter delight.

An engineering marvel, sleek and
grand, Advanced technology right here
in our land.

A big salute to the heroes, both seen
and unsung, Who built this marvel
brick by brick, rung by rung.

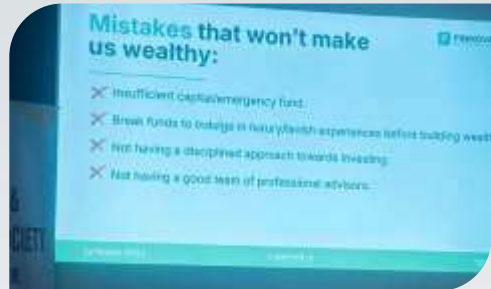
With Metro and Coastal Road,
We are making great progress
Now Mumbaikar can travel with a
smile and no stress,
They are changing our lives for the
better
Our gratitude flows, now and forever



Zonal Meet Mirabhayander



Zonal Meet Dahisar



Zonal Meet Vasai Virar



Zonal Meet Palghar



Menstrual Cup Distribution



Zonal Meet Bhiwandi





Building the Future: Redevelopment Guidelines -A Comprehensive Bulletin for Housing Societies along with considering interest of existing Doctor's Clinic & Hospitals

Adv. Anilkumar Marlecha

Marlecha & Associates

INTRODUCTION - Many neighbourhoods across Mumbai, Thane and nearby suburbs are experiencing rapid urbanization as growing populations and aging infrastructure shape the region's development. This change has resulted in an increasing number of cooperative housing societies, hospitals, clinics and doctors' residences facing issues of both structural wear and outdated functionality. Structures that were built 30 to 40 years ago, while suitable at the time, are now falling short of current safety norms, advanced medical requirements and contemporary standards for hospital environments. As a result, numerous hospitals continue to operate out of decades-old buildings that struggle to meet the increasing demands of modern healthcare and the expectations for patient safety now considered essential.

IN THE HEALTHCARE SECTOR

especially, the risks are heightened, many private hospitals and nursing homes operate from old structures not originally designed for medical use. These buildings often lack sufficient load-bearing capacity, fire exits, modern HVAC systems, or

biomedical waste management infrastructure, stretcher lift/s, separate entry and exit points. Similarly, many doctors live and practice in mixed-use housing societies that were never equipped to handle the demands of today's healthcare environment.

Advantages under the New UDCPR Norms

The UDCPR, implemented across Maharashtra, aims to standardize and simplify development regulations, including those applicable to healthcare facilities. Key advantages for hospitals considering redevelopment include:

- Increased Floor Space Index (FSI)
- Relaxation in Setback and Height Restrictions.
- Special Provisions for Healthcare Facilities.
- Incentives for Green and Sustainable Buildings.

Against this backdrop, redevelopment presents a once-in-a-generation opportunity to upgrade infrastructure, improve patient and resident safety, optimize space utilization and align with modern regulatory standards.

The introduction of the Unified Development Control and Promotion Regulations (UDCPR) and the DCPR 2034 in Mumbai has provided a uniform policy framework that simplifies redevelopment and enables better planning. However, redevelopment involving hospitals, clinics, or doctors' premises is not straightforward. It requires more than just a builder and a blueprint -it demands meticulous planning, legal clarity, stakeholder consensus and specialized design thinking tailored to medical environments. This bulletin provides a step-by-step guide to help doctors, clinics, hospitals and cooperative societies navigate the redevelopment process with confidence and clarity.

LEGAL FRAMEWORK FOR REDEVELOPMENT IN MAHARASHTRA- The legal framework for redevelopment in Maharashtra is guided by several key laws and policies, with significant reforms introduced in 2025 to address previous gaps, a new housing policy 2025 has been proposed a separate RERA-like law dedicated to redevelopment projects, as Redevelopment is not covered by the existing Real Estate Regulatory Authority Act, 2016 (RERA). This new framework aims to protect homeowners, increase accountability, and revive stalled redevelopment and other projects.

KEY LEGAL PROVISIONS-

- Minimum Consent: For cooperative

housing societies, the minimum member consent required for redevelopment has been updated to 51% for smaller societies and up to 60-70% for larger ones.

- Transparency Rules: There are mandatory requirements for transparent tendering, project agreements, and protection of member interests in redevelopment contracts.
- Development Regulations: All projects must comply with the Unified Development Control and Promotion Regulations (UDCPR) regarding FSI, TDR, and planning parameters specific to the region.
- Self-Redevelopment Incentives: The policy encourages self-redevelopment with reduced government premiums and subsidized loans for societies opting to lead their own projects.
- Rent Compensation: Developers must provide either direct transit accommodation or monthly rent compensation to members displaced during the redevelopment process, ensuring adequate support while construction is ongoing.

SUPPORTING ACTS AND POLICIES-

- Maharashtra Regional and Town Planning (MRTP) Act, 1966 (Governs planning, land use, development rights, and layout approvals)

- Maharashtra Co-operative Societies Act, 1960 (Regulates housing societies, members consent and 79(A) guidelines).
- Maharashtra Ownership Flats Act (MOFA) -Protects flat owners' rights and ensures developers disclose all terms transparently.
- Real Estate (Regulation and Development) Act, 2016 (RERA) - Mandatory registration of redevelopment projects for saleable area and enforces timelines and offers redressal mechanisms.
- The Unified Development Control and Promotion Regulations (UDCPR) 2020 and the Development Control and Promotion Regulations (DCPR) 2034 are key regulatory frameworks governing urban development and building construction in Maharashtra, with distinct scopes and features. The UDCPR 2020 is a statewide regulation applicable across Maharashtra, covering urban and suburban areas outside Mumbai and UDCPR 2034 is specifically tailored for the city of Mumbai, governing development and construction activities within the Municipal Corporation of Greater Mumbai (Defines FSI, TDR, height restrictions, and norms).

Here is Step-by-Step Redevelopment Guidelines and Process – Under 79(A) Guidelines (GR dated 4th July 2019) that mandate procedural safeguards which are not mandatory but directive in nature to be followed:-

1.To Convene the First Special General Meeting (SGM)

If any Competent Authority has declared the building of a co-operative housing society as ruinous or dilapidated or dangerous for inhabitation or as posing danger to the passers-by or any structure or place in the neighbourhood and the society is eligible to redevelop the building under the Development Control Regulations, then such society calls the SGM with clear 14 days' notice period. This notice period is crucial for members to provide their inputs and for the society to have proper (2/3rd) quorum and consent before proceeding with the redevelopment proposal.

The decision regarding re-development of the buildings of housing societies shall be taken in the Special General Meeting of the society held as per the registered byelaws of such society in accordance with the procedure prescribed by these guidelines. The Authorised Officer/ Administrator appointed by the Registrar cannot take the decision regarding re-development of the buildings of co-operative housing societies.

In this meeting the members discuss about the necessity of redevelopment, present initial assessments and obtain consent of the majority of the members for the Redevelopment i.e., Minimum 51-70% member consent depending on society size for redevelopment approval and all such

Documentation & Recording of the minutes must be recorded; it is recommended to video record the meeting for transparency to avoid future disputes.

The Society may appoint a dedicated committee and give responsibility to look after redevelopment process, communications and decision tracking. Lastly, for appointment of PMC / Architect and Legal Advisor the Society shall call for minimum 3 proposal.

2. Appointment of Project Management Consultant (PMC) / Architect and Legal Advisor -

Once the Proposal are received by the Redevelopment / Managing Committee they shall select PMC / Architect and Legal Advisor.

3. To Conduct Feasibility Study and Prepare Report -

The PMC will conduct building structural assessment, prepare feasibility report, guide tendering and detailed reports and the PMC shall lead this with structural engineers and architects to assess potential FSI, Redevelopment benefits available under the applicable schemes and all the detailed feasibility report to be made and presented to members at a subsequent SGM, recorded and minutes taken.

4. Tendering and Developer Selection-

The Committee and PMC facilitate tendering to invite proposals from multiple developers transparently.

Upon receipt of minimum 3 bids, the PMC shall take comparative analysis and same to be archived and shared widely among members and thereafter the decision to select Developer by member vote at an SGM after reviewing bids shall be video recorded in presence of the Officer appointed by the DDR.

For the sake of transparency, the societies which have proposed redevelopment shall create a website on the internet. All sorts of information concerned with the re-development such as Notices, Minutes and Project Management Consultant's Report etc. shall be placed on this website. This information shall be accessible to the members of the society. The notices and minutes pertaining to such Project shall be communicated to the members by e-mail/in presence/registered post. To facilitate despatch of notices and minutes pertaining to the said Project, each member shall be required to furnish his e-mail id and contact details. The Registrar shall be informed about the said website. Moreover, the afore stated information shall be displayed on the Notice Board of the Society for the information of the members.

Thus, the said decision shall be approved by a majority of not less than 51% of the total membership strength of the society (e.g. if total membership strength of a housing society is 100 then the quorum of the Special General Meeting convened for the redevelopment of the society shall be

66.66 i.e. 67 members and for the majority, approval of 51 or more of such members shall be required. In other words, if 67 members are present at the meeting the approval of 51 or more members out of these 67 members present shall be required for the majority. Furthermore, if 75 members are present then also the approval of 51 or more members out of these 75 members present shall be required for a majority and so and so forth).

5. Draft and Registration of the Redevelopment Agreement (DA) and Permanent Alteration Accommodation Agreement (PAAA)

The society's legal advisor will do vetting of the Draft Development Agreement and Power of Attorney (it is advisable to call for Draft Agreement copy along with Bid or before appointment of Developer by vote) so that all the terms on timelines, carpet area, bank guarantee / lien mark of saleable area, financials, rent compensation, corpus, dispute resolution, termination, Exit clause, handover of possession and such other legal points are taken care off and the copy of the said draft to be distributed among all the members and to be approved by the SGM before registration of DA and simultaneously for the PAAA too.

6. Additional points to be taken care by the PMC and Legal Advisor –

- Temporary Relocation and Rent Compensation

- Commencement and Monitoring of Construction
- Completion, Occupation Certificate (OC), and Handover
- The developer shall give a Bank Guarantee to the society, to the extent of 20% of the total value of the Re-development Project or to lien mark the saleable area of equivalent amount.
- Carpet area to be offered should be clearly mentioned in the Agreement as required by the Real Estate (Regulation and Development) Act, 2016.
- Development Rights given to the developer shall be Non-Transferable.
- Tenement holding members shall vacate their tenements only after all legal sanctions are accorded for the building re-development and upon the registration of Permanent Alternative Accommodation Agreements executed with the individual members.

7. Common Pitfalls to Avoid:-

- Skipping Structural Audits
- Unclear Title or Legal Disputes
- Lack of Transparency
- Inadequate Professional Advice
- Ambiguous Agreements
- Ignoring Dissenting Members
- Premature Handover

8. Special Focus: Hospitals, Clinics & Doctors' Residences and Critical Considerations for Medical Use Redevelopment:

- Utility & Design Load: Plan for higher demands in power, HVAC, water, and medical gases.

- **Separate Circulation:** Ensure distinct pathways for patients, residents, and service staff to maintain privacy and infection control.
- **Ambulance Access & Patient Drop-off Zones:** Design dedicated, unobstructed access for emergency vehicles and patient movement.
- **Fire & Safety Compliance:** Integrate fire lifts, refuge areas, smoke management systems, and ensure compliance with NBC and local fire norms.
- **Biomedical Waste Management:** Incorporate systems for safe collection, storage, and disposal of biomedical waste from the design stage.
- **Infection Control & Noise Insulation:** Use appropriate materials and layouts to minimize infection risks and noise disturbance.
- **Change of User (CoU) Approval:** Secure CoU from the municipal corporation before commencing hospital operations in redeveloped premises.
- **Approved Plans by Corporation:** All hospital and clinic layouts must be approved by the relevant municipal authority; unauthorized alterations are strictly prohibited.
- **Occupation Certificate (OC):** Do not commence hospital operations or allow occupation until the OC is granted by the competent authority along with newly designed interior work and partition, chambers, lifts, cabins, etc.
- **Commercial Conversion of Premises:** Any conversion from residential to commercial (hospital/clinic) use must be legally approved, with all requisite licenses and permissions in place.
- **Biomedical waste management, infection control, noise insulation.**

Conclusion

Redevelopment in Maharashtra is transformative — it upgrades safety, infrastructure, and housing. With reduced consent norms, strong government support, and expert guidance, societies can achieve smoother, value-enhancing redevelopment. Success depends on transparency, compliance, and professional oversight

Disclaimer

This article is intended for informational purposes considering redevelopment in Mumbai and Thane districts.

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AMC & Tata AIG: Your Journey, Our Assurance

Manish Singhania

Vice President & Zonal Sales Manager
-Agency MotorTata Motor Insurance

AMC & Tata AIG: Your Journey, Our Assurance The exclusive Motor Insurance Program between AMC and Tata AIG has been specially designed keeping medical professionals in mind. This association ensures that members and their institutions enjoy not just insurance, but a truly seamless and value-driven experience.

Highlights of the AMC–Tata AIG Association: Exclusive Benefits for AMC Members: Special discounts of up to 85% on Own Damage (OD) cover and attractive add-ons tailored for doctors and medical institutions. **Comprehensive Coverage:** Protection for private cars, hospital ambulances, and institutional vehicles. **Enhanced Add-On Options:** Zero Depreciation, Engine & Gearbox Protection, NCB Protection, Roadside Assistance, EMI Protection, Loan Protection, and more.

Value-Added Services: Daily garage allowance, substitute vehicles, Uber/Ola coupons in case of delays, cashless repairs through an extensive authorized garage network, and guaranteed service satisfaction. **Dedicated AMC Support:** Exclusive claims manager, operations

relationship manager, toll-free AMC helpdesk, WhatsApp support, fast-track VIP claims desk, and real-time claim tracking.

Technology at Members' Fingertips: AMC-branded portal and mobile app, instant policy downloads, claim intimation, real-time tracking, WhatsApp support, and quarterly analytics. **Engagement & Awareness:** Co-branded digital campaigns, active participation in AMC events and conferences, and regular training/webinars to empower members.

Long-Term Commitment: An agreement with scope for annual reviews, ensuring continued enhancements based on member feedback. This tie-up brings together AMC's commitment to its members and Tata AIG's trusted expertise in motor insurance, ensuring every journey is backed with unmatched protection, convenience, and care.

Drive Worry-Free with Tata AIG Motor Insurance Owning a car is more than just a convenience—it's your freedom, your family's safety and often, one of your most valued possessions. But with freedom comes

responsibility. Every journey brings with it uncertainties. That's why having the right motor insurance is not just mandatory, but essential. With Tata AIG Motor Insurance, you get more than just a policy—you get peace of mind, every mile of the way.

Why choose Tata AIG Motor Insurance? Protection that actually matters – From accidents to third-party damage, the coverage keeps financial worries off the road. Safety first, always – Up to ₹15 lakh personal accident cover for the owner-driver means peace of mind wherever you drive.

Claims without the chaos – Quick policy issuance and fast claim settlements mean more time enjoying the journey, not paperwork.

Help is never far – Thousands of partner garages across India make cashless repairs simple and stress-free. A name you can rely on – Tata's trusted legacy ensures every drive feels secure, every mile of the way. Choose Tata AIG Motor Insurance and turn every drive into a worry-free journey—because your car deserves protection, and you deserve peace of mind.

Regards
Manish Singhania

Classified Ads

Outright sale of MCGM approved Property/Healthcare Facility/ Infrastructure/Business in **Kandivali West near Mahavir Nagar, Mumbai: 612 sqft** MOFA carpet area unit is fully-furnished, with two consulting cabins, two self-contained restrooms with 24 hours water supply, operating as pathology laboratory for 35 years. Perfect for Multi-specialty Diagnostic/Consultation/Wellness care unit. Contact: **9819824224**

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Accessories



Bodily Injury
& Death
(Unlimited)



Property Damage
(6k - upto 7.5 L)



Paid Driver



Passenger



Owner
Driver



Employees

Plan Name	Includes
Silver	Repair of Glass, Fiber, Plastic & Rubber Parts
Gold	Silver + Loss of Personal Belongings + Emergency Transportation and Hotel Expenses + Key Replacement + Road Side Assistance
Pearl	Gold + Depreciation Reimbursement
Pearl Plus	Pearl + Engine Secure + Consumable Expenses
Pearl ++	Pearl Plus + Return to invoice
Coral	Pearl + Consumable Expenses
Platinum	Pearl + Engine Secure (with deductible) + Return to Invoice
Sapphire	Pearl + Consumable Expenses + Tyre Secure (Full Replacement Basis)
Sapphire Plus	Pearl plus + Tyre Secure (Full Replacement Basis)
Sapphire ++	Pearl Plus + RTI + Tyre Secure (Full Replacement Basis)



Depreciation Re-imbursement

Cover pays the amount of depreciation deducted on the value of parts replaced under own damage claim. The cover is available for vehicles up to 7 years old and operates for maximum 2 claims during the policy period.



Engine Secure

Repair & Replacement damage to Internal parts of the engine, Gear Box, Transmission or Differential Assembly. Loss or damage is due to ingress of water in the engine or leakage of lubricating oil from engine / respective assembly.



Return to Invoice

Offers to pay if the insured vehicle being a Total Loss / CTL following an accident or stolen during the period of insurance & not covered.

The shortfall between the amount receivable and the purchase price of the vehicle as in the sale invoice OR current replacement price of new vehicle in case exactly same make/model is available, whichever is less. Additionally, we will also reimburse the first time registration fees and road tax which were incurred on the insured vehicle.



Tire Secure

Expenses for repair and / or replacement will be covered, arising out of accidental damage to tires and tubes only.

Maximum of 4 (four) replacements (post claim) will be allowed during the Period of insurance.\



Daily Allowance

DA offers to pay a fixed sum towards a hired transport which customer may need to take while vehicle is under repair for valid claim.



NCB Protection

Protects the NCB of the insured even if he/she claims during the policy in-force period.



Repair of Glass, Fiber, Plastic & Rubber Parts

Repair of Glass / plastic / rubber / fiber parts at our authorized workshops/authorized dealers/authorized service stations.



Loss of personal belongings

Loss or damage to insured's personal belongings while they are in the vehicle at the time of loss or damage to the vehicle in excess of Rs.250.



Emergency Transport & hotel expenses

Cost of overnight stay and taxi charges for returning back to the insured's place of residence or the nearest city insured was travelling to.



Key Replacement

Cost of vehicle keys if the same are lost/stolen and that of locks and keys both if the vehicle is broken into.



Consumable Expenses

Engine oil & Gear box oil, Lubricants, Nut & Bolt, Screws, Distilled water & Grease, Oil filter, Bearings & Washers & Clip, Brake oil, Air conditioner gas



Roadside Assistance

A service facilitated to take care of insured vehicle & worries in an unfortunate event of vehicle meeting with an accident or breakdown.

From Paper to Precision: Why Digitization Is Now a Clinical Imperative

and how PAIRnexus turns intent into impact inside Indian healthcare

The quiet problem every clinic knows

Most Indian clinicians can diagnose a case in minutes, yet our systems may take days to follow through. Paper OPD sheets, voice notes on phones, scanned PDFs, and photos of prescriptions—these are the real “systems of record” in everyday practice. They are fast to create, but hard to search, validate, or action. The result is missed follow-ups, fragmented histories, and avoidable leakage of care across labs, pharmacies, and hospitals.

Digitization is not about replacing a doctor’s judgment or changing how you write. It’s about ensuring what you write actually lives on—in a form that is searchable, shareable (with consent), and actionable. The act of recording must finally lead to the act of care completion.

Why digitization-now?

- **Unstructured-first reality:** Real clinics run on unstructured data—handwritten notes, quick abbreviations, shorthand meds, and ad-hoc voice notes. Modern AI can read these messy formats and preserve your style while converting it into structured data behind the scenes.
- **Patient follow-through matters as much as diagnosis:** The biggest gains in outcomes occur after the prescription. Digitization that ends at storage is not enough; the data has to drive completion.
- **Interoperability is finally practical:** Lightweight adapters can map clinical elements into FHIR resources that can flow to HIS, CRM tools, labs, and pharmacies.

“If your notes can’t be found, followed, or finished, they’re not yet digital—just photographed.”

What great digitization looks like (and what it isn’t)

- **It rescues your existing workflow:** doctors continue writing naturally; the system does the structuring.

- It turns features into journeys: prescriptions become guided, patient-friendly steps.
- It closes the loop: confirms completion and flags exceptions back to the clinic.
- It protects trust: privacy-first, consented sharing, and audit trails.
- It lifts throughput: reduces waiting time and clerical load.

Enter PAIRnexus: digitization that finishes the job

Most platforms stop at 'we stored your note.' PAIRnexus goes further: it turns every doctor's note into a completion engine—quietly, in the background, with your existing style intact.

- Reads what you already write: doctors write as they prefer—PAIR extracts features into standardized data.
- Creates a patient journey automatically: each feature becomes a patient roadmap delivered digitally.
- Closes the loop across your network: tracks completion of investigations, meds, and follow-ups.
- Respects privacy and consent: consented sharing, pseudonymization, and audit logs.
- Works with what you already have: integrates with HIS/EMR or runs as a thin overlay.

“Digitization is not new. Completion is.”

About PAIRnexus

PAIRnexus is a clinician-first digitization and completion platform that converts unstructured clinical inputs into standardized data and guided patient journeys. It integrates with existing hospital systems and trusted partners, closes the loop on investigations, medications, follow-ups, and escalations, and keeps privacy and consent at the core.

Contact: info@pairnexus.health

This Doctor's Day AMC in association with Prudent Brokers introducing Umbrella Package policy for your Medical Establishment.

Exclusively for AMC Members!
Now Save BIG on your Property Insurance Premium!

As Medical professionals, we understand the importance of safeguarding our establishments against any unforeseen risk and losses. AMC Mumbai, in association with Prudent Brokers, is pleased to introduce comprehensive property insurance program tailored specifically for Medical Establishment.

Advantage (Why through AMC?):

- **Thoughtfully customized coverage:** Every business is unique, so are medical setups. AMC has engaged with industry experts to curate a program which ensures effective and essential coverage to your business setup
- **Cost Efficiency:** Avail advantage of heavily negotiated premiums by AMC which otherwise are accessible to large corporates only.
- **Easy buying process:** Hassel free online buying process with instant premium calculation.
- **Claims Assistance:** AMC and Dedicated claims assistance team of Prudent to help you through the claims process and advocate on your behalf and help ensure a fair and prompt resolution from the insurance company.
- **Ongoing support and review:** As your business evolves, insurance too needs to change. Dedicated team can provide ongoing support, help hassle free policy and endorsement management.
- **Risk Management:** Beyond just purchasing insurance, the program includes guidance on risk management practices to help reduce the likelihood or impact of potential losses.

Comprehensive Coverage (What is Covered ?)

The Umbrella Package policy encompass all essential covers for Medical establishment, including

- Fire and Allied Perils
- Burglary including theft
- Machinery Breakdown
- Electronic Equipment including portal items
- Money Insurance
- Fidelity Cover
- Neon Sign Cover
- Directors and Officers liability cover
- Cyber Insurance
- Plate Glass Cover
- Public liability
- Workmen Compensation cover

AMC VS RETAIL RATES COMPARISON:

For the Sum Insured Upto INR 5 Cr

COVERAGE SECTIONS	AMC NEGOTIATED RATES	RETAIL RATE
FIRE AND ALLIED PERILS	0.15‰ (<= INR5 Cr) & 0.40‰ (> INR 5 Cr)	.55‰
BURGLARY AND HOUSEBREAKING	0.0008‰	1‰
MACHINERY BREAKDOWN	0.16‰	0.25‰
ELECTRONIC EQUIPMENT	0.18‰	0.25‰
ALL RISK – PORTABLE EQUIPMENT	0.09‰	1‰
MONEY	0.004‰	1‰
FIDELITY	0.01‰	1‰
NEON	0.1‰	1‰
FIXED PLATE GLASS	0.1‰	1‰
PUBLIC LIABILITY	0.05‰	1‰
DIRECTORS AND OFFICERS	0.5%	1.5‰
WORKMEN COMPENSATION	1,600 Per worker	2,000 per worker
CYBER INSURANCE	0.40%	1%

PREMIUM ILLUSTRATION

COVERAGE SECTIONS	AMC NEGOTIATED RATES	RETAIL RATE
5 CR SUM INSURED Fire, Terrorism, Burglary, MBD, EEI, PEI – 5Cr Money, Fidelity , PLI– 1Cr Neon – 10L Plate Glass – 25L D&O – 50L WC – 1Lac Cyber – 5L	42630	258500
10 CR SUM INSURED Fire, Terrorism, Burglary – 10 Cr MBD, EEI, PEI – 5Cr Money, Fidelity , PLI– 1Cr Neon – 10L Plate Glass – 25L D&O – 50L WC – 1Lac Cyber – 5L	81670	342500

• MINIMUM 5 SECTIONS REQUIRED.

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We look forward to helping you safeguard your medical establishment.



Cyber Security Compliance In Indian Hospitals - Protecting Patient Data In The Digital Era

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In the current era of digital healthcare, hospitals across India are increasingly dependent on advanced technologies to manage patient care, streamline operations, and facilitate communication between departments. From Electronic Health Records (EHR) to connected medical devices, digitization has transformed healthcare delivery. While these technologies offer unprecedented efficiency and convenience, they also expose hospitals to serious cyber risks. The stakes are particularly high because healthcare data is highly sensitive, including personal identification information, medical histories, insurance details, and financial records. A breach in cybersecurity not only undermines patient trust but also exposes hospitals to legal liabilities, regulatory penalties, financial losses, and, in severe cases, risks to patient safety.

The legal and regulatory framework for healthcare cybersecurity in India has evolved to address these challenges, though it remains in a developmental phase compared to some global counterparts. The Information Technology Act of 2000, while foundational for electronic governance and cybersecurity, does

not provide healthcare-specific provisions. Nevertheless, it criminalizes unauthorized access, hacking, and data breaches, establishing a baseline legal protection. More recently, the Digital Personal Data Protection Act of 2023 has introduced comprehensive obligations for organizations handling personal data, requiring hospitals to implement measures such as encryption, secure storage, consent management, and breach notification protocols. The proposed Digital Information Security in Healthcare Act (DISHA), though still under discussion, aims to establish a national framework for protecting digital health information, including the creation of a national health data repository. Complementing these regulations, the National Health Policy of 2017 emphasizes the importance of cybersecurity in digital health initiatives. Indian hospitals remain attractive targets for cybercriminals due to the high value of healthcare data and often inconsistent implementation of cybersecurity measures. The range of threats is wide, from ransomware attacks that encrypt hospital systems and demand payment for data recovery, to phishing scams that trick staff into disclosing credentials. Insider threats, whether

malicious or accidental, pose another significant challenge, as employees or contractors can inadvertently compromise data through negligence. Additionally, connected medical

devices, often operating on outdated software or lacking adequate security controls, create vulnerabilities that cyber attackers can exploit. Data breaches, arising from weak access controls, outdated systems, or unmonitored third-party services, are increasingly common, with sensitive patient information being exfiltrated or leaked online.

Several incidents in India highlight the consequences of insufficient cybersecurity in healthcare. In 2022, the All India Institute of Medical Sciences (AIIMS) Delhi fell victim to a ransomware attack that encrypted data across multiple servers. The attack severely disrupted hospital operations for nearly two weeks, demonstrating the fragility of digital infrastructure and the operational risks posed by cyberattacks. Investigations revealed that the attack originated from overseas, underscoring the global nature of cyber threats and the importance of international collaboration in addressing cybersecurity challenges.

Another notable incident occurred in 2024 when one of India's leading health insurers, suffered a data breach affecting over 31 million customers. The compromised data, which included personal and health-related

information, was leaked via Telegram chatbots, highlighting not only the risks posed by third-party platforms but also the difficulty in controlling sensitive data once exposed.

Addressing these challenges requires hospitals to adopt a proactive and holistic approach to cybersecurity. Hospitals must implement robust data encryption protocols to protect sensitive information both at rest and in transit. Access to systems should be strictly controlled using role-based access permissions and multi-factor authentication to ensure that only authorized personnel can interact with critical data. Regular security audits and vulnerability assessments are essential to identify potential weaknesses in IT infrastructure and rectify them before attackers exploit them. Beyond technical measures, hospitals must invest in continuous training programs to enhance staff awareness about cybersecurity risks, phishing attacks, and safe handling of patient data. Developing and routinely updating a comprehensive incident response plan ensures that, in the event of an attack, hospitals can respond swiftly to contain the breach and minimize damage.

Medical devices, increasingly connected to hospital networks, also demand attention. Ensuring that all devices are updated with the latest security patches and configured according to best practices is vital. Cybersecurity cannot be treated as an isolated IT responsibility; it must be integrated into the overall risk

management strategy of the hospital, accounting for both digital and physical security considerations. Furthermore, compliance with regulations such as the Digital Personal Data Protection Act and anticipated frameworks like DISHA is not only a legal obligation but also an ethical imperative to protect patient privacy and maintain public trust.

Implementation of these measures is not without challenges. Smaller hospitals and clinics often face resource constraints, making it difficult to invest in advanced cybersecurity solutions or hire specialized personnel. Legacy IT systems and medical equipment may not support modern security protocols, creating persistent vulnerabilities. Awareness gaps among staff can lead to inadvertent breaches, and ambiguity in regulatory enforcement may leave hospitals uncertain about compliance obligations. Nevertheless, these challenges underscore the need for hospitals to collaborate with cybersecurity experts, engage stakeholders in understanding the importance of data security, and adopt a continuous improvement mindset toward cybersecurity practices.

Looking ahead, the resilience of hospitals against cyber threats will depend on adopting a multi-faceted strategy. Collaborating with cybersecurity consultants and firms allows hospitals to benefit from external expertise and threat

intelligence. A holistic cybersecurity posture integrates technical, administrative, and operational measures, ensuring that cybersecurity is embedded in every aspect of hospital operations. Engaging all stakeholders, including patients, fosters a culture of shared responsibility, encouraging safe digital practices across the healthcare ecosystem. Moreover, hospitals can advocate for policy reforms and active government support to bridge regulatory gaps and promote standardized cybersecurity practices across the industry.

In conclusion, as Indian hospitals increasingly embrace digital transformation, robust cybersecurity compliance becomes essential. Protecting patient data is not merely a regulatory requirement but a moral and professional obligation that preserves trust, mitigates operational risks, and ensures continuity of care. By implementing strong technical safeguards, cultivating awareness among staff, adhering to evolving regulations, and preparing for incidents with well-defined response plans, hospitals can fortify their defences against cyber threats. The evolving threat landscape demands vigilance, adaptability, and foresight, but with proactive measures, hospitals can ensure that digital innovation enhances patient care without compromising data security.

Friendship Day Poem By Dr. Sangeeta Agrawal

Friends and friendship in modern day

Back then dil mein dost the
Aaj hai followers

Back then we sought friends and
friendship
Now we seek likes and followers

Back then We played langdi and kabaddi
Now we play online games with
anybody

Back then We did katti and batti
Now we express with emoji

Back then we shared lunch dabba
Now we are friends over data

Back then we just met up
Now we need google calender set up

Back then we shared secrets and had
trust
Now Keeping your secret with yourself
is a must

Back then we swore loyalty
Now is it there ... ask yourself honestly !!

Even today, friendship can still be 5G
strong When you have people around
who belong

When life is a bruise and you hit the
blues Today friends will still be there
for you

Even if it is only an emoticon on
WhatsApp At least the response
was asap!!

Happy friendship day !!!





Healing Hands, Regulatory Demands: Navigating the Complex Landscape of Medical Facility Setup in India"

Dr. Mayur Sarode

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Establishing a medical facility in India is a noble pursuit, but it's also a complex and highly regulated endeavor. As healthcare providers, it's essential to balance the art of healing with the science of compliance. With the ever-evolving landscape of national and state-specific healthcare standards, navigating the web of regulations, licenses, and No Objection Certificates (NOCs) can be daunting. Yet, it's a crucial step towards ensuring the quality and safety of medical services, protecting patient rights, and maintaining public health standards.

From registering with the National Medical Commission to securing clearances from local municipal bodies, healthcare providers must adhere to these regulations to operate legally and ethically. This article provides a comprehensive guide for aspiring healthcare entrepreneurs, outlining the essential licenses and NOCs needed to set up a medical facility in India.

Here is a comprehensive list of applicable legal documents with their brief description and relevant links. Some of these may not be applicable to specific hospitals, depending upon

the scope of service, type of infrastructure, location etc.

1. Legal documents required for establishing the business of hospital

1.1. Registration under the clinical establishment act (Registration and Regulation) act, 2017 This act has been enacted by central government and is being adopted by states of India. It requires a one-time registration for a premise to be operated as hospital. The registration shall be done by the respective state government that has adopted the said act. For registration, hospitals must fulfill the minimum requirement under the category which it falls. Each state has described the process of registration of the hospitals that falls within their territory.

In Maharashtra Bombay Nursing Home Registration Act of 1949 regulates nursing homes in Maharashtra, India, ensuring quality care and patient rights. Key aspects include:

1.Registration requirement 2. Periodic renewal 3. Inspections for compliance 4. Patient rights (dignity, informed consent, confidentiality) 5. Penalties for

non-compliance (fines, imprisonment)6. Local authority powers (inspections, registration cancellation, complaint investigation)

Minimum standard norms for nursing homes, outlining specific requirements for different units.:

Ward Requirements A. Minimum floor space per bed: 65 sq.ft.B. Minimum distance between bed centers: 6 ft.C. Minimum door width: 3 ft.D.Minimum dado height: 3 ft.

Sanitation and Hygiene A]. Toilets: 1 per 8 bedsB]. Baths: 1 per 4 beds (separate from toilets)C]. Wash basins: 1 per 4 beds

Operation Theatre (OT) Requirements A] Clean zone: 100 sq.ft.B]. Neutral zone: 120 sq.ft.C]. Sterile zone: 140 sq.ft.4. Minor OT: 140 sq.ft.

Labor Room Requirements 1. Minimum area: 140 sq.ft.2. Bath and toilet: 30 sq.ft.

Other Requirements 1. Consulting and examination room: 140 sq.ft.2. Infant warmer room: 100 sq.ft. for two infant warmers3. Signage: Clear signage in English, Hindi, or local language4. Certifications: PCPNDT, MTP, AERB certificates (where applicable)

Registration of nursing home under

'The Bombay Nursing Home Registration Act, 1941': Similar to Delhi nursing home, nursing homes in Mumbai must be registered under this act, after fulfilling the minimum basic requirements.

1.2. Registration under companies' act, 2013 This act is applicable If the hospital is being established under the ownership of a company. The act requires that the company is registered and fulfils the requirement of incorporation such as memorandum of association, articles of association, capital structure formation, securities allotment, account audits etc.

2. Legal documents required for the hospital's building and its installations

2.1. NOC from fire safety - A no objection certificate shall be obtained from the local chief fire officer before the building can be used. The NOC implies that the building is constructed taking into consideration fire safety requirements. The NOC is valid for a given period, generally 3 to 5 years, depending upon the local rules and must be renewed on time.

2.2. Electrical installation certificate This certificate is required as a compliance to Indian electrical rules, 1956 and electricity act, 2014. The certificate is given after satisfactory inspection of electrical installation and sub-station, by the

chief electrical office of the district.

2.3. License for operating lift If the hospital's building has lifts installed in it, a certificate must be obtained for operating the same. The certificate is issued after inspection by Lift safety inspector, who assess if the requirements stated under Lifts and Escalator acts act has been fulfilled. The license generally is given for one year and must be renewed annually.

2.4. Building occupancy certificate - This certificate must be obtained from the local municipal corporation. The certificate implies that the building is fit to be occupied by people. Building cannot be used for hospital or for any other purpose unless occupancy certificate is obtained.

2.5. Structural audit of building from structural engineer.

2.6. exclusive parking for hospital with marking as per building plan

2.7. potable water connection exclusively for hospital with proper storage and supply

2.8 NOC FROM TOWN PLANNING DEPARTMENT; Hospital building must be built as per National building code (NBC). This is a comprehensive building standard, issued by Bureau of Indian Standards, that is used for regulating construction of buildings

across India. The above licenses and permits largely depends upon whether or not the building is as per NBC. Town planning department inspect for hospital sanction building plan, with bed plan, parking allotted, occupancy for giving NOC

2.8. Layout approval for radiation departments area If the hospital uses radiology or radiation therapy departments the layout and design of the area must be approved by AERB.

3. Legal documents required for the equipment, machines, vehicles etc.

3.1. Type approval certificate of radiation emitting equipment Carm, Xray- Each radiation emitting equipment that are installed in the hospital must have a type approval certificate from AERB. This is for prevention of excessive scattered radiation which can be hazardous to people.

3.2. Certificate for using Boilers under the Indian Boilers act, 1923 If the hospital uses large Boilers, a certificate for its use must be obtained under Indian Boiler's act from Boiler inspectors. The certificate is generally issued for a period of 3 years and must be renewed in a timely manner.

3.3. Ambulance vehicle registration - The ambulances that are used in hospital must be registered as

Ambulance with the road transport department. The process and rule of registering Ambulances

3.4. PNDT registration of Ultrasound machines under PCPNDT act, 2015 -under this act every ultrasound machine or any other machine that can be used for pre-natal sex determination must be registered under PNDT act. It also requires that every radiologist who will be using ultrasound or similar equipment also be registered.

3.5. Arms licenses under arms act 1959 If arms are possessed by hospital or its staff (such as by security guards), a license for the same must be available.

4. Legal documents related to medical professionals and employees

4.1. Qualification certificates of doctors The doctors who practice in the hospital must have necessary qualification certificates as per IMC act and registered with medical council with renewal of registration.

4.2. Registration of doctors The doctors practicing in hospital must be registered with medical council of India, in Indian Medical Register, and displayed at entrance of hospital

4.3. Qualification certificates of nurses of The nurses working in the hospital must possess necessary qualification certificate, renewals as

per the Indian Nursing Council act.

4.7. Technicians' qualification certificate Various technicians in hospitals such as Lab technician, OT technician, radiology technician, physicists etc. must possess necessary qualification certificate as per AICTE rules for technician, 1987.

4.8. Registration for EPF: This one-time registration is required for hospitals to employ with Employee Provident Fund Requirements

4.9. Accreditation from organizations like NABH, NABL

5. Legal documents for environment protection

5.1. NOC from pollution control board [MPCB] This NOC must be obtained from the state's pollution control board, under Water Act, Air Act and Hazardous waste act. The NOC is required before commencing the work in hospital and then renewed periodically for operating the patient care activities. The certificate is given if the effluent/sewerage from hospital, air pollution emission etc.

5.2. Authorization for generation of Bio-medical waste - The authorization is required on a yearly basis from pollution control board of the state. The authorization is given if the hospital complies with the rules and regulations of Biomedical Waste

(Management and Handling) rules, 1989 and amendments thereafter.

- 5.3. Radiation protection certificate This certificate must be obtained which requires periodic inspection of radiation areas. The certificate is issued by AERB through its approved agencies.

6. Legal documents for storing and usage of medical and non-medical products

- 6.1. Drug sale license for medical store: For each pharmacy in the hospital, which is involved in selling of medicine to OPD, IPD or outside patient, a separate license must be obtained from Drug Standard Control Organization. This license is required to ensure that regulations under Drugs and Cosmetics act is being fulfilled, specifically the area, storage, technical staff and compliance to drug schedules.

- 6.2. License for storing and usage of Narcotic Drugs and Psychotropic Substances (NDPS): The hospitals that uses NDPS for patient care, must obtain license under NDPS act, 1985 from Food and Drug Administration of the state. The license specifies the quantity and type of NDPS allowed and need to be renewed from time to time.

- 6.3. Excise permit to store spirit: To store spirit beyond a certain quantity, hospital is required to

obtain a permit from state excise department. This is done to ensure that the facility is safe for storing spirit, which is combustible in nature and also that it is not sold illicitly as liquor.

- 6.4. License for radioactive substances: If the hospital uses radioactive substances such as Iodine-125, Fluorine-18 etc., for treatment, it will need a license from AERB to procure and store the same. The license is given for specific radioactive substances for a specific quantity and license must be renewed periodically.

- 6.5. Permit for storing Diesel - If the hospital stores large quantity of petroleum product such as Diesel for using in Diesel generator a permit must be obtained from Controller of explosives, under Petroleum act 1934. The permit is required generally if the storage required is in excess of 30 litres. The rules given under the act must be complied with and the permit must be renewed from time to time.

- 6.6. Permit to store LPG cylinder If the hospital stores large quantity of LPG cylinder for use in hospital's kitchen or any other purpose, it shall take a permit from Controller of Explosives under Petroleum act, 1934.

7. Legal documents related to other specific services offered by the hospital

7.1. Registration under MTP act- If the hospital performs 'Medical Termination of Pregnancy', they must be registered with their respective state under the MTP act, 1971. Only after registration the place will be approved for carrying out MTP. The approval for MTP is given under 2 categories, category A (without operation theatre facility) and category B (with operation theatre facility). The rules under MTP act, 1971 must be adhered to for carrying out MTP.

7.2. License for operating blood bank - If the hospital has a blood bank, it shall comply to the space, manpower and equipment requirements specified under Drugs and Cosmetics act. A license to operate blood bank must be obtained from Standard Organization.

7.3. Registration for transplantation of human organ - If the hospital conducts human organ transplantation or organ harvesting, it shall be registered by the appropriate authority under Transplantation of Human Organs Act, 1994. The registration is given on the basis of availability of infrastructure required for conduction of transplant.

7.4. License for provision of Psychiatric services - Hospitals providing certain type of services such as de-addiction, treatment of psychiatric disorders, child/adolescent

psychiatric clinic etc. are required to register with their state

You must follow the private hospital rules and regulations set by the Ministry of Health and Family Welfare (MoHFW), as well as state-level authorities

7.5. Documents related to other specific services like cashless facility by insurances and government schemes offered by the hospital

Here's a step-by-step guide to opening a hospital in India:

Step 1: Research and Planning

- Conduct market research to determine the need for healthcare services in your chosen location
- Plan the type of hospital you want to open (specialty, multi-specialty, general, etc.)

Step 2: Legal Entity Registration

- Register your hospital as a legal entity (partnership, private limited company, trust, etc.)

Step 3: Acquire Land and Building Plan Approvals

- Obtain land or lease premises
- Submit building plans to local municipal authority for approval

Step 4: Obtain Licenses and Permits

- Clinical Establishments Act registration

- Medical Waste Management License
- Fire Safety Certificate
- Building/Occupancy Certificate
- Diagnostic Services License
- Surgical License
- Pharmacy License
- Blood Bank License (if applicable)

Step 5: Infrastructure and Equipment Setup

- Procure medical equipment
- Establish patient wards, diagnostic rooms, and operating theaters

Step 6: Staff Recruitment and Training

- Hire qualified doctors, nurses, technicians, and administrative staff
- Train staff on hospital protocols and emergency preparedness

Step 7: Hospital Accreditation

- Apply for accreditation from organizations like NABH

Step 8: Launch and Marketing

- Promote your hospital through various channels

Additional Requirements:

- Renew licenses periodically (fire safety, pollution control, clinical establishment registrations)

- Conduct regular audits and inspections
- Maintain equipment safety standards and medical professionals' qualifications

Timeline for various licenses

Initial Requirements

1. NOC from Local Municipal Office: Obtain a No Objection Certificate (NOC) from the local municipal office for compliance with building by-laws. FIRE, MPCB, BMW.
2. License for Pharmacy, Storage of Diesel and Petrol: Obtain a license for storing diesel and petrol, valid for 2 years.
3. Income Tax Registration/PAN: Register for income tax and obtain a Permanent Account Number (PAN).
4. Registration for VAT/Sales Tax: Register for Value Added Tax (VAT) or sales tax.
5. Registration for EPF: Register for Employees' Provident Fund (EPF).
6. Registration for ESI Coverage: Register for Employees' State Insurance (ESI) coverage.
7. Accreditation from organizations like NABH, NABL

6 MONTHLY

1. FIRE B FORM

Biennial (Every 2 Years)

1. License for Storage of Diesel and Petrol: Renew the license for storing diesel and petrol.
2. Authorization for Generation of BMW: Obtain authorization for

generating biomedical waste (BMW).one yarely at some places

3. License for Operating Lift: Renew the license for operating a lift.

Triennial (Every 3 Years)

1. Income Tax Exemption Certificate: Renew the income tax exemption certificate.
2. Renewal of hospital registration under Bombay nursing home act

Five-Yearly

1. Drug License for Medical Store: Renew the drug license for the medical store.
2. License to Operate Blood Bank: Renew the license to operate a blood bank.
3. Registration under PNDT Act 1994: Renew registration under the Pre-Natal Diagnostic Techniques (PNDT) Act.
- 4.MPCB NOC

Annual Requirements

1. Indemnity Insurance Policy: Renew the indemnity insurance policy.
2. Standard Fire and Special Perils Policy: Renew the standard fire and special perils policy.

One-Time Requirements

1. Registration for Operation of X-ray: Register for the operation of X-ray equipment.
2. Registration MTP Center: Register the Medical Termination of Pregnancy (MTP) center[1]. summary of periodic reports and returns for hospitals:

Monthly Reports

1. MTP (Medical Termination of Pregnancy) Reports: Submit reports on MTP cases.
2. PNDT (Pre-Natal Diagnostic Techniques) Reports: Submit reports on prenatal diagnostic tests.
3. Employees Provident Fund (EPF) Returns: Submit EPF returns.
4. ESI (Employees' State Insurance) Returns: Submit ESI returns.
5. VAT (Value Added Tax) Returns: Submit VAT returns.

Quarterly Reports

1. TLD (Thermoluminescent Dosimeter) Badges for Radiologists: Submit reports on radiation exposure.
2. Beauty Services: Submit reports (possibly related to infection control or other regulatory requirements).

Annual Reports

1. Income Tax Returns: Submit annual income tax returns.
2. ESI Returns: Submit annual ESI returns (if not already submitted monthly).

On-Occurrence Reports

1. Births and Deaths Registration: Register births and deaths.
2. Post-Polio Paralysis Cases: Report cases of post-polio paralysis.
3. Communicable Disease Reports: Report cases of communicable diseases.
4. Needlestick Injuries: Report needlestick injuries.

Other Requirements

1. Blood Bank Reports: Submit reports on units processed in the blood bank.
2. USG Machine Registration: Register ultrasound machines under PNDT Act.
3. Radiologist Registration: Register radiologists under PNDT Act [1].

There are many regulatory clearances required to establish and operate a hospital. The management of hospital must be aware about all such legal documents, requirements and process to obtain the same. By understanding and complying with these regulatory requirements, healthcare providers can focus on what matters most – delivering exceptional patient care.

Dr. Mayur Sarode
[MBBS, DOrth. DNB. MNAMS. LLB]
(Medicolegal Expert. Nashik)



MEDICATION ERRORS - LIABILITY OF HOSPITAL

Dr. Suganthi Iyer

Director- Hinduja Hospital, Mumbai

Around 40% of injury in patients are due to preventable medication errors. It may be due to illegible prescription, erroneous dispensing and administration of medication and also lack of adequate monitoring after administration. Other factors could be usage beyond validity date, improper storage due to non-adherence of recommendations of the manufacturer, mixing up look-alike and sound-alike drugs, lack of protocols for high risk medication, implants, etc. as is seen in the cases enumerated below:

D:II (2023) CPJ 608 (NC)-- B Chowdhury v/s W Hospital

Complaint:

K Chowdhury, diagnosed as Non-hodgkin's lymphoma at TMH, Mumbai, underwent initial treatment there. Later the patient was then airlifted for next round of chemotherapy to W Hospital, Kolkata. Since 17th February, Medical Oncologist, OP2, administered 3 cycles of chemotherapy. He was advised next cycle of chemotherapy with different medications. The patient got admitted on 18th June for the same. The doctor, OP3, administered chemotherapy by

injecting vincristine intrathecally instead of giving it Intravenously and hence patient's condition deteriorated. On 20th June, the patient was discharged from W Hospital, Kolkata and transferred to TMH, Mumbai for emergency management. He was admitted with fever and weakness of lower limbs. The family was counselled about progressive deteriorating condition and slim chances of survival. On 24th June, patient was again shifted to Belle Vue Clinic, Kolkata and later discharged and ultimately expired on 9th July at home. Being aggrieved by the untimely death of the patient at the age of 37 years who was a software engineer and sole earning member of the family, case was filed in Consumer Court.

Proceedings:

W Hospital, OP1, submitted that death of the patient was an act of negligence of OP2 and OP3, who were visiting doctors of the hospital. The treating doctors were responsible for the entire medical negligence and the hospital has no role in the treatment, except it provided infrastructure and nursing assistance. Thus, the hospital had limited role and hence not liable.

The medical oncologist, OP2 of W Hospital, Kolkata submitted that the management included two drugs that are given, one intravenous and intrathecal. In this case, as per protocol, the drug vincristine was to be given intravenous and Arabinocide Cytarabine was to be given intrathecally. He submitted that he was not involved in the wrong administration of injection vincristine and the same was administered by OP3. He also stated that he had requested OP3 to be available on 18th June so that the medications both Intravenous and intrathecal could be done under the supervision of OP2. However, OP3 had administered the medications in his absence. OP2 submitted that OP3 had acted negligently and committed grave error in not being cautious while dealing with the administration of the drug Vincristine. The drug Vincristine comes with the box with a warning “FOR INTRAVENOUS USE ONLY”.

OP3 submitted that he is a qualified anaesthesiologist and administered intrathecal chemotherapy on the request of OP2 as it involves lumbar puncture. He had administered intrathecal chemotherapy to the patient on three occasions earlier and on all three occasions the OP2 was not present. OP3 further submitted that the injections was transported from Pharmacy on all occasion. The intrathecal drugs were not packed separately in designated container. The hospital had not followed the international recommendation and

there were procedural lapses on the part of the Hospital. The hospital has not implemented specific guidelines in chemotherapy instructions. The hospital is also responsible to provide necessary trained support staff to treat cancer patient which was not done in this case.

The Complainant submitted that the Opposite Parties are shifting on one another and hence all the Opposite Parties are liable for negligence causing the death of the patient.

Held:

- All chemotherapy should be administered only by qualified/trained Medical Oncologist. In the present case, vincristine was administered intrathecally by OP3, Anaesthesiologist in the absence of OP2, Medical Oncologist.
- It was neither an inadvertent error nor an accident in the instant case. OP3 did not check **the medication details before administration.** OP3 prepared the vincristine, performed LP, and injected the drug intrathecally, under the impression that it was injection Arabinocide – Cytarabine.
- OP2 and OP3 failed to adhere to the established protocol for the administration of chemotherapy and hence treated the patient negligently.
- **Intrathecal drugs were not packaged separately** for delivery to the ward in designated containers and clearly

labelled on the outer containers “For Intrathecal use” as is required as per International recommendations.

- Literature on vincristine states that in a case of medical error of intrathecal chemotherapy is nearly always fatal with an irreversible painful ascending paralysis as destruction of central nervous system occurs radiating from the injection site.
- In the case of medical negligence it is the failure of medical practitioners to exercise certain acts or omission while discharging their duties with respect to their patients.
- A mistake which would tantamount to negligence cannot be pardoned and in some situations the principle of Res Ipsa Loquitur can be applied. Even delegation of responsibilities to another without eligibility criteria may amount to negligence in certain circumstances as in this case.
- When a patient goes to a hospital, he goes there on account of the reputation of the hospital and with a hope that due and proper care will be taken by the hospital authorities. If the hospital fails to discharge their duties through their doctors, it is the hospital which has to justify the acts of Commission or Omissions of the doctors. **It is the duty of the hospital to satisfy that there was no lack of care or diligence.** In the given case, chemotherapy administration should have been given by the Medical Oncologist OP2 and this was not followed.

It was concluded that it was a case of Res Ipsa Loquitur where **the medical negligence is attributable to both the doctors OP2 and OP3 and the hospital has vicariously liability** for the same. A **compensation** of 60 lakhs **was awarded** in this case.

II) IV (2024) CPJ 115 (NC)--M Dadu v/s F Hospital

N Dadu, 62 years old, diabetic, visited F Hospital for routine check-up. Angiography was done which revealed that 2 arteries were blocked and 3rd artery was ballooning. Angioplasty was done for the 2 blocked arteries. Patient was on anti-platelet medication. Follow-up angiography reveal 60-70% blockage of 3rd artery and that the earlier 2 stented arteries were fine. Angioplasty was conducted for the 3rd artery on 10th May. Post procedure the patient was shifted to ICU and put on ventilator as he had breathing problem. Patient was started on Heparin. On 12th May, CT-Scan of the brain was conducted which revealed brain haemorrhage and ventriculostomy was performed on 12th May. Repeat CT-Scan on 13th May, revealed hematoma and surgery was performed in the evening of 13th May. Post-surgery patient remained in coma for around a month and later suffered complete paralysis of left side of the body and lost his ability to speak, hear or understand other people. Patient ultimately went home on 11th August in a vegetative state needing constant help of an attendant.

Hence, the patient who was admitted in a healthy condition and doing his regular job has been discharged with grievous injury due to gross negligence committed by the hospital and the doctors. Hence a case was filed in the Consumer Court.

Proceedings:

As per the hospital and the doctors, patient was taken up for angioplasty after explaining the risks and taking informed consent. He was given heparin in the right dose at the start of angiography procedure. He became further unstable for which IABP was inserted and further anticoagulants was given to prevent clots. Unfortunately the patient suffered a major brain haemorrhage and hematoma for which he was operated by Neuro surgical team. He survived with major residual neurological deficit. The doctors had treated with standard protocol.

Held:

From the Medical record it was proved that **the statement of the doctors that only two small doses of heparin were given on 10th May** (one before commencement of procedure of angioplasty and other to support low blood pressure) **was incorrect.** Heparin was given to the patient continuously till 12th May in spite of the fact the patient was already on Anti-platelet medication. Patient was neurologically non-responsive, bleedings were noticed from various vital organs and platelet level was regularly falling down considerably.

As per medical record, the CT scan on 12th May revealed “Intraventricular Bleed” and subsequently ventriculostomy was performed on 12th May. From this record, it is proved that convulsion has started from night of 11th May but the procedure was performed late on 12th May with a considerable delay. Repeat CT scan was taken on 13th May revealed hematoma and neuro-surgery procedure was again performed with considerable delay.

Platelets were falling day to day, bleeding in urine, endotracheal tube and other organs commenced on 11th May and patient was neurological non-responsive with convulsion on 11th May. **But heparin was continued till 12th May, despite the fact that the patient was already on other anticoagulants thus causing the complications of haemorrhage and hematoma.**

For above reasons **hospital and the doctors were judged negligent and compensation of 65 lacs was awarded.**

TAKE HOME MESSAGES:

- Hospital should have safe organized medication management processes. The availability, safe storage, prescription, dispensing and administration of medication to be done as per established guidelines.
- Hospital should ensure correct storage (temperature, light, high-risk medications, etc.) expiry dates and maintenance of documentation.

- Hospital should have monitoring mechanism to ensure that the required medications are always stocked and well within expiry dates.
- High risk medication order should be verified to ensure accuracy of dose, frequency and route of administration.
- Safety is paramount when using narcotics, chemotherapeutic agents, high-risk medication and radio pharmaceuticals.
- Medication management also includes monitoring of patient after administration.
- There should be procedures for reporting and analysing near misses, medication errors and adverse drug reactions.
- Medications also include blood, implant and devices

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Classified Ads

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Thane Zonal Program at MRR Hospital



Meeting with Principal Sec Health & Medical Education Minister to discuss Homeopathy issue





Should Non-allopathic Doctors Be Allowed To Practice Allopathy?

Jehangir B. Gai

There notification issued by the Government of Maharashtra allowing non-allopathic doctors to practice allopathy after completing a “bridge course” has generated a controversy amongst the medical profession. However, the most important person in the entire controversy, viz. the consumer, had not been heard or considered. So, let us analyze the legality and advisability from the consumer perspective of allowing such practice.

The legal validity of the notification:

The Medical Council of India Act of 1956 used to regulate the qualifications and practice of allopathic medicine. This has now been replaced by the National Medical Commission Act (NMC) of 2019. The old legislation and the new legislation have many provisions which are in common. The Section (2)® defines “recognised medical qualification” to mean a medical qualification which is recognized under the Act. The Graduate Medical Education Regulations, 2023 framed under the NMC Act contemplates providing medical education to a student to make a complete Bachelor of Medicine and Surgery, and a

competent physician to practice “modern scientific medicine”. The Act makes it clear under section 34 that any person who contravenes these legal provisions shall be punished with imprisonment for a term which may extend to one year or with fine which may extend to five lakh rupees, or with both.

A bare analysis of the above provisions of law makes it clear that only the Central Government has the authority to prescribe qualifications and recognize institutions for teaching allopathic medicine, while the State Government does not enjoy similar powers.

A “bridge course” is neither a qualification prescribed under the Indian Medical Council Act of 1956, nor is it conducted by any of the teaching institutions recognized under the Act. Hence, the notification issued by the Government of Maharashtra permitting non-allopathic doctors to practice the allopathy on completion of the “bridge course” would be ultra vires the provisions of the Indian Medical Council Act of 1956.

The judicial interpretation:

The Hon'ble Supreme Court of India, in the case of Poonam Verma vs Ashwin Patel & Ors. decided on 10.05.1996, was required to consider whether a qualified homoeopathic doctor was entitled to prescribe allopathic medicine. The Court observed that even though the anatomy and physiology are similar, a person having studied one system of medicine cannot treat a patient by drugs of another system, the reason being that the pharmacology of all systems such as ayurvedic, unani and homoeopathic is entirely different and drugs are prepared and manufactured according to their own formulate and pharmacopoeia. The Court concluded that a person having studied one particular system of medicine cannot possibly claim deep and complete knowledge about the drugs of the other system of medicine.

It is well known that drugs have side-effects as well as inter-drug reactions. A doctor who has qualified from any other system of medicine cannot have a deep and complete knowledge of allopathic drugs. The decision of the State Government to permit non-allopathic doctors to register themselves as allopathic practitioners would be against the well settled principles enunciated by the Supreme Court.

Conclusion:

Many of the provisions of the new National Medical Commission Act of 2019 are in pari material with the provisions of the repealed Medical Council of India Act of 1956. Hence the decisions rendered under the old law would also continue to apply even under the new Act.

The analysis of the law and its interpretation by the Court makes it evident that the State Government's decision to allow non-allopathic doctors to practice as allopathy is detrimental to consumer interest and would violate a patient's right to get proper treatment at the hands of a qualified medical practitioner. It will only result in endangering lives by compromising on patient safety, and there will be a spurt in litigation when "half-baked" doctors doing a "bridge course" are allowed to practice allopathy. The decision, being contrary to law, judicial interpretation, and also against common sense, requires to be scrapped immediately.

The author is a consumer activist and has won the Govt. of India's National Youth Award for Consumer Protection. His e mail is jehangir_gai@hotmail.com

Amc Georgia Armenia Conference





Chronic Foot and Ankle Pain

Dr. Raj K Singh

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Interventional pain and palliative care medicine

Pain in the foot can be Plantar fasciitis

This usually happens due to the swelling and redness of a band/bands of tissue connecting the heel bone and the toes. Pain due to plantar fasciitis can be felt in the heel or the arch and is usually worse in the morning. Common reasons for plantar fasciitis include high level of physical activity, standing for prolonged periods on hard surfaces, faulty foot structure like flat-foot, tight calf muscles, overweight or improper footwear

Heel spur

When low grade plantar fasciitis remains untreated for a long time, a bony spur or spike may form where the fascial tissue band connects to your heel bone. Having a heel spur may not cause pain and need not be operated.

Direct injury

In case one steps on a hard object such as a rock or stone, you can damage the fat pad on the underside of your heel. The pain might ease away gradually with rest.

Pain Behind the foot can be

Calcaneal bursitis

The bursa acts as fluid filled cushion when tendons slide over bones. The bursa located at the back of the heel, is

known as calcaneal bursa. Excessive use or trauma to the heel may cause the bursa to swell up and become painful, leading to this condition called calcaneal bursitis.

One may experience mild to severe pain in the heel, especially with walking, running or on touching the heel.

Achilles Tendonitis

Achilles tendon connects the calf muscles to the heel. This tendon is used for walking, running and jumping. In this condition the tendon gets swelled up and becomes painful due to overuse of the ankle joint. It often occurs in athletes below 35 years of age, engaged in sports activity involving running or jumping. The pain starts in the heel and along the length of the tendon while walking or running. The area might swell up, and one may have trouble in standing up on one toe.

Ankle Pain

Pain in the ankle can be

Ankle Sprains

Injury to the strip of ligaments that connect the lower end of the bones of the leg to the foot is known as ankle sprain. It usually happens when one accidentally twist or turn the ankle in sudden manner. This can tear the

smaller strips of the ligaments that hold the ankle bones and joints together.

Rheumatoid Arthritis

It is a disease of the joints that occurs when the one's own immune system starts destroying the thin membrane (synovium) that lines the joints from inside. This damages the joint surface and cause pain, swelling and disability of the joint. In about 90% patients with rheumatoid arthritis, ankles joint is affected.

Gout

Gouty arthritis occurs when excess uric acid circulating in the bloodstream, is deposited as urate crystals in the tissues of the body and joints. This leads to severe pain and swelling in the foot especially the big toe. Subsequent attacks may occur off and on in other joints, including the ankles. After few years of the disease, deposits of uric acid form beneath the skin around the joints of the foot and ankle.

Treatment of Heel & Ankle Pain

Conservative Care

Rest

Try to avoid walking long distances and standing for long periods

Ice/Hot Fomentation

Alternate hot and cold fomentation might help reduce the pain and swelling.

Regular stretching exercises

Stretching your calf muscles and foot regularly helps reduce the severity of the pain.

Comfort shoes

Proper fitting footwear that supports and cushions your foot, running shoes are particularly useful.

Brace

Using supportive devices and rigid supports inside your shoe and strapping can help control pain in the ankle and foot.

Interventional Pain management technique

Small joint injections in the ankle & foot have been found to provide significant pain relief in cases where medicines have not given the desired pain relief. Such injections should be followed by regular stretching and exercises for better results.

Platelet Rich Plasma (PRP) / Growth factor Concentrate (GFC) Therapy

PRP/GFC injection into the joint / Ligaments is one of the most preferred minimally invasive technique for treating pain in the foot and ankle. PRP/GFC has been used in many cases of foot and ankle pain, with very positive results. PRP/GFC therapy involves injecting platelets/growth factor from the patient's own blood to rebuild a damaged tendon or cartilage. It has been successful in not only relieving the pain, but also in starting the healing process quickly. The platelet-rich plasma is injected into the damaged portion of the joint.

Important Update: Homeopathy Issue Featured in Midday

The Midday newspaper has highlighted the urgent concerns raised by our medical community regarding the recent government directive allowing homeopathy practitioners with a one-year CCMP certificate to register and practise modern medicine. The article details the IMA Maharashtra's call for a one-day strike on Thursday, with over 50,000 doctors participating. AMC Mumbai fully supports this movement, emphasizing that the move endangers patient safety, undermines professional standards, and erodes public trust in healthcare. Key points from the article:

- The strike will see a complete shutdown of medical services across private hospitals, including emergency care, as a protest against this dangerous decision.-
- The medical fraternity demands strict separation between homeopathy and modern medicine, ensuring only qualified practitioners provide allopathic treatments.-
- The focus is a fight for safeguarding patient safety and resisting unscientific, agenda-driven policies.

Members are encouraged to read the full article in Midday, stay united, and spread awareness regarding this crucial issue impacting all stakeholders in healthcare. Regards Team AMC Mumbai 25-26



'This is a fight for patient safety'

Doctors practising modern medicine to go on strike on Thursday; day-long shutdown of complete medical services looms

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THE Indian Medical Association (IMA), Maharashtra, with its 50,000-plus members, will hold a one-day strike on Thursday against the state government's fresh notification on the registration of homoeopathic practitioners who have completed the Certificate Course in Modern Pharmacology (CCMP).

Earlier this year, the state government directed the Maharashtra Medical Council (MMC) to register homoeopaths who had completed the one-year CCMP, allowing such practitioners to prescribe modern medicine to patients in some cases.

The IMA is opposing CCMP-qualified homoeopaths' registration with the MMC, saying the move is a serious threat to the safety of patients. Strike leaders claim there will be disruptions in healthcare services in Mumbai and across the state, saying they have been forced to the wall through the anypic, agenda-driven and dangerous decision.

In an interview, Dr Rajeev Agarwal, president of the Association of Medical Consultants (AMC), which has 16,000 specialists and super specialists as its members, decodes the strike. AMC Mumbai has offered unconditional support to IMA, Maharashtra.

Excerpts from the interview:

The IMA has called for a strike on Thursday. What kind of strike is this?

This is a one-day strike, and we plan a shutdown of all medical services, including emergency services, across private hospitals in the city and the state. At least services in small and medium-sized hospitals will be closed, and so will Outpatient Departments (OPDs). Since the government claims infrastructure is adequate,

'This is a one-day strike, and we plan a shutdown of all medical services, including emergency services, across private hospitals in the city and the state'

Dr Rajeev Agarwal, president, Association of Medical Consultants



Doctors in Maharashtra stage protest against the government allowing homoeopathic practitioners to practise modern medicine. FILE PHOTO: KAMELE

50,000
No. of doctors expected to join the agitation

those experiencing an emergency or needing urgent care will be referred to the nearest government hospitals. This is a fight for our existence and for patient safety.

What has sparked a call for this action?

We have no problem with homoeopathy or any other 'pathy'. Yet, there is a problem when they are pushed together with allopathic medicine, which the government is trying to do here. Homoeopathy is patient-centric and patient-specific. This means that if patients A and B both have fevers, they may get different medicines. This is what I mean by patient-specific. In allopathic medicine, we treat the disease and the symptom. So they cannot come under this 'pathy'. The specific teaching of the subject is totally different. An MBBS student studies

for at least 5.5 years, while homoeopathy students attend class once a week for one year for the CCMP course. We also know that some homoeopaths have been prescribing allopathic medicines, which is illegal. We did demonstrate some opposition to this earlier but never took to the streets.

The government claims there is a shortage of doctors in the rural areas.

Allopathy doctors have to do one year of rural service after completing their studies. The truth is that there is no infrastructure to admit so many doctors. There are no vacancies for doctors in rural places. Doctors who have finished their studies are on the waiting list to complete this mandatory rural posting. The basic agenda is a backdoor entry of homoeopathic practitioners into the allopathic field. In fact, the government is considering scrapping the one-year compulsory MO [Medical Officer] ship for MBBS students.

What other problems do you anticipate with this 'mixopathy', as it has been termed?

There will be legal problems. How can a doctor belong to two councils? The Maharashtra Medical Council and the

Homoeopathic Council? In case of any accusation of negligence, each council will pass the buck. Besides, the National Medical Commission, the overarching body, has a very clear definition of allopathic doctors; by that definition, they do not fit in. How will a patient know who is a homoeopathy doc and who is an allopath? By this yardstick, even nurses and pharmacists know some medicine. Should they too be allowed to practise as allopathic doctors? We will see hatred for doctors in the future if this is allowed. A lot of medico-legal cases will come up, and most importantly, it will be the patients who will suffer.

What support have you got for the strike?

This matter is sub judice, so what is the hurry of registering them? The matter is in the high court. If we do not see any results of this strike, we will need to escalate the matter with a march to Azad Maidan, an andolan... we will see about the final decision. We have been getting a lot of support from NGOs, GPA and from medical teachers, students and parents of allopathic students and several associations. We want the public to support us too, by becoming aware of the problem, speaking out, and raising questions and concerns on forums available to them, like social media for instance.



The revamped version of the Van Rani, which is battery-operated. PHOTO: SGNP

Revamped Van Rani will run on batteries, has additional bogey

Sources say over ₹43 crore has been spent buying new toy train and setting up supporting infrastructure at SGNP

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THE iconic Van Rani, a mini train that was once one of Sanjay Gandhi National Park's (SGNP) biggest attractions, will be up and running by the end of the month if everything goes according to plan. The service, which was started in 1970, has been non-operational since May 2021 after the toy train sustained significant damage when Cyclone Tauktae struck the city.

The train, comprising a diesel locomotive and three bogies, was operated along a 2.7-km stretch. Its replacement is battery-operated and has four bogies, while tourists will enjoy the view of the park through vista domes coaches. The technical verification process and trial run with passengers were completed in July this year.

An official from the Maharashtra Forest Department said, "The majority of the work is complete, and we hope to resume services by this month's end."

Sources from the department also told this newspaper that over ₹43 crore has been spent on the purchase of the new train and civil work related to the same.

It was anticipated that the toy train services would commence by the end of 2024, but it was announced that it would happen in July-August this year. However, as some work is pending, the

opening was pushed back. Around 70 to 80 people could travel in the three coaches of the old toy train, and the revamped service is anticipated to boost SGNP's revenue.

The work of laying new tracks, new stations, and other related activities has been done by the Rail India Technical and Economic Service.

Pride of place

It's not only people staying in and around Mumbai who visit SGNP; tourists from other states and foreigners also visit the park. It is one of the most visited national parks within city limits in the whole of Asia. The toy train route lies in an area measuring approximately 5.5 sq km known as Krishnagiri Upavan.

This spot is reserved as an easily accessible public recreation zone. Among the several attractions of Krishnagiri Upavan is a mini-zoo, where visitors can view animals up close.

The narrow-gauge toy train plies the tourist zone where rich biodiversity is on display. When the toy train was operational, it was operated every 30 minutes from 9 am to 12 pm, and from 1.30 pm to 5.30 pm. A minimum of 20 passengers are required for the train to depart.

2.7 KM
Length of train's tracks



The Silent Side of Healing: What Happens to Hospital Waste After You Leave

Dr. Lata Ghanshamnani

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Healing Has a Hidden Cost

As a young medical student, I was taught that saving a patient's life does not end with diagnosis or surgery – it extends to every detail of care. Years later, as an ophthalmologist working in hospitals, I realized that this lesson applies to waste as much as medicine. Behind every injection, every dressing, and every surgery lies another story we rarely talk about: the story of medical waste. Some of it is harmless, but some is dangerous. If not managed properly, this biomedical waste (BMW) does not remain inside hospital walls – it seeps into our streets, our water, and our communities.

This realization changed the way I viewed hospitals. Patients see clean wards, white coats, and healing. But hidden in the background are colored bags, sealed containers, and silent treatment facilities working tirelessly to protect society. The truth is simple: the safety of our patients depends as much on what happens after treatment as during it. And unless we manage waste responsibly, we risk undoing the very care we provide.

What Exactly Is Biomedical Waste?

Biomedical waste is any waste

generated during diagnosis, treatment, or research involving humans or animals. It includes everything from blood-stained cotton and syringes to expired medicines and chemicals. According to the Bio-Medical Waste Management Rules, 2016, about 15% of hospital waste is infectious – meaning it can spread diseases, cause injuries, and contaminate our environment if not handled correctly.

India generates about 710 tonnes of biomedical waste every day. While 90% is non-hazardous, the remaining 10% is hazardous enough to cause immense harm if mismanaged. Since 2019, all waste bags and containers must carry barcodes, ensuring traceability. By law, waste must reach authorized treatment facilities within 24–48 hours, and hospitals must file an annual report with the Pollution Control Board by June 30th. These measures aren't red tape – they're vital safeguards.

Mismanaged waste doesn't vanish. A syringe thrown carelessly could prick a waste handler and transmit hepatitis. A bottle of antibiotics discarded improperly could seep into soil and water. A sharp left uncollected could injure a child. The risks multiply once waste escapes hospital control.

The Color Code of Safety

To prevent such harm, biomedical waste must be segregated right where it is generated. India uses a color-coded system that creates clarity and discipline in a chaotic environment:

- **Yellow Bag:** Infectious waste like soiled dressings, anatomical waste, expired or contaminated medicines, and items from cancer treatment. These require incineration or deep burial.
- **Red Bag:** Contaminated but recyclable plastic items like IV tubes, catheters, and syringes without needles. These can be disinfected and recycled.
- **White (Translucent) Container:** Sharps such as needles, blades, and scalpels. These must be disinfected and shredded so they cannot be reused.
- **Blue Container:** Glassware like broken medicine vials, ampoules, and metallic implants. These are sterilized and recycled.

This system is not about colors alone. It is about reducing risk. A needle in the wrong bag can endanger a worker. A plastic tube mixed with infectious waste may lose the chance of recycling. Segregation is the first and most critical step in protecting people.

The Journey of Waste: From Bedside to Treatment

Segregation is only the beginning.

From that point onward, biomedical waste must be managed in a tightly controlled chain of steps.

It begins at the bedside, the laboratory, or the operating theatre. Waste must be placed immediately in the correct container. In one real case, a nurse avoided injury because she was trained to drop the syringe directly into the white container instead of carrying it across the ward. A small habit prevented a dangerous accident.

From there, hospitals must ensure staff safety. Doctors, nurses, and waste handlers are all vulnerable, which is why protective gear – masks, gloves, aprons, and boots – is essential. Vaccinations against Hepatitis B and Tetanus are also part of this protection. When a mercury thermometer broke in an ICU, staff who had practiced spill management calmly used protective gear and a spill kit. Because protocols were in place, what could have been a toxic disaster was contained quickly.

Once collected, bags and containers should never be overfilled. They must be sealed securely and collected daily. Committees often discover during audits that staff tend to overstuff bags, which increases risk. Correcting such practices reduces injuries and improves compliance.

Every bag must carry a barcode, allowing traceability from hospital to treatment facility. This prevents theft, pilferage, or illegal resale. In one incident, a yellow bag of waste

discovered in a landfill was traced back to its source hospital because of barcoding, ensuring accountability.

Finally, waste is sent to authorized Common Biomedical Waste Treatment Facilities (CBWTFs) within 48 hours. These facilities use incineration, autoclaving, or chemical treatment to render the waste harmless. Even small clinics with just a few beds achieve this by designating a waste officer and tying up with a CBWTF. The message is clear: no hospital is too small to be responsible.

The Law Has Teeth

This rigorous process is backed by law. India's Biomedical Waste Management Rules, 2016 make it mandatory for all health care facilities – from large hospitals to small clinics – to manage waste responsibly. Non-compliance can lead to penalties under the Environment Protection Act, 1986:

- Closure of the facility.
- Fines up to one lakh rupees and imprisonment up to five years (extendable to seven).
- Daily fines for repeated violations.

These penalties exist for a reason: one hospital's negligence can put entire communities at risk. Just as hospitals cannot compromise on sterilization during surgery, they cannot compromise on waste after surgery. Committees, Audits, and the Paper

Trail of Safety

Good systems require good oversight. Every hospital with more than 30 beds must form a Biomedical Waste Management Committee. This committee, which includes doctors, nurses, and administrators, monitors compliance, conducts regular training, and ensures protocols are followed.

Monthly audits check whether segregation is done properly, bags are sealed correctly, and waste is sent to CBWTFs on time. These audits also uncover small mistakes – like red bag waste mixed into yellow – which can then be corrected with refresher training.

Equally important is documentation. Hospitals are required to maintain waste registers, accident registers, and training records. Each incident, whether a minor spill or a major accident, must be recorded. This documentation creates accountability and ensures that learning follows every error.

Hospitals as Guardians of Waste

Health Care Facilities have wide-ranging responsibilities that go beyond day-to-day disposal. They must:

- Segregate waste at the point of generation.
- Train all categories of staff on waste protocols.
- Provide protective gear and

vaccinations for workers.

- Store waste securely for no more than 48 hours.
- Hand over waste only to authorized CBWTFs.
- Submit annual reports to the Pollution Control Board.

These responsibilities are not bureaucratic burdens; they are safeguards that protect staff, patients, and society at large.

When Specialties Create Special Waste

Different departments in a hospital generate waste that requires special handling. A one-size-fits-all approach simply does not work.

- Oncology Departments deal with cytotoxic drugs and contaminated linens. These are extremely hazardous and must go into yellow bags for incineration.
- Dentistry Clinics generate amalgam fillings containing mercury, extracted teeth, and blood-stained cotton. Dental needles belong in white containers, while amalgam must be disposed of through specialized systems.
- Radiology Departments create waste from X-ray films, developer solutions, and lead aprons. Silver can be recovered from films, but lead and

radioactive materials must be handled through regulated disposal routes.

- Laboratories deal with cultures, blood and urine samples, and slides. These require autoclaving or chemical disinfection before disposal.

Each department has unique waste streams, and each requires tailored handling. Recognizing these differences ensures safety at every level of care.

Building a Culture of Responsibility

Hospitals that take biomedical waste seriously move beyond compliance to build a culture of responsibility. This means:

- Training every staff member, from doctors to ward attendants. For example, an attendant once used a spill kit immediately after a patient vomited blood, preventing exposure for others. This was possible only because training was inclusive.
- Conducting regular audits to identify weak spots and reinforce discipline. When a hospital found red bag waste mixed with yellow, it quickly organized training, and compliance improved.
- Creating accountability through a designated biomedical waste officer and committee that meet regularly. These discussions create ownership and reduce negligence.
- Encouraging innovation with

technologies like needle destroyers or on-site autoclaves.

- Protecting workers through vaccinations, protective gear, and regular health checkups. In one hospital, simply providing protective boots drastically reduced injuries among waste handlers.

By embedding such practices into routine hospital life, waste management becomes part of patient care itself.

NGOs: The Bridge Between Policy and Practice

While hospitals and laws provide the backbone, NGOs often act as catalysts for change. Their contributions make systems stronger:

- Training and Capacity Building: NGOs conduct workshops to train hospital staff, extending support even to small clinics. RNisarg Foundation, for example, has trained hundreds of healthcare workers across Mumbai and Thane, ensuring BMW protocols are followed at every level.
- Awareness and Advocacy: By working with communities and medical associations, NGOs keep waste management visible as a public health priority. RNisarg's education campaigns and easy-to-read IEC materials simplify complex rules for staff and citizens alike.
- Practical Solutions: Projects like RNisarg's Take-Back Bins have safely

collected over 200 kilos of expired medicines in Thane, preventing dangerous waste from entering landfills and informal recycling chains.

- Partnerships: NGOs act as bridges between hospitals, municipal bodies, and regulators, helping smooth compliance and spread best practices. RNisarg's compliance audits have supported several hospitals in passing inspections and avoiding penalties.

These collaborations turn rules on paper into action on the ground, closing dangerous gaps in the system. They show that biomedical waste management is not just a technical challenge but a shared civic responsibility.

Conclusion: Waste Is Everyone's Responsibility

When we take the doctor's oath "Primum non nocere", we pledge to do no harm. That promise extends beyond diagnosis and treatment – it includes protecting patients, staff, and communities from the hidden dangers of biomedical waste. Each syringe, dressing, and vial carries responsibility.

India's hospitals generate **710 tonnes of BMW daily**, with **15% infectious waste** that demands careful handling. Laws mandating **barcoding, 24–48 hour disposal, and annual reporting** are not just compliance checkboxes – they are shields of safety.

Hospitals must lead with discipline, NGOs like RNisarg must keep building awareness and practical solutions, and citizens must recognize their shared role. As a doctor, I know that our duty does not end when a patient leaves the ward. It continues in how we manage the waste their healing creates.

Honoring that duty means ensuring waste never harms the living we vowed to protect. In fulfilling this responsibility, we uphold our oath, safeguard public health, and secure a healthier tomorrow for all.

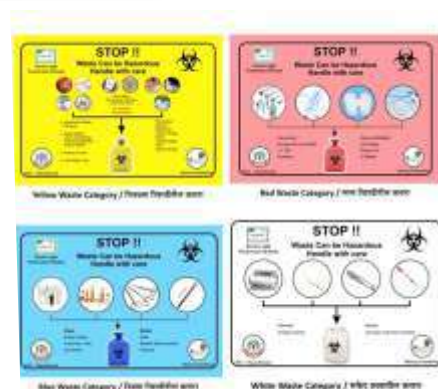
RNisarg Foundation, is a NGO founded by doctors who believe in the need to have greener practices in healthcare.

Under the initiative of Green healthcare practices, the NGO works on 4 verticals,

1. Green procurements (Judicious use of consumables),
 2. Biomedical waste management,
 3. Community outreach programs -Green Pharmacy - Take back for medicines from Households
- Sakhi - Menstrual Health and sustainable menstrual product use
 - Plant based diet - Prevent NCD and protect environment

The foundation supports hospitals with training, IEC and ETP consultations.
Contact: Support@rnisargfoundation.com

Kindly Scan the QR Code for Handbook on BMW for hospitals





**Meeting with Mr SEGAR Sampath
Director GI Council in AMC office**



Bombay Hosp Zonal Program

Invitation To Sri Sri Ravishankar Gurudev At His Ashram In Bangalore



Request letter to Sri Sri Ravishankarji to bless us for AMCON 2026 by coming as Chief Guest





Health Benefits of a Whole-Food, Plant-Based Diet: A Review of Current Evidence By

Dr. Rupa Shah
MBBS



A whole-food, plant-based (WFPB) diet emphasizes the consumption of minimally processed plant foods, including fruits, vegetables, whole grains, legumes, nuts, and seeds, while minimizing or excluding animal products and processed foods. This dietary pattern has garnered attention for its potential to prevent and manage various chronic diseases. We should always give a chance to our patients to modify diet and lifestyle before we get tempted to give prescription.

Cardiovascular Health

Numerous studies have demonstrated the cardiovascular benefits of a WFPB diet. A study published in the American Journal of Health Promotion found that a 16-week WFPB intervention led to significant reductions in body mass index (BMI), blood pressure, and cholesterol levels among participants (PMC). Additionally, a review in Nutrients highlighted that plant-based diets are

associated with improved lipid profiles and reduced risk of cardiovascular events (PMC).

Type 2 Diabetes Management

A WFPB diet has been shown to improve glycemic control in individuals with type 2 diabetes. Research indicates that such diets can lead to reductions in hemoglobin A1c levels and improved insulin sensitivity (PMC). Furthermore, a study in Diabetes Care reported that plant-based diets are associated with a lower risk of developing type 2 diabetes (PMC).

In India, we have work of Dr. Pramod Tripathi's research work on reversing diabetes which is now well published in international prestigious journals as well. So we have most required Indian data for reference. (Dr. Pramod Tripathi)

Weight Management

Adherence to a WFPB diet has been linked to weight loss and improved body composition. A study in Obesity found that individuals following a plant-based diet experienced greater weight loss compared to those on conventional diets (PMC). Moreover, long-term adherence to a WFPB lifestyle has been associated with sustained weight management and

reduced body fat percentage (PMC).

Cancer Prevention

Evidence suggests that a WFPB diet may lower the risk of certain cancers. A review in *The Lancet Oncology* reported that plant-based diets are associated with a reduced risk of colorectal cancer (PMC). Additionally, a study in *Cancer Epidemiology, Biomarkers & Prevention* found that higher intake of fruits and vegetables is inversely related to cancer risk (PMC).

Gastrointestinal Health

The high fiber content of a WFPB diet supports gastrointestinal health by promoting regular bowel movements and a healthy gut microbiota. A study in *Gastroenterology* indicated that plant-based diets are beneficial for individuals with inflammatory bowel disease (PMC).

Neurodegenerative Diseases

Emerging research suggests that a WFPB diet may have protective effects against neurodegenerative diseases. A study in *Frontiers in Aging Neuroscience* found that plant-based diets are associated with a lower risk of Alzheimer's disease (PMC).

Foundational Texts for Medical Professionals

1. Plant-Based Nutrition in Clinical Practice

An evidence-based guide that delves into the practical application of a plant-based diet across various health conditions, including cardiovascular

diseases, diabetes, and cancer. (Amazon)

2. Becoming Vegan: Comprehensive Edition by Brenda Davis & Vesanto Melina A comprehensive resource providing in-depth answers to common questions about plant-based nutrition, covering essential nutrients and dietary planning. (Michael Klaper, MD)

3. The China Study by T. Colin Campbell & Thomas M. Campbell A seminal work presenting findings from a comprehensive study on the relationship between diet and disease, advocating for a plant-based diet to prevent chronic illnesses.

Clinical and Lifestyle Applications

4. What's Missing from Medicine: Six Lifestyle Changes to Overcome Chronic Illness by Dr. Saray Stancic This book explores lifestyle interventions, including plant-based nutrition, as primary tools in preventing and managing chronic diseases.

5. Nourish: The Definitive Plant-Based Nutrition Guide for Families by Reshma Shah, MD, MPH & Brenda Davis, RD A practical guide for healthcare professionals and families, offering evidence-based recommendations for plant-based nutrition across all life stages. (Plant Based Health Professionals UK)

Scientific and Research-Oriented Reads

6. The Plant-Based Solution by

Dr. Joel Kahn A cardiologist's perspective on how a plant-based diet can prevent and even reverse heart disease, supported by scientific research. (Dr. Joel Kahn)

7. The Proof is in the Plants by

Simon Hill An evidence-based exploration of the health benefits of a plant-based diet, addressing common myths and providing practical guidance. (Rosemary Nutrition)

Mental Health and Lifestyle Integration

8. The Plant-Based Power Plan by

TJ Waterfall Focuses on optimizing plant-based nutrition for athletic performance, energy, and overall health, with insights applicable to active individuals.

9. How Not to Die by Dr. Michael Greger Examines the top causes of premature death and how lifestyle and diet changes, particularly plant-based nutrition, can prevent and reverse these diseases.

Recipe Books:

Dairy Alternatives by Dr. Rupa Shah

What About My Calcium? By Dr. Rupa Shah

Guilt Free Vegan by Nandini Gulati and Mala Barua

Conclusion

The adoption of a whole-food, plant-based diet offers a promising approach to the prevention and management of

various chronic diseases. Healthcare professionals should consider integrating plant-based dietary recommendations into patient care to promote long-term health benefits.

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Total Membership of the Association	: 15693
Members under professional Indemnity Scheme of AMC	: 11120
Persons (Members & Family) under H & A Scheme	: 4840
Members under CBS Scheme	: 1576



President AMC attending CII CONFERENCE



Blood Donation Program At Bhayandar Station



YOGA DAY



A Holistic Way To Manage Mental Health And Stress In Life By

Dr. Anil Garg

**Senior Faculty
The Art Of Living**

The goal of our life is to become Happy, Healthy and Peaceful. To achieve this goal, we do lot many things in life, but we hardly pay attention on the fact that the peace in inside us, we just need to unveil it for happy and healthy life.

The Mental health is a buzz word after the Corona. After Corona people are very much aware of Mental health, Yoga and Immunity. People are also aware that there is a need to see our life from a holistic perspective rather than just focusing on our physical body. I am really thankful to my Gurudev Sri Sri Ravishankar for giving me a wonderful life which I am enjoying for last 25 years.

I am the Devotee to **Gurudev Sri Sri Ravishankar who is the founder of an NGO the Art of Living.** The Art of living is a non-profit, educational and humanitarian organization founded in 1981 by the World-renowned humanitarian and Spiritual leader his holiness Gurudev Sri Sri Ravishankar.

The Art of living is now present in 190+ countries and more than 50 Crore people across the globe are practicing “SUDARSHAN KRIYA” a breathing technique taught in the

Happiness Program of The Art of living.

I am also the faculty to the Art of Living and teaching Happiness Program, A program designed by Gurudev Sri Sri Ravishankar to experience the real happiness in the life. In the Happiness Program Sudarshan Kriya is being taught apart from Yoga and Meditation. Besides 5 Golden keys are given in the program, by which one can open the locks of any problems in the life.

These happiness programs are conducted at various places in the whole country on a regular basis. If you want to join the Happiness Program of the Art of Living you can log in to www.artofliving.org and can find out the nearest place where happiness programs are being conducted or you can Write to me on my email garg.dranilkumar@gmail.com or WhatsApp me on +919322599875.

The Philosophy of the Gurudev Sri Sri Ravishankar is that: “Unless we have a stress-free mind and a violence-free society, we cannot achieve world peace.” The Art of Living community is diverse and attracts people from all walks of life.

When Gurudev Started the Art of Living, initially he was teaching meditation to the people but later on he realised that this is not enough. Then he went into silence for 10 days and the most precious gift was given to the humanity by Gurudev is **SUDARSHAN KRIYA**.

Yoga and Meditation is not a new thing. Thousands of years ago Maharshi Patanjali has talked about the Yoga. Today the whole world is acknowledging the power of **YOGA** and **MEDITATION**, which is evident that **21st June** has been declared as **INTERNATIONAL DAY OF YOGA** and **21st December** has been declared as **INTERNATIONAL DAY OF MEDITATION** by **United Nations** and people across the Globe are now realising and experiencing the power of Yoga and Meditation.

Gurudev said that there are **seven layers** of our existence on this planet. I discuss **four layers** of our existence in **my Workshop on Stress Management** which I conduct regularly at various places. **These Workshops are for 120 Minutes on the topic "Stress Management" (A Holistic Way to Manage Mental Health and Stress in Life)**

These four wheels are **BODY, MIND, BREATHE AND SOUL**. If there are no alignment and balancing in these four wheels there is a lack of chemicals called **ENDORPHIN** in our body. Due to the lack of chemical endorphin in our body we are stressful. So, in my

workshop of 120 minutes, I discuss how you can align these four wheels and live happy and healthy life.

My workshops are a combination of interaction, yoga, Pranayam and meditation. One can easily learn to live happy and healthy life in just two hours. I have conducted more than 2500 workshops on **STRESS MANAGEMENT** and transformed thousands of lives who are benefited from my workshops.

My workshops have had a significant positive impact in both professional and personal lives of many and I would like to create a similar impact in the personal and professional lives of thousands of people on this planet.

The pedagogy of my workshop is the holistic development of the people with Yoga, **Pranayama, Meditation and interactive sessions**.

The methodology will include Self-Exercise, Management Games, Self-Learning, Interactive sessions with **NO PPT, Fun, Masti and Feedback**.

I have conducted these workshops at C.I.S.F, Airport Authority of India. Association of Chartered Accountants and Company Secretaries, All India council of Technical Education-New Delhi, Canara Bank, B.M.A., E.S.I.C. and thousands of Institutes, Corporates and Colleges and transformed thousands of lives.

By the end of the Workshop, participants will be able to have- A Holistic approach towards personal and professional life, Happy and Healthy life, enhance their Interpersonal skills/relationships, learn proactive, positive and holistic approach, significantly improve their self-confidence, increase productivity and performance and Manage the resources efficiently.

Thousands of people got benefited from my workshop and living happy and healthy life. If you would like to conduct this workshop in your Hospital, Society, Association of for any others you may contact me on myemail garg.dranilkumar@gmail.com or WhatsApp me on +919322599875.

I am the man on mission to transform 500 thousand lives on this planet.

I wish each one of you a Happy, Healthy and Peaceful life.

(The Writer Dr. Anil Garg-A Senior faculty to the Art of living has a rich and profound 40 + years of experience in Corporate and Academic World. He served brands like Kores, Pidilite, Goldstar, BVIMSR etc. He is currently running his own company-FINKO-BUSINESS SIMPLIFIED where he provides one stop solution to corporates for all their needs. He is known as SALES GURU and Converting loss making Units into Profits in corporate world. He has also been conferred many awards including “Dada Saheb Phalke Memorial Foundation award” for his social service, “Master Trainer Pride of India award by Navbharat Group of Newspaper, & MCG, Rajasthan Shiromani and many more.)



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10 Cr Sum Insured Fire, Terrorism, Burglary – 10 Cr MBD, EEI, PEI – 5Cr Money, Fidelity , PLI- 1Cr Neon – 10L Plate Glass – 25L D&O – 50L WC – 1Lac Cyber – 5L	INR 81,670	INR 3,42,500

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Money changes in new financial year

Taxation

New tax regime: Budget made income up to **₹12.75 lakh** tax-free

- ▶ Rebate of **₹60,000** will offset tax liability on ₹12 lakh income
- ▶ Standard deduction of **₹75,000** will offset the rest
- ▶ New tax slabs to increase appeal of new tax regime

TCS (general purpose): Nil on foreign remittance up to **₹10 lakh**

- ▶ Above ₹10 lakh: TCS of **20%**
- ▶ Threshold revised upwards from **₹7 lakh**



Overseas education (loan): Nil TCS

Earlier, TCS of **0.5%** over **₹7 lakh** threshold

Self-occupied property:

- ▶ Can claim nil tax on 2 SOPs without conditions
- ▶ Reason for not living in owned property no longer required

Senior citizens: No TDS on interest income up to **₹1 lakh**

- ▶ Revised upwards from **₹50,000**
- ▶ Nil tax on NSS withdrawals on or after 29 August 2024

NPS Vatsalya: Parent can claim NPS-like benefits

So, tax deduction on contribution up to **₹50,000**

TDS & TCS corrections: Allowed only up to six years

- ▶ Earlier, deductors could make multiple corrections with no time-limit
- ▶ Creating difficulty for tax-payers in claiming credit in IT returns



Investing

SIFs: Sebi regulations to be effective from 1 April

- ▶ SIFs can offer more sophisticated investment strategies
- ▶ Minimum investment: **₹10 lakh**

DigiLocker: Users will be able to fetch stock and MF holdings

MF Mitra: Investors will be able to trace unclaimed MFs

NFOs: Lower commission rate to be applicable in switches

- ▶ Aimed to curb mis-selling of NFOs for higher commission

TCS stands for Tax Collected at Source; TDS for Tax Deducted at Source; Sebi for Securities and Exchange Board of India; SIFs for Specialized Investment Funds; MF for Mutual Funds; NFOs for New Fund Offers

PM – Surya Ghar: Muft Bijli Yojana

Subsidy for residential households

Rs. 30,000/- per kW up to 2 kW

Rs. 18,000/- per kW for additional capacity up to 3 kW

Total Subsidy for systems larger than 3 kW capped at Rs 78,000

Suitable Rooftop Solar Plant Capacity for households

Average Monthly Electricity Consumption (units)	Suitable Rooftop Solar Plant Capacity
0-150	1 – 2 kW
150-300	2 – 3 kW
>300	Above 3 kW

Subsidy for Group Housing Society/ Resident Welfare Association (GHS/RWA)

Rs. 18,000 per kW for common facilities, including EV charging, up to 500 kW capacity (@3 kW per house) with the upper limit being inclusive of individual rooftop plants installed by individual residents in the GHS/RWA

Online Applications may be submitted on the National Portal at <https://pmsuryaghar.gov.in>

Note: For detailed information, scheme guidelines may be referred.



महाराष्ट्र शासन



IMPORTANT NOTICE FOR PATIENTS & THEIR RELATIVES

As per the recently introduced Maharashtra Medical Service Persons and Medicare Service Institutions (Prevention of Violence & Damage or loss to Property) Act 2010 :

Section 3

Any act causing damage or loss to the property of hospital/clinic or any act of violence against any of the employee of hospital/clinic or abusing, such an act is prohibited.

Section 4

The offenders could be punished with imprisonment which may extend to Three (3) years and fine of Rs. 50,000/-

Section 5

The offence would be **cognizable** and **Non Bailable** and tried by the court of Judicial Magistrate of 1st class.

Section 6

In addition to above punishment the offender would be **liable to pay compensation of Twice the amount of damage or loss** caused to the property of hospital/clinic, which if not paid the same sum shall be recovered as if it were an arrear of land revenue.

You are requested to maintain silence and decorum inside the hospital/clinic premises. Incase of Complains Or Dissatisfaction, One Should Used Non-violent & Constitutional, democratic Ways

सावधान

डॉक्टर्स, नर्स, रुग्णालयातील कर्मचारी यांच्यावर हल्ला करणारे अथवा करणाऱ्यास चिथावणी देणारे....
दवाखान्याच्या, रुग्णालयाच्या मालमत्तेची अथवा उपकरणांची नासधूस करणारे....

- १) ३ वर्षेपर्यंत सक्तमुजरी.
- २) रु ५०,००० पर्यंत दंड
- ३) अजामीनपात्र गुन्हा
- ४) झालेल्या नुकसानीच्या दुप्पट रकमेची वसुली
- ५) ही वसुली महसुल यंत्रणे मार्फत केली जाईल.

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- Run-Off Cover available for retiring doctors and closing medical establishments

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 - Cosmetic Surgery
 - Lasik Surgery
 - Radioactive Treatment
- Retroactive date coverage included for past liabilities
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