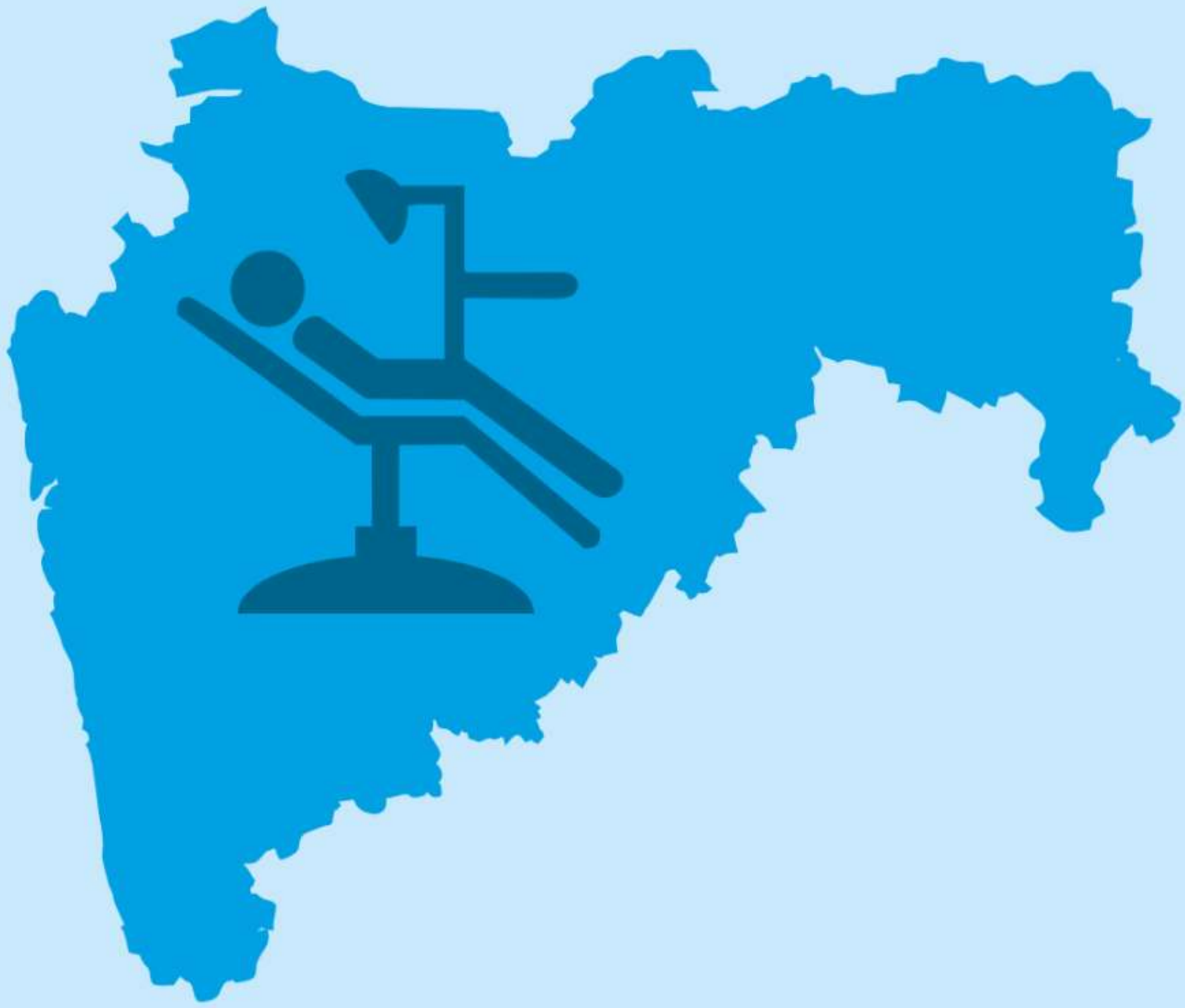
HANDBOOK OF DENTAL PRACTICE MANAGEMENT

(A Comprehensive Guide For Running a Successful and Ethical Dental Practice)



MAHARASHTRA STATE DENTAL COUNCIL
MUMBAI

MAHARASHTRA STATE DENTAL COUNCIL

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HANDBOOK OF DENTAL PRACTICE MANAGEMENT

(A Comprehensive Guide For Running a Successful and Ethical Dental Practice)

HANDBOOK OF DENTAL PRACTICE MANAGEMENT

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Maharashtra State Dental Council

Publisher

Maharashtra State Dental Council

3rd Floor, St. George Hospital Compound,
Near CST Railway Station, Fort,
Mumbai - 400 001 (Maharashtra)

www.msdcmumbai.in

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Printer

Bookmark

25/5, Ramchandra Gopal Budhale Path,
Y P Powar Nagar, Kolhapur - 416 008

ISBN

978-81-991517-8-9

Price

Rs. 500/-

MAHARASHTRA STATE DENTAL COUNCIL

Annual General Meeting

Executive Committee Meeting

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President

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EC Member

Dr. Vivek Pakhmode
Joint Director
(Ex. Officio Member)

Mrs. Shilpa Parab
Registrar

Message From
President

Greeting to one and all!

It is a great pleasure to circulate this small practice management reference manual to dentists. This reference manual is a small effort from the Maharashtra State Dental Council to help dentists to gain knowledge of fieldwork. We do not claim that the knowledge herein is complete or entirely up to date. New regulations are always being framed, and old ones abolished. Therefore, we advise you to take this document only as a pilot guide and to thoroughly read and refer to the current website of apex bodies.

I extend my gratitude to contributors, editorial board, authors , Hon. Council members, Office staff and all those who have work on this handbook. Their expertise and dedication are evident on every page, and their efforts will undoubtedly benefit dental community. I am also thankful to all the Dental practitioners of the state for supporting and believing in us.

MAHARASHTRA STATE DENTAL COUNCIL

We are trying to uplift the Dental professionals to provide quality oral & dental health services to people of the state.We heartily congratulate the newly passed BDS/MDS graduates who are registered with us and wish them good luck in setting up their dental practice & service to the people of great Maharashtra State.

Thank you all

Dr. Narendra Kale
President, Maharashtra State
Dental Council, Mumbai

Message from
Editor's Desk

Greeting to one and all!

With New Dental Schools coming up ever faster like never before, new dental graduates are being added to practising Dental Community, every single day. Every one of them comes from different social, financial & educational background. Every Dental School nurtures a different Teaching & learning culture. But once degree is attained, they all float in the same sea of uncertainty, & are posed same question & challenge of completion & survival of the fittest.

Taking up Dentistry as a career, faces difficult times, in this age of Al & Digital Innovations. The entire set of ideas of clinical practice, which were once there, are now turning upside down.

Oral scanners, 3-D printers, CBCT, CT navigated procedure & possibility of Digital Transfer of information and data for planning & executing Dental procedures has brought new questions in existence.

Old concepts of Ethics & morality are facing an emotional turmoil. This transformed Dental field prompted us top set up a new guiding path for New Dentists, which will lead them to an Ethical Dental practice. So, this is a humble effort form MSDC, to compile we are trying to keep this manual as short as A Guideline Manual for Practicing possible & point wise.

I sincerely thank MSDC president Dr. Narendra Kale for giving me as opportunity to interact with eminent Dental academicians & practioners, to come up with such a document.

I cannot thank enough MSDC body, Registrar, office staff & MSDC members for making it happen.

Thank you all.

Dr. Mrs. Surekha Bhedasgaonkar

Dr. Arun Dodamani

Dr. Sameer Patil

Dr. Rajesh Gaikwad

Message from
Registrar

A warm welcome to all!

On behalf of the Maharashtra State Dental Council, it is my great pleasure to welcome you all to our esteemed Council. I am delighted to present you with the Practitioners Guide for reference purposes. As the head of this apex body, which regulates dental practices, it is my duty to ensure that all dental professionals adhere to the highest standards of care and ethics.

In addition to this Practitioners Guide, I strongly recommend visiting the current websites of apex bodies at both national and global levels for the latest information and updates. The topics covered in this guide have been written by dentists with extensive experience in the field of dentistry.

I heartily congratulate the newly graduated BDS/MDS professionals and welcome you all to the Maharashtra State Dental Council.

Thank you all

Mrs. Shilpa Kiran Parab
Registrar, Maharashtra State
Dental Council, Mumbai

Renewal of Registration : All Registered Dentist should renew their Registration before **31st March every year.**

www.msdcmumbai.in

MAHARASHTRA STATE DENTAL COUNCIL

सत्यमेव जयते

देवेंद्र फडणवीस
मुख्यमंत्री
महाराष्ट्र

मंत्रालय
मुंबई ४०० ०३२

जा.क्र/मु.मं.स/ज.क./१३०/२०२५
दि. २८ जुलै, २०२५

शुभेच्छा

महाराष्ट्र राज्य दंत परिषद दंतवैद्यकीय चिकित्सा पद्धतीच्या व्यवस्थापनाबाबत हस्तपुस्तिका प्रकाशित करत असल्याचे समजून आनंद झाला.

दंतवैद्यकीय चिकित्सा पद्धतीच्या व्यवस्थापनासारख्या अत्यंत महत्त्वपूर्ण विषयावर आधारित मार्गदर्शक पुस्तिका प्रकाशित करण्याचा दंत परिषदेचा हा प्रयत्न प्रशंसनीय आहे. दंतचिकित्सेप्रमाणेच तिचे व्यवस्थापनही परिणामकारक असणे आवश्यक असते. या क्षेत्रातील शिस्तबद्ध व्यवस्थापन, रुग्णसेवेतील गुणवत्ता आणि व्यावसायिक कार्यपद्धती यांचे महत्त्व लक्षात घेता, ही पुस्तिका निश्चितच दंतवैद्यकीय क्षेत्रात काम करणाऱ्यांसाठी उपयोगी ठरेल, अशी खात्री वाटते.

महाराष्ट्र राज्य दंत परिषदेच्या या स्तुत्य उपक्रमासाठी मनःपूर्वक शुभेच्छा !

(देवेंद्र फडणवीस)

दूरध्वनी : ०२२-२२०२५१५१/२२०२५२२२, ई-मेल: cm@maharashtra.gov.in,
वेब साईट : www.maharashtra.gov.in

एकनाथ संभाजी शिंदे
उप मुख्यमंत्री
महाराष्ट्र

सत्यमेव जयते

मंत्रालय
मुंबई ४०० ०३२

शुभेच्छा

महाराष्ट्र राज्य दंत परिषदेच्या माध्यमातून दंत चिकित्सक मार्गदर्शक तत्वे पुस्तिका प्रकाशित करण्यात येत असल्याचे समजून आनंद झाला.

तोंडाचे आरोग्य राखण्यासाठी नियमित दंत तपासणी महत्वपूर्ण ठरते. या विषयाच्या सखोल ज्ञानासाठी दंत चिकित्सक मार्गदर्शक तत्वे पुस्तिका प्रकाशित करण्याचा परिषदेचा मानस प्रशंसनीय आहे. पुस्तकात रुग्णसेवेतील मूल्ये, क्लिनिकल प्रोटोकॉल्स अशा विविध विषयांवर लिखाण करण्यात आले आहे. रुग्णांना उत्तम सेवा देण्यासाठी ही पुस्तिका सर्व दंत चिकित्सकांना उपयुक्त ठरेल, असा विश्वास वाटतो.

महाराष्ट्र राज्य दंत परिषदेच्या पुढील वाटचालीस व प्रकाशित होणाऱ्या दंत चिकित्सक मार्गदर्शक तत्वे पुस्तिकेच्या प्रकाशनास माझ्या मनःपूर्वक शुभेच्छा !

(एकनाथ संभाजी शिंदे)

कार्यालय : ६ वा मजला, मुख्य इमारत, मंत्रालय, मुंबई ४०० ०३२, **दूरध्वनी** : ०२२-२२०२ ५०१४ / २२०२ २४०१
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सत्यमेव जयते

उप मख्यमंत्री
महाराष्ट्र राज्य

दि. २९ जुलै, २०२५

शुभेच्छा

महाराष्ट्र राज्य दंत परिषदेच्या वतीने दंतवैद्यकीय चिकित्सा पद्धतीच्या व्यवस्थापनाबाबत हस्तपुस्तिका प्रकाशित करण्यात येत असल्याचे समजून आनंद झाला.

दंतवैद्यकीय चिकित्सा पद्धतीचे व्यवस्थापन हे दंत वैद्यकीय सेवा पुरवठ्यासोबतच रुग्णालयाच्या प्रशासकीय, आर्थिक पैलूंचा समन्वय साधण्यासाठी आवश्यक आहे. दंतवैद्यकीय चिकित्सा पद्धतीच्या व्यवस्थापनाबाबत प्रकाशित होत असलेल्या हस्तपुस्तिकेच्या माध्यमातून या महत्वपूर्ण विषयावर आवश्यक माहिती उपलब्ध होईल, असा विश्वास आहे.

महाराष्ट्र दंत परिषदेच्या या स्तुत्य उपक्रमास मनःपूर्वक शुभेच्छा !

(अजित पवार)

सत्यमेव जयते

मंत्री
वैद्यकीय शिक्षण
महाराष्ट्र राज्य
मंत्रालय मुंबई ४०० ०३२
www.maharashtra.gov.in

दिनांक :

-: शुभेच्छा संदेश :-

महाराष्ट्र राज्य दंत परिषद तर्फे प्रकाशित करण्यात आलेली दंत चिकित्सक मार्गदर्शक तत्वे पुस्तिका ही राज्यातील सर्व दंत चिकित्सकांसाठी एक अत्यंत उपयुक्त आणि वेळेची गरज असलेली संकल्पना आहे. या पुस्तिकेद्वारे व्यावसायिक आचारसंहिता, क्लिनिकल प्रोटोकॉल्स आणि रुग्णसेवेतील नैतिक मूल्ये यांचे मार्गदर्शन मिळणार आहे, जे आपल्या दंत चिकित्सक समुदायाला अधिक सक्षम आणि विश्वासार्ह बनवेल.

आजच्या गतिमान वैद्यकीय युगात आधुनिक तंत्रज्ञानासोबत नैतिकतेची आणि व्यावसायिक शिस्तीची सांगड घालणे आवश्यक झाले आहे. ही पुस्तिका केवळ दैनंदिन दंतचिकित्सेतील दिशा दाखवणारी नसून, एक व्यापक दृष्टिकोन देणारी आणि गुणवत्तापूर्ण रुग्णसेवेचा पाया मजबूत करणारी आहे.

या स्तुत्य उपक्रमासाठी महाराष्ट्र राज्य दंत परिषद व सर्व तज्ज्ञ सदस्यांचे मी मनःपूर्वक अभिनंदन करतो. ही पुस्तिका राज्यातील सर्व दंत चिकित्सकांपर्यंत पोहोचून त्यांना त्यांच्या सेवेत उत्तम मार्गदर्शन करेल, असा मला विश्वास आहे.

सर्व दंत चिकित्सकांनी ही मार्गदर्शक तत्वे अंगीकारुन, आपल्या सेवेच्या माध्यमातून जनतेच्या आरोग्यासाठी योगदान द्यावे, हीच अपेक्षा.

(हसन मुश्रीफ)

MAHARASHTRA STATE DENTAL COUNCIL

The President, MDSC would have acknowledged and appreciated the efforts of the Minister of Medical Education during the unprecedented challenges of the COVID-19 pandemic.

A tribute to the unwavering courage of those who faced the pandemic head-on. You are true inspirations.

The dentists who served the society in the covid pandemic were honoured by MSDC with the hands of health minister and health education minister

The President of the Maharashtra State Dental Council (MSDC) engaged in discussions with newly registered dentists to guide them on professional conduct, registration procedures, and continuing

MSDC, provides financial assistance to Chief Minister's Relief Fund Covid-19

State Councils Summit At Jaipur, Rajasthan

PREAMBLE

In the recent past, Entire world was struck by a never-seen-before scale of a deadly pandemic of COVID ERA The "unpreparedness" of all the allied branches of medical field, underlined the necessity to lay down Good clinical practice Guidelines in all the fields of medical fraternity.

Restricting our discussion to "Dental Fraternity', it was one branch, which remained worst struck by COVID & affected the dental practice of many individual dentists & institutions alike.

Doctor community, Health care, professionals, and general public suddenly realized that they don't-have enough knowledge, how to face this situation. And there were no readily available reference documents, all in one place.

Event once occurred can occur any time again in future. And this small reference manual is a step ahead in the direction of increasing our preparedness to face any type of medical calamities.

As the saying goes, prevention is always better than cure. So let us all try and understand these guidelines to that we can implement them best for ours & patients benefit.

Once ready, Always Ready.

Stay alert! Stay updated!

● *DISCLAIMER* ●

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INFORMATION OF DCI, MSDC & NDC

1. DENTAL COUNCIL OF INDIA (DCI)

The Dental Council of India - a Statutory Body- was constituted on 12th April 1949 under an Act of Parliament - The Dentists Act, 1948 (XVI of 1948). The Dental Council of India has been entrusted with the following objectives:

1. Maintenance of uniform standard of Dental education - both at Undergraduate and Postgraduate levels.

2. It envisages inspections/visitation of Dental Colleges for permission to start Dental Colleges, increase of seats, starting of new Postgraduate courses.

3. To prescribe the standard curricula for the training of dentists, dental hygienists, dental mechanics and the conditions of such training.

4. To prescribe the minimum standards of examinations and other requirements to be satisfied to secure qualifications for recognition under the Act.

5. Supervision over all the dental institutions to ensure that they maintain the prescribed standard.

2. MAHARASHTRA STATE DENTAL COUNCIL (MSDC)

The Maharashtra State Dental Council is a statutory body created under the provisions of Section 21 of the Dentist Act, 1948, with the objective of regulating the profession of dentistry. As the regulatory body, the Council handles complaints received from both the public and dental professionals. Apart from issuing Registration Certificates, the Council also provides various other certificates. This maintains clarity and professionalism while effectively conveying the additional services provided by the Council.

Maharashtra State Dental Council take efforts to maintain the ethical dental practice and dignity of the profession in the state.

State council also give valuable inputs to State Government regarding the oral health services in the state.

ACTIVITIES OF MAHARASHTRA STATE DENTAL COUNCIL

1. Preparing of Dental Register
2. Provisional Registration for the B.D.S Students
3. New Registration for the Dentists, Dental Hygienists and Dental Mechanics
4. Renewal of Registration of Dental Practitioners
5. Issuance of Good Standing Certificate
6. Issuance of Country Wide Certificate
7. Issuance of Change of Name
8. Issuance of Duplicate Certificate
9. Issuance of Additional Qualification Certificate
10. Issuance of No Objection Certificate
11. Verification of Dentist from National Dental Register
12. Verification of Registration Certificates, Good Standing Certificate
13. Complaint Grievances - Complaints about unethical practices, unethical advertisements, malpractices, etc. and taking disciplinary actions against the dentists if found guilty
14. CDE Credit Points for CDE Programme
15. To Provide data of Dental Practitioners to the State Government if required
16. Reply to Government Correspondences
17. Expert opinion to State Government regarding Dental Health Care Service if required
18. Efforts to maintain ethical practice.

NATIONAL DENTAL COMMISSION BILL, 2023

Ministry of Health and Family Welfare

National Dental Commission Bill, 2023 Passed by the Parliament to Elevate Dental Education and Healthcare Standards

Posted On: 08 AUG 2023 9:58PM by PIB Delhi

In a significant step towards enhancing healthcare quality and aligning dental education with global standards, the Parliament has passed the National Dental Commission Bill, 2023. This landmark legislation underscores the government's unwavering commitment to ensuring the highest standards of dental care for its citizens.

The National Dental Commission Act 2023, will introduce a groundbreaking regulatory framework by establishing the National Dental Commission (NDC), which will replace the existing Dental Council of India (DCI) and repeal the Dentists Bill, 1948. The Act envisions a complete overhaul of the dental education and profession landscape to bring it on par with international benchmarks. Key features include:

1. Constitution of National Dental Commission and State Dental Councils: The Act establishes the National Dental Commission and mandates the formation of State Dental Councils or Joint Dental Councils. This structure aims to decentralize authority and enhance effective regulation.

2. Three Autonomous Boards: The Act will empower three distinct Autonomous Boards: the Under-Graduate and Post-Graduate Dental Education Board, the Dental Assessment and Rating Board (DARB), and the Ethics and Dental Registration

Board (EDRB). These boards will carry out specific functions, contributing to a comprehensive regulatory framework.

3. Fixed Tenure and Professional Development: The Act will introduce a fixed tenure for the Chairperson, Members, and Secretary of the Commission, with no possibility of reappointment. The NDC will emphasize promotive and preventive dental care services and will focus on fostering the soft skills necessary for career advancement among dentists and dental auxiliaries.

4. Industry Collaboration and Technological Innovation: Recognizing the importance of collaboration and research, the Act will encourage partnerships with industry and institutions to promote advancements in dental research. It also emphasizes the integration of cutting-edge technology into dental education.

5. Online National Register and Dental Advisory Council: The Act will provide for maintaining an online and live National Register of licensed dentists and dental auxiliaries. Furthermore, it establishes a Dental Advisory Council with representation from all States/Union Territories to ensure comprehensive insights and guidance.

6. Merit-Based Selection Process: Under the Act, the NDC will be led by a 'selected' Regulator. This entails the appointment of the NDC Chairman and Members through a merit-based selection process conducted by a Search–cum-Committee chaired by the Cabinet Secretary.

7. Collaborative Approaches: The Act will facilitate joint sittings with relevant statutory bodies, including the National Medical.

DENTAL ETHICS & LEGAL PROVISIONS

- Revised Code of Ethics
- Standard Operating Procedure or Allegation by Patient or Person Against any Registered Dentist in the State
- Legal Provisions for Punishment of Quack / Bogus Dentists, Dental Mechanics and Dental Hygienists

A. DENTAL ETHICS / REVISED CODE OF ETHICS FOR DENTIST

Dr. Narendra Kale

Dental Council of India with the previous sanction from Government of India revised the code of ethics for Dentist in the country on 27th June 2014.

This newly formed regulation is called as 'Revised Dentist Regulation – 2014 or revised code of ethics – 2016'

The important points of this act are as following-

1. Every dentist must be courteous sympathetic, friendly and helpful to and always ready to respond to call of his patients, and that under all conditions his behavior towards his patients and the public shall be polite & dignified.

2. Dentist should follow all the rules and regulation prescribed by DCI, State dental Council & health Department.

3. The principle objective of the Dental profession is to render service to humanity with full respect for the dignity of profession and man.

They should try continuously to improve medical knowledge and skills to improve the service to the patients.

4. Display of Registration Number:

Every Dental Practitioner shall Display the registration number accorded to him by the state dental council in hisclinic and in all his prescriptions, certificate and money receipt.

5. Dental Surgeon Shall Display as suffix to their names only recognized Dental degrees which are recognized by the council or other qualifications such as certificates and diplomas and honours / fellowships which are confirmed by recognized universities / recognized bodies approved by the council and obtained by convocation in person or in absentia.

Any other qualifications such as medical degrees / doctorate, post doctorate degrees or any degree that has bearing on the person's knowledge or exemplary qualification may be used as suffix in a manner that does not convey to the observer or patient a false impression regarding the practitioners knowledge or ability as a dental profession.

Abbreviation of membership in association or organization of professionals should not be used.

6. Every dental surgeon should take care to prescribe and administer drugs in a responsible manner and ensure safe and rational use of drugs.

He should as far as possible prescribe drugs in a generic form.

7. A dental surgeon should expose, without fear or fevers incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.

It is the responsibility of the dentist to report to the competent authorities about quackery and other misconduct.

8. A dental surgeon should announce his fees before rendering service and not after the treatment or treatment in under way.

It is unethical to enter into a contract of 'No care - No

Payment.'

9. A dental surgeon involved independently in the treatment of dental and oral surgical problems may be called upon to sign certificates, notifications, reports etc.

He is bound to issue such certificates and sign them.

Documents relating to disability, injury in the oral and maxillofacial region and also death occurring while under the care of such dental surgeons should be signed by them in their professional capacity for subsequent use in the courts or for administrative purpose etc.

If any dental surgeon who is signed a certificate which is untrue, misleading or improper is liable to have his name deleted from register.

Duties of Dental Practitioners to their patients :

1. Though a dental surgeon is not bound to treat each and every person asking his services, he should attend emergencies reporting to the clinic.

Once having undertaken a case, the Dental Surgeon should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family. He shall not willfully commit an act of negligence that may deprive his patient or patients from necessary Dental/Medical Care.

2. Dentist can refuse treatment using his discretion but it should not be on the basics of any discrimination of colour, caste religion nationality or the presence of ailments such as HIV or other contagious diseases.

3. Confidentiality :

Dentist should maintain the confidentiality of the individual or domestic life entrusted by patients to a dental surgeon.

4. The dental surgeon should neither exaggerate nor minimize the gravity of a patients disease.

Duties of dental surgeon & specialist in consultation :

1. A dental surgeon should ordinarily be able to deal with all common diseases of the oral cavity by virtue of his qualification and training. However if the patient requires expert care of the nature of the problem.

It is the duty of a specialist to refer the back to patients original dentist after treatment for which the referral was made.

Specialist can collect the fee from patient but it is unethical to pay commission or any kind of gratuity to the referring dentist.

2. A dental surgeon should not receive from radiologist, laboratory or dispensary chemist any kind of commission in the form of money, gifts or gratuity for referrals.

3. Punctuality for consultation should be observed by a dental surgeon except in the case of unavoidable professional delays which use justifiably.

4. All statements to the patient or his representative made by any consulting health care professional or paramedical staff should take place in the presence of the dental surgeon.

Responsibility of Dental Surgeon to one another

1. A dental surgeon should consider it is a pleasure to render gratuitous service to other dentists, physicians and their

immediate family dependents. However there is no mandatory bar on one accepting fee particularly when it involves expensive material and time. But it will be deemed a courtesy to offer free or subsidized consultation and treatment to them in situation where no significant expenses are insurance.

2. No statement or remark be made about other dentist in presence of patient or their representative.

3. Whenever a dental surgeon request another dental surgeon to attend his patients during his temporary absence from his practice, professional courtesy requires the acceptance of such appointment only when he has the capacity to discharge additional responsibility along with his other duties.

The dental surgeon acting under such an appointment should give the at most consideration to the interests and reputation of the absent dental surgeon and all such patients should be restored to the care of the latter upon his future. Unethical Act

1. Advertisement :

The global position on the issue of ethics of advertisement by dental / medical professional has drastically changed over last few decades.

A dentist or group of dentist may advertise provided that they maintain decorum keeping in mind the high moral obligations and the value that society places on the important nature of their work and the moral character and integrity expected of them.

Dentist can advertise :

. In following conditions :

1) On starting of practice.

2) On change of type of practice.

3) On temporary absence or resumption of practice after break.

4) About availability of new instrument or service.

5) Though maintenance of websites about dentists or dental clinics where all information is factual will not be consider as unethical practice.

Website can also carry details of treatment facilities available and fee for the same.However websites should not make claims or statements that are not factual and there for misleading to the public.

But such advertisement is unethical under following circulations.

1. False promises.

2. Advertisement not maintaining decorum and moral obligations.

3. To employ any agent for the purpose of obtaining patient.

4. Advertisement in improper size boards in front of clinic or any where.

5. Commercial articles like toothpaste, tooth brush should not carry the name of dentist.

6. To advertise in electronic media such as in television programs that display names addresses and telephone numbers of the dentists as on screen scrolls or of the clinics employing such dentists is unethical.

7. Printing of self photograph on letter head or sign board is unethical.However, printing of sketches, diagrams, picture of

human system shall not be treated as unethical;

Using or exhibition of any sign, other than a sign which in its character, position, size and wording is merely such as may reasonably be required to indicate to persons seeking the exact location of and entrance to the premises at which the dental practice is carried on is considered unethical.

8. The sign board should be proper in size no extra large not or such type which will loose the dignity is unethical.

Use of sign-board with the use of such words which trivialize the dignity of the profession or notices in regard to practice on premises other than those in which a practice is actually carried on, or show cases, or flickering light signs and the use of any sign showing any matter other than his name and qualifications is unethical.

Affixing a sign-board on a chemist's shop or in places where the dentist does not reside or work.

Running and open shop (Dispensing of Drugs and Appliances by Physicians):

A dental surgeon should not run an open shop for sale of medicine for dispensing prescriptions prescribed by doctors other than him or for sale of dental medical or surgical appliances. It is not unethical for a dental surgeon to prescribe, supply or sell drugs, remedies or dental appliances in his clinic as long as there is no exploitation of the patients.

Naming and Styling of Dental Establishment :

A dental surgeon or a group of dentists / dental surgeon shall refer to their establishment as a dental clinic. It may however

be referred to as a dental hospital if the practice involves surgical treatment of oral and dental diseases under local or general anaesthesia and if the patients need to be maintained as an in-patient for part of a day or for several days for post-operative care provided the hospital fulfils the statutory requirements for such hospitals or establishments in the respective states.

Abiding by all laws of the land:

A dental surgeon shall not aid or abet in any violation of the laws of the land or be involved in any matter that is against public policy. He shallnot be convicted by a court of law for offences involving moral turpitude / criminal acts.

Relationship with Pharmaceutical Companies and Medical and Dental Industry :

a. Gift, Travel, Hospitality, Monetary Grants :

A dental surgeon shall not receive any gift from any pharmaceutical or allied health care industry and their sales people or representatives. A dental surgeon shall not accept any travel facility inside the country or outside, including rail, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshop, CDE/CME program etc. as a delegate. A dental surgeon shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions and Professional Organizations by modalities laid down by law / rules / guidelines adopted by such

approved institutions, in a transparent manner. It shall always be fully disclosed.

b. Dental / Medical Research :

A dental surgeon may carry out, participate in, and work in research projects funded by pharmaceutical and allied healthcare industries.

c. Affiliation:

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

Ensure that his professional integrity and freedom are maintained.

Ensure that patients interest is not compromised in any way.

Ensure that such affiliations are within the law.

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

Important :

A dental surgeon shall not claim to be a specialist either through displayed signs on the name board and other stationary unless he has a special qualification in the specialty a dental surgeon can however practice all the branches of dentist provided he shows adequate qualification, competence and bonfide training in the concerned branch.

PUNISHMENTS AND DISCIPLINARY ACTIONS:

A Dental Surgeon shall not aid or abet or commit any acts which shall be construed as unethical.

It must be clearly understood that the instances of offences and unethical conducts which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which calls for disciplinary action, and that by issuing this notice the Dental Council of India and or State Dental Councils are in no way precluded from considering and dealing with any other form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances as in all others, the Dental Council of India and/or State Dental Councils have to consider and decide upon the facts brought before the Dental Council of India and/or State Dental Councils.

It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Dental Council for Disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Dental Council would hold an enquiry and give opportunity to the registered Dental practitioner to be heard in person or by pleader. If the Dentist/ Dental Surgeon is found to be guilty of committing professional misconduct, the appropriate Dental Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register the name of the delinquent registered practitioner. Deletion from the

Register shall be widely publicized in local press as well as in the publications of different Medical and Dental Associations/ Societies/Bodies.

In case the punishment of removal from the register is for a limited period, the appropriate Council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed.

Decision on complaint against delinquent Dental Surgeons shall be taken within a time limit of **6 months.**

During the pendency of the complaint the appropriate Council may restrain the Dental Surgeon from performing the procedure or practice which is under scrutiny.

Professional incompetence shall be judged by peer group as per guidelines prescribed by State Dental Council. For this purpose the State Dental Council shall institute an Ethics Committee consisting of qualified persons of integrity and good name from amongst prominent registered Dental Surgeons in the State.

Where either on a request or otherwise the State Government or any competent authority is informed that any complaint against a delinquent practitioner has not been decided by a State Dental Council within a period of six months from the date of receipt of complaint by it and further the State Government or any competent authority has reason to believe that there is no justified reason for not deciding the complaint within the said prescribed period, the State Government or any competent authority may.

Impress upon the concerned State Dental council to conclude and decide the complaint within a time bound schedule.

May decide to refer the said complaint pending with the concerned State Dental Council straightaway or after the expiry of the period which had been stipulated by the Regulation in accordance with para (9.7.1) of this document, Revised Dentists Code of Ethics Regulations, 2012) above, to itself and refer the same to the Ethical Committee of the State Dental Council for its expeditious disposal in a period of not more than six months from the receipt of the complaint with the State Government.

Any person aggrieved by the decision of the State Dental Council on any complaint against a delinquent Dental Surgeon, shall have the right to file an appeal to the State Government within a period of 60 days from the date of receipt of the order passed by the said State Dental Council.

Provided that the State Government may, if it is satisfied that the appellant was prevented by sufficient cause from presenting the appeal within the aforesaid period of 60 days, allow it to be presented within a further period of 60 days.

B. AS PER BOMBAY DENTISTS RULES, 1951, UNDER RULE 72 A STANDARD OPERATING PROCEDURE (SOP)

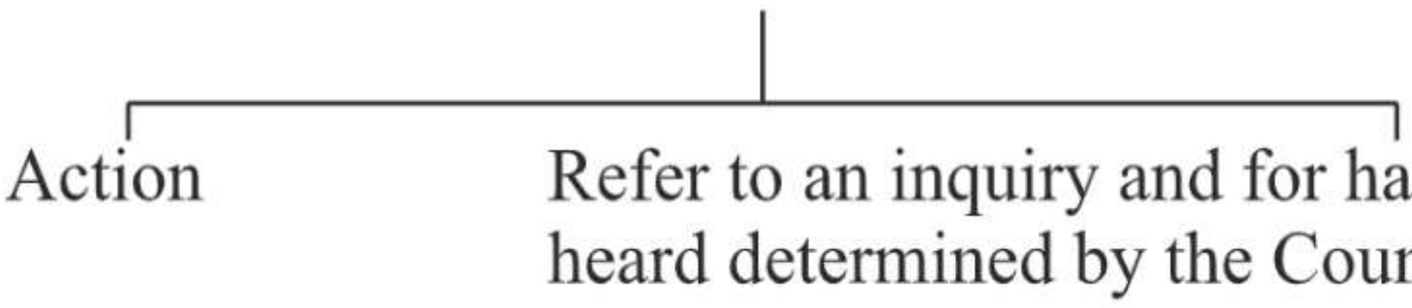
1. Complaint -Information /direct allegations by a person

2. Where the information in question is in the nature of a complaint by a person or body such complaint shall be made in writing addressed to the Registrar and shall state the grounds of complaint and shall be accompanied by one or more declaration as to the facts of the case.

3. Refer to the President

Explanation not required — Call Explanation

4. Referred to the Executive Committee



Action — Refer to an inquiry and for having the case heard determined by the Council

5. Notice with charges

6. Inquiry

7. Judgement

C. LEGAL PROVISIONS FOR PUNISHMENT OF QUACK / BOGUS DENTISTS, DENTAL MECHANICS AND DENTAL HYGIENISTS

Dr. Mahendra Lomte
Ph.D. (Law) & B.A.M.S.

Introduction:

No express definition is provided for the quacks in any law. Honourable Supreme Court coined the term "quack" in its judgment in Poonam Verma vs Ashwin Patel & Ors on 10 May, 1996 and defined it as "A person who does not have knowledge of a particular System of Medicine but practices in that System is a Quack and a mere pretender to medical knowledge or skill, or to put it differently, a Charlatan" and further held that a person without being qualified in any system and practising in such system will be held guilty of negligence per se i.e. no further proof of negligence is needed. In the light of system of dentistry same principles also would be applicable by the virtue of legal provisions enacted for the regulation of the profession of dentistry.

Abstract:

1) Practise by unqualified or/and unregistered person as a dentist or dental mechanic or dental hygienist as the case may be makes liable such person for negligence per se i.e. no further proof of negligence

2) Such acts and like a nature acts are also prohibited by the relevant provisions of The Dentist Act 1948 and the said act also prescribes punishment for the same.

3) Government of Maharashtra constituted different committees at different level for effective implementation of relevant provisions of The Maharashtra Medical Practitioners Act, 1961 in order to punish the wrong doers according to provisions of Sections 33, 33 A and 38 of the said act.

4) The Maharashtra Medical Practitioners Act, 1961 is silent about the wrong doers in relation to unregistered dentists, dental mechanics and dental hygienist so for that purpose Government passed a resolution dated 22nd January 2019 thereby extending the rights of Taluka and District level committee to take action against unregistered dentists, dental mechanics and dental hygienist in the state of Maharashtra but according to provisions of sections 47 to 51 (both inclusive) The Dentist Act 1948.

Legal Provisions: The Dentist Act 1948 - Section 2:

(j) "recognised dental qualification" means any of the qualifications included in the Schedule;

(k) "recognised dental hygiene qualification" means a qualification recognised by the Council under section 11;

(l) "registered dentist", "registered dental hygienist" and "registered dental mechanic" shall mean, respectively, a person whose name is for the time being registered in a register of dentists, a register of dental hygienists and a register of dental mechanics.

Section 47.

If any person whose name is not for the time being entered in a register falsely represents that it is so entered, or uses in connection with his name or title any words or letters reasonably calculated to suggest that his name is so entered, **he shall be**

punishable on first conviction with fine which may extend to five hundred rupees, and on any subsequent conviction with imprisonment which my extend to six months or with fine not exceeding one thousand rupees or with both.

Section 48.

(a) If any person, - not being a person registered in a register of dentists, takes or uses the description of dental practitioner, dental surgeon, surgeon dentist, or dentist, or

(b) not being a person, whose name is entered on a register of dental hygienists, takes or uses in [State] where such register has been published, the title of dental hygienists, or

(c) not being a person, whose name is entered on a register of dental mechanics, takes or uses in a [State] where such register has been published, the title of dental mechanic, [or]

(d) not possessing a recognized dental qualification, uses a degree or a diploma or an abbreviation indicting or implying a dental qualification], **he shall be punishable on first conviction with fine which may extend to five hundred rupees, and on any subsequent conviction with imprisonment which may extend to six months or with fine not exceeding one thousand rupees or with both.**

Section 49

(1) After the expiry of 3[three years] from 4[the date appointed under sub section (2) of section 32] in the case of dentists, and in the 5[States] where a register of dental hygienists or dental mechanics has been prepared under section 36 from such date as may be specified in this behalf by the 6[State] Government by

notification in the Official Gazette, in the case of dental hygienists or dental mechanics, no person, other than a registered dentist, registered dental hygienist or registered dental mechanic, shall practice dentistry, or the art of scaling, cleaning or polishing teeth, or of making or repairing dentures and dental appliances, as the case may be, or indicate in any way that he is prepared to so practice:

Provided that the provisions of this section shall not apply to—

(a) practice of dentistry by a registered medical practitioner;

(b) the extraction of a tooth by any person when the case is urgent and no registered dentist is available, so however that the operation is performed without the use of any general of local anaesthetic;

(c) the performance of dental work or radiographic work in any hospital or dispensary maintained or supported from public or local funds.

(2) If any person contravenes the provisions of sub-section (1), he shall be punishable on first conviction with fine which may extend to five hundred rupees, and on any subsequent conviction with imprisonment which may extend to six months or with fine not exceeding one thousand rupees or with both.

<u>The Maharashtra Medical Practitioners Act, 1961</u>

Section 33. [Prohibition of medical practice by persons not registered. [Section 33 was substituted for the original by Maharashtra 30 of 1979, Section 17.]

(1) Notwithstanding anything contained in any law for the time

being in force or in any judgment, decree or order of any Court, no person other than a medical practitioner whose name is entered in -

(i) the register maintained under this Act; or

(ii) the register or the list prepared and maintained under the Bombay Homoeopathic and Biochemic Practitioners' Act, 1959 or under any other law for the time being in force in relation to the qualifications and registration of Homoeopathic or Biochemic Practitioners in any part of the State; or

(iii) the register prepared and maintained under the Maharashtra Medical Council Act, 1965; or

(iv) the Indian Medical Register prepared and maintained under the Indian Medical Council Act, 1956.

shall practice any system of medicine in the State:

Provided that, the State Government may, by notification in the Official Gazette, direct that subject to such conditions as it may deem fit to impose and the payment of such fees as may be prescribed by rules, the provisions of this section shall not apply to any class of persons, or to any area, as may be specified in such notification.] [The original sub-section (2) was deleted by Maharashtra 30 of 1979, Section 13, and this sub-section (2) was inserted by Maharashtra 23 of 1982, Section 25(b).]

(2) [Any person, who acts in contravention of any of the provisions of sub-section (1) shall, on conviction, [be punished,-

(a) for the first offence, with rigorous imprisonment for a term which shall not be less than two years but which may extend to

five years and with fine which shall not be less than thousand rupees but which may extend to ten thousand rupees; and

(b) for a second or subsequent offence, with rigorous imprisonment for a term which may extend to ten years and with fine which may extend to twenty-five thousand rupees:]

Provided that, when the contravention is continued after the order of conviction, a further fine which may extend to five hundred rupees, for each day of continuation of such contravention, may be imposed.] [Sub-section (2) was substituted by Maharashtra 21 of 1993, Section 5.

Section 33A. [Unregistered persons not to hold certain appointments. [Section 33A was inserted by Maharashtra 17 of 1965, Section 9.]

(1) [Notwithstanding anything contained in any law for the time being in force,] no person, who is not a practitioner registered under any of the Acts referred to [in section 33] [These words and figure were substituted for the words 'in that section' by Maharashtra 21 of 1993, Section 6(a).], shall after the commencement of this Chapter, hold any appointment as,

(a) physician, surgeon, or other medical officer, in any hospital, infirmary or dispensary not supported wholly by voluntary contribution;

(b) medical officer of health of any local authority;

(c) teacher in medicine, surgery or midwifery in any public institution.]

[Explanation. - For the purposes of this sub-section a practitioner

registered under this Act shall not include a practitioner registered under Part III of the register maintained under this Act.] [This Explanation was inserted Maharashtra 30 of 1979, Section 18(b).]

(2) [Any person, who contravenes the provisions of sub-section (1) shall, on conviction, [be punished,-

(a) for the first offence, with rigorous imprisonment for a term which shall not be less than two years but which may extend to five years and with fine which shall not be less than two thousand rupees but which may extend to ten thousand rupees; and

(b) for a second or subsequent offence, with rigorous imprisonment for a term which may extend to ten years and with fine which may extend to twenty-five thousand rupees:]

Provided that, when the contravention is continued after the order of conviction, a further fine which may extend to five hundred rupees, for each day of continuation of such contravention, may be imposed.] [Sub-section (2) was substituted by Maharashtra 21 of 1993, Section 6(b).

Section 38. Cognizance of offences. - All offences under this Act shall be [cognizable and non-bailable] [These words were substituted for the word 'cognizable' by Maharashtra 9 of 2001, Section 4, w.e.f. 13.3.2001.]

Government Resolutions Dated 5th September 1991, 7th February 2000, 5th December 2001, 5th February 2003 and 22nd January 2019

By the virtue of abovementioned Government of Resolutions, Government of Maharashtra constituted different committees at

different level for effective implementation of relevant provisions of The Maharashtra Medical Practitioners Act, 1961 in order to punish the wrong doers according to provisions of Sections 33, 33 A and 38 of the said act, but the said act is silent about the wrong doers in relation to unregistered dentists, dental mechanics and dental hygienist so for that purpose Government passed a resolution dated 22nd January 2019 thereby extending the rights of Taluka and District level committee to take action against unregistered dentists, dental mechanics and dental hygienist in the state of Maharashtra but according to provisions of sections 47 to 51 (both inclusive) The Dentist Act 1948.

ABOUT THE DENTAL PRACTICE

- A) Focus Areas For Starting Private Practice
- B) Understand This, Before You Start Clinic
- C) List Of Certificates And Voluntary Display
- D) Clinical Record Keeping
- E) Role Of The Dental Auxillaries
- F) Maharashtra Model Prescription Format
- G) Biomedical Waste Management In Dentistry

A. FOCUS AREAS FOR STARTING PRIVATE PRACTICE

Dr. Sujit Pardeshi

Starting a private-dental practice is like a roller coaster ride. On one side you are excited, happy, and thrilled to start this wonderful journey and at the same time you are equally anxious, nervous and full of confusion. You know that it's not going to be easy and a smooth journey simply because you know nothing about it and unfortunately nobody taught you how to start it in the perfect way.

Throughout our academics, we learn about clinical skills and as you are on the verge of starting your own practice, you are well equipped with all the skills, equipment, and instruments that you need to start your practice. However, the challenges are on the front of growing and managing the practice. This is simply because you have no idea about the systematic approach you should take as you build your practice neither about what are the things to be considered as you embark on this journey.

They say that 'Well beginning is half done'. So, let's focus on 10 important areas you need to work upon once you decide to venture into the private dental practice journey, If you do your homework right and work on these 10 focus areas, I assure you that your beginning will be well planned, well executed, and you will be very well prepared to handle the challenges and build your own practice. .

1. Right mind set

This is the most important thing you should remember and work on even before you start practicing dentistry independently. I always say that 'Your practice is just the reflection of who you are, and you need to work more on yourself than your practice in order to build a successful private practice.

Many youngsters are too skeptical about building a successful practice simply because of the thought that there is tremendous competition around, and how will they survive with so many dentists around, many of whom charges very little for the treatments, not focusing on treatment quality, and sometimes doing all unethical things to attract the patients.

Start with an absolute positive mindset, focus on giving your best and always be optimistic for developing the right practice. Your mind will be your lighthouse during this journey.

2. Practice area &location

One of the first important things to consider before starting your private practice is the area where you want to start this journey, This is important because the location of your practice affects the outcome and the way you're going to grow eventually.

Every area has different demographics and socio-economic strata of people. Starting a practice in low socio-economic area, low spending capacity and less dental awareness will need more efforts and hard work from your side to build the practice and vice versa. The location should preferably be commercial area rather than the residential one. The residential area limits your clientele

whereas in the commercial areas, you can get walk-in patients who come to the marketplace for different purchases.

3. Branding

You might be thinking that why I should focus on branding in order to start my practice because I'm just starting a solo private clinic? Is it really important? Does it matter or going to make a difference? The answer is - a big YES!

Remember, branding is the most essential clement of any venture that you start simply because branding is your identity, your message, and your image that you portray to the world. It answers many questions like what patients should think about your new dental clinic, what you have to offer them, what can they expect from you as a dentist and how you are different from the competition etc.

Branding comprises of the following elements:-

Clinic name - Add some uniqueness to your clinic's name and make it catchy, easy to pronounce and remember for the people.

Tag line - Have a tag line that conveys your philosophy of working or what you are good at.

Color theme - Keep in mind that each color conveys different emotion and message. Therefore, the color combination you select is also important.

Logo - Get a good logo designed from a professional logo designer and carry the same logo and theme on all your printing materials as well as online presence.

Working on these foundational elements will help you to 'get noticed' in the people's eyes in your neighborhood areas and it will help you to kick start your practice faster.

4. Investment

One of the biggest mistakes made by majority of the new practitioners is they think of starting the practice with minimum investment. Many times, this is because of lack of sufficient funds, lack of knowledge, or sometimes lack of confidence of building, a successful practice and recovering the money.

If you start with minimum investment, you will have to compromise a lot on everything, including your clinic interior, armamentarium and the overall look & feel of your practice.

'The right thing is to always start with 'optimum' budget and not the minimum one. You should look at starting a practice as investing in a new venture that you are starting and whatever optimum investment it requires - is required and any compromise here will compromise your message and even the work quality as you start practicing.

5. Clinic interior

You must spend the optimum money on creating decent interior of your clinic. Remember - first impression is the last impression, and you never get second chance to make the first impression. As any patient walks in your clinic, the look and feel of the place should make them calm, happy and confident about getting the treatment done at your center.

You do not need to spend a lot and have a five-star kind of interior, but soothing, relaxing, and decent ambience is a big add-

on and a boost for any dental Clinic.

So, take help of a good interior designer and make sure that you spend to make your clinic appear decent and a good place to get the treatment done for the patients.

6. Armamentarium

This's another area where you should never think of starting your practice with least investment. Many young practitioners think of starting small & adding the equipment and different treatment facilities as their practice starts flourishing.

In fact, it is other way round - having good set of equipment and using high-quality materials will always help you to enhance the treatment quality for your patients and in return, build your practice faster. Good armamentarium is the foundation of your practice. It will give the right message to the people in your vicinity that there is a 'good dentist' nearby so don't unnecessarily compromise on having good set of instruments and equipment.

7. Inauguration ceremony

You must plan a decent inauguration ceremony and invite as many people as you know in the surrounding area. You can arrange some snacks or high tea kind of event and offer warm hospitality to everyone who visits your new practice. This is simply because it is an opportunity for you to tell the world about your presence in that location. This also gives a chance for you to show your clinic, the equipment and treatment facilities available at your center.

This will help you in getting those first few patients which eventually will become your brand ambassadors to spread the word of mouth and build your practice. This also gives an

opportunity to the people who visit you for the inauguration to know about you as a person and your practice as for their dental needs.

8. Day-to-day operations

Few important elements to work upon about day-to-day functioning of your practice are - staff selection, deciding the treatment charges and keeping the treatment records, You should do the selection preferably a couple of weeks before the inauguration function. This will help you to understand them and give them the basic training about the manners and etiquette they need to practice on daily basis, understand the basic dental terminology and prepare themselves to work in your team.

The treatment charges should be decided depending upon the area you select for the practice. You can take feedback about the same from the existing practitioners or from the known people in that area. Your charges should not be too high or too low as compared to the other dental practitioners in that given area.

You should also know the rules and the DCI guidelines about record keeping and maintaining certain set of records is mandatory for every practicing dentist. You can visit the DCI website to know the details about the same.

9. Up gradation

The real game changer of your practice will be constant up gradation. Many youngsters make this mistake that they focus too much on their practice in the early years of practicing dentistry and they completely forget about keeping themselves updated with the advancements happening in dentistry and also at becoming better

at patient consultations.

Remember, unless you're able to convince the patients for the treatment, you will not be able to treat them. It is therefore equally essential to learn about communication skills, presentation skills, management skills and interpersonal skills. The more effective you are in these soft skills, the faster you will be able to build your practice. So, keep on constantly upgrading yourself so that you don't have to wait for years to build your practice.

So now that you know the 10 focus areas for starting your private practice and you are ready for embarking on this journey to become a successful private practitioner, accept my heartiest congratulations! ...and welcome to the world full of challenges as well as opportunities to create your name and live a great life.

B. UNDERSTAND THIS, BEFORE YOU START YOUR CLINIC

Dr. Surekha Bhedasgaonkar

You need to display a citizen's charter, in your waiting room, with following essential information.

1. Yours full name, address, phone numbers, website, email address.
2. Yours degree with date & place.
3. Your Registration Number with state of registration.
4. Provide printed broacher about

- ▶ Your clinic, address, Location, Landmark
- ▶ Guide to services provided
- ▶ Opening & closing Hours
- ▶ Day when you clinic is closed
- ▶ Contact numbers
- ▶ A chart of costs of services, including initial consultation, case paper registration, Investigations & treatments, prescription only.
- ▶ Inform about any special services provided.
- ▶ Where to contact in case in case of emergency.

5. Display your infection control policy

ESSENTIAL COMPONENTS OF DENTAL CLINIC

- ▶ Spacious Waiting space
- ▶ Work area around Dental Chair
- ▶ X-ray Room
- ▶ Laboratory Area
- ▶ Resting place for Doctor, Toilet for Patients
- ▶ Durable/Esthetic/comfortable furniture
- ▶ Sound proofing (Nose Buffer)

C. LIST OF ESSENTIAL CERTIFICATES AND VOLUNTARY DISPLAY

Dr. Surekha Bhedasgaonkar

1) B.D.S./M.D.S, Degree Certificate
2) State Dental Council Registration Certificate (With yearly renewal receipt retained)
3) Shop Act Certificate
4) Bio-waste Management Contract Certificate
5) Pollution Control Certificate
6) Fire Safety Norm Clearance
7) Local Body Permission for Clinic
8) TLD Badges for Radiation Safety
9) ISO if Applicable
10) Citizen's Charter
11) Rate Chart for different Treatment

VOLUNTARY DISPLAY

1. Information about your Specialty Work
2. Yours Work and Payment Policy
3. Your infection Control Norm

D. CLINICAL RECORD KEEPING

Dr. Sameer Patil

Uniformity in patient's treatment records is an important pre-requisite for providing optimal oral health. The dental records should reflect accurately the interaction between patients, clinicians and any related services.

Suggestions

Entries should be made without delay of all the events worth recording,

All records should be original, Complete, clear, accurate, updated and easy to understand.

When referring a patient to a specialist, provide a written referral form to the specialist and file a copy in the patient's record together with the specialist's report.

Individual records should be stored securely, not left unattended or in public areas. .

No entry should be erased.

All entries made in pen should be legible and reproducible.

All errors in the records should be indicated and the correct entry should be mentioned along with the date, time and a signature.

Additions should be separately entered with date (and time).

It is important with computerized records that the clinician ensures that the Information is correct before confirming the entry.

Corrections or errors in the computerised records should also be mentioned.

Findings of extra- and intra-oral clinical examinations should be recorded. The method of recording may be standardised using diagrammatic charts to allow rapid and simple comparison in the future.

An evaluation of the periodontal status by charting- including location and measurement of pockets. gingival bleeding, mobile teeth, furcation involvement, trauma and any disease process present, should be undertaken

Any existing radiographs should be viewed for usefulness in diagnosis and the need for further radiographs and any other special tests should be recorded together with their results. Last. there should be a short summary of observations and comments pointing towards a differential and definitive diagnosis.

Need for Record keeping

- Diagnosis or the ongoing treatment procedure and long term follow up care of the patient.
- Conducting clinical trials.
- Administrative or any other purposes.
- Promote teaching and research.
- Evidence against litigation.
- Case review purpose.

- Promote good clinical and laboratory practice.
- Historical purposes.
- Serve us the basis of accreditation.

Computer Records

The standard and the manner in which the computer records are maintained depend on the data management and storage method adopted. This can range from simple tabular form to full chart-based presentation. Practice management suppliers should be encouraged to improve and update their systems regularly.

Computer-based patient records should fulfill the following criteria:

The data should be entered in a way so that the old information be overwritten and the new information can be added.

The data should be encrypted and protected by a password so as to prevent any unauthorized person from gaining access.

There should be a copy of the data available in the dental practitioner's room in a read only format.

Back up copy of the data should be stored in a different computer drive so as to protect it from tampering or to compare with the original data in case of suspicion of tampering.

Back up system to retrieve the data should be tested from time to time.

Irrespective of any future change in the technology, the old data entered should be capable of retrieval.

The right of the patients to privacy, security and

confidentiality should be protected at all times.

Manual Records

The following basic information should be maintained in all patient records. This includes:

Patient Information

Accurate general patient information which includes the patient's full name, address and contact details. It should also include the time and date of the patient's visit.

History

A detailed record of the patient's medical history should be made. The practitioners should be satisfied that the information is correct. This information is sensitive and should not be made available to those who are not involved in the clinical care of the patient.

A detailed medical history form can be made available for the patients.

Dental History

Before the formal first clinical examination, the dental history should record details of previous analgesia/anesthetics, any oral allergic reactions not recorded in the medical history, previous dental experience, including the most recent and any other information the patient volunteers to give. Patients should be questioned with respect to:

- Their ability and confidence to chess food.
- Sensitivity to hot or cold stimuli.

- Previous endodontic treatment.
- Previous periodontal treatment.
- Previous oral surgical procedures.
- Previous orthodontic treatment.
- Previous restorative procedures involving fixed and removable prostheses.

Habits / Behavioral History This includes:-

· Potential risk behaviour such as frequency and amount of sweet intakes, smoking. gutka. pan, chewing tobacco, erosive foods/drinks and alcohol intake.

Oral habits like grinding, clenching or outer habits that may interfere with the treatment.

- Oral hygiene awareness.
- Tooth-brushing-frequency and method
- Use of mouthwash.
- Fluoride supplements.
- Other oral health aids.
- Any physical impairment such as loss of hearing or eyesight.

Chief Complaint

A detailed record should be made for the reasons why the patient's needed the dentist. The record should be made in patients own words as far as possible. Accurate description of the pain, known lesions or any conditions present on initial examination or

mentioned by the patients should also be noted.

Clinical Examination

A record of a thorough clinical extra and intra oral examination. The method of recording may be standardized using diagrammatic charts or examination forms to allow rapid and simple comparison in the future.

Any existing radiographs should be viewed for usefulness in diagnosis and the need for further radiographs and any other special tests should be recorded together with their results. Last, there should be a short summary of observations and comments pointing towards a differential and definitive diagnosis.

Radiographs

It is important that all the radiographs are maintained in order. Both pre and post treatment radiographs should be preserved along with the radiograph report.

Diagnosis and Treatment plan

A written treatment plan should be constructed and maintained by the dental practitioner and a copy of the plan should be given to the patient. Records, radiographs, models, photographs and clinical details should be retained by the practitioners for a minimum period of eight years.

The treatment plan should include the proposed method for dealing with the patient's dental problems and describe the anticipated outcome of treatment. It should also include the materials, drugs and a brief description of the treatment procedure. Alternative treatment plans should be discussed and noted

together with reasons for selection or rejection.

It should also be noted that definitive treatment may be influenced by the success of the initial phases of treatment and further patient Co- operation in the post treatment phase.

Referring to a Specialist

Any need for referral for specialist assistance should be recorded.

Treatment plan signed

Patients should be given the most appropriate treatment options along with the options for alternative treatment procedures. Patients consent to treatment should be obtained and noted. The treatment plan should be signed by the patient indicating their acceptance. Patient's refusal for accepting the recommended treatment should also be recorded.

Patient Fee

The patient should be given complete details of the total expenses involved in the treatment procedure. Where a patient fee is due this should be recorded.

It is very important that an accurate financial record is maintained along with the details of date, time and the mode of payment.

Confidentiality

Patients have a right to expect that their personal information shared in the course of their health care will not be disclosed without their knowledge. The duty of confidentially is towards all patients, including mature and immature minors and

adults who lack the capacity to take decision for themselves. Non-disclosure is held valid even after the individual's death. There are many instances when confidentially can be breached unintentionally, such as leaving a message with a third party about the patients appointment with the dentist or discussing personal information in the waiting room in front of other patents.

Treatment Progress Records

The treatment records are a dynamic document that will record the progress of an individual and any subsequent course or courses of treatment. It must include:

Date and description of treatment.

Type and reason for that specific treatment based on the diagnosis.

Any discussion regarding choice of treatment and materials used together with any tests, such as thermal, percussive, electrical or other Vitality tests.

Name of clinician who provided the treatment

Any medications dispensed or prescribed with details of the dosages.

Any significant advice concerning the post-operative complications or instructions given to the patient, either verbally, in writing or over the telephone.

Any changes to the agreed treatment plan.

Any advice given to the patient relating to diet, smoking or oral hygiene.

A written report of the results of any radiographs exposed including the reasons for those of no diagnostic value and the number of repeats of the latter.

A differential diagnosis should be recorded. Full details of the anaesthetic and analgesic used should be recorded including the drug name, dose and site of administration, any adverse reaction should be noted. When the entire treatment plan is completed, there should be a final summary and conclusion indicating the prognosis along with the patient instructions for continued care and recall.

Retention of Records

It is difficult to maintain a standard record keeping format which can be accepted internationally. Dental records contain both clinical and personal details. Such records simplify both the future treatment and satisfy the legal requirement of record- keeping. Ideally records should be retained on a permanent basis. The Indian Dental Association recommends that the records, radiographs, models, photographs and clinical correspondence should be securely retained for at least the legal minimum period of eight years.

Examination by Patient needs

Patient examination requires categorizing the patients in various subgroups. The subgroups of patients are new patients, recall patients, unscheduled patients and patients requiring referral.

New patient

Let the patient describe any symptoms or other

abnormalities experienced, then carry out intra-oral and extra-oral examinations for signs of abnormalities and give appropriate treatment.

Recall patient

A recall patient must be given additional encouragement to maintain their oral health and motivation to revisit the dentist. Patients must be seen at proper intervals on the basis of their risk-level. During recall the patient must be motivated to manage or modify an oral habit which leads to poor oral health,

Unscheduled examination

Patients in pain or in emergency should be promptly diagnosed and treated. The complete treatment procedure must be explained to the patient in order to prevent the re occurrence of the problem.

Patients needing referral

Accurate information must be sent to the concerned practitioner. A referral letter should contain the diagnosis details and the treatment procedure selected by the referring practitioner.

SAMPLE RECORD FORM

New Patient Record Form

Date :

Name _____ Reg. No. _____

Sex _____ Age _____ Marital Status _____

Address _____

_____

A. Chief Complaint

i C/o.
ii Onset
iii Duration
iv Progress
v Aggravating / Precipitating factors
vi Relived by

B. History

a. Past Dental History

i C/o
ii Treatment Given
iii Adverse Reaction, if any

b. Past Medical History

i H/o Diabetes Mellitus
ii H/o Hypertension and Cardiovascular disease
iii H/o Tuberculosis and Cardiovascular disease
iv H/o Epilepsy
v H/o Allergy, Asthma etc.
vi H/o Bleeding disorders
vii H/o Medications
viii H/o Blood transfusion, Hospitalisation and Surgery
ix H/o Kidney / Liver disease
x H/o Trauma-Head and Neck injuries
xi H/o Menstrual irregularities
xii H/o Pregnancy And Breast feeding
xiii H/o Any other disease

C. Family History

i H/o Tuberculosis
ii Rheumatic fever
iii Diabetes Mellitus
iv Hypertension
v Bleeding Discover
vi Allergy
vii Any other

D. Personal History

1 Occupation Income
2 Habits

i Alcohol.....
day since.....years
ii Bidi.....
day since.....years
iii Cigarette.....
day since.....years
iv Tobacco.....
day since.....years
v Paan Masala.....
day since.....years
vi Clenching and Bruxism
vii Oral Hygiene Habit

3 H/o Exposure - Any Primary lesions on skin mucosa genital
4 H/o anxiety tension / nervousness / depression
5 Any other

Extra Oral and Intra Oral Examinations

Examination Record Form

A. Extra Oral

I General

i	Built	Well built / Average built / Small built
ii	Gait	Normal / Abnormal
iii	Skin	Scars, Sinus, Pigamentation
iv	Nails	Shape, Pallor, Cyanosis
v	Conjunctiva	Erythema, Ecchymosis, Pallor
vi	Sclera	Icterus, Ecchymosis
vii	Facial Symmetry and profile	
viii	Lips	Competent / incompetent

II TMJ

i	Normal	Well built / Average built / Small built
ii	Movement	Normal / Abnormal
iii	Tenderness	Scars, Sinus, Pigamentation
iv	Dislocation	
v	Sub-luxation	
vi	Any Referred pain	
vii	Any Congenital / Post Surgical Defects	

III Lymph Nodes

IV Abnormality, if any

B. Intra Oral

1 Teeth

i Teeth present
ii Teeth missing
iii Mobility
iv Hypoplasia and other development defects
v Attrision / Abrasion / Erosion / Abfraction
vi Caries / filled teeth
vii Supernumerary / Supplementary teeth / Over retained teeth
viii Discoloured teeth
ix Contact points
x Calculus and stains
xi Any Restoration / Crown / Bridge

XII **Periodontal Status**

i Gingiva
ii Colour
iii Consistency
iv Contour
v Pockets
vi Frenal Attachment
vii Festoons
viii Furcation involvement
ix Food lodgment
x Material Alba Calculus / Stains

XIII Occlusion

i Occlusion — Angle's Class I, II, III
- Overjet
- Overbite
- Openbite

ii Deranged

iii Any occlusal interference

2. Soft tissues

i Lips
- Normal / any defect
- Competent / incompetent

ii Toungue
- Papilla / Coating
- Movement
- Size
- Lesions, if any

iii Cheek
- Linea Alba
- Parotid Papilla (secretion)
- Lesions, if any

iv Hard Palate
- Lesions, if any

v Soft Palate

vi Floor of Mouth
- **Wharton's Duct Orifices (secretion)**
- **Lingual varicosities**
- **Edentulous ridge**
- **Tonsillar and Pharyngeal areas**

- **Detailed examination of area of chief complaint**

a. Teeth in the area of chief complaint

i Discoloured
ii Caries
iii Exposure
iv Cracked teeth
v Tooth
vi Pockets
vii Mobility
viii Vitality
ix Percussion

b. Swelling

i Brief description
- Size
- Shape
- Surface
- Borders
- Consistency
- Colour
- Temperature
- Tenderness

ii Spaces involved

c. Any other

Findings

vii Provisional Diagnosis

Periodontal Record Form

Name of Patient _____

Age _____ Reg. No. _____

Occupation _____ Family Income _____

Address _____

_____ Education _____

Chief Complaint _____

Patient's tooth cleaning _____

Habits _____

Oral Habits _____

Medical History _____

Oral Examination Form

I) General Oral Hygiene Status

Plaque : Calculus : Stains :

II) Gingiva

Colour
Bleeding
Consistency
Shape
Position
Surface Texture
Width of attached gingiva
Suppuration
Any other specific condition of gingiva

III) Any Oral Lesions

IV) Dentition

Teeth present
Occlusion
Caries
Wasting Diseases
Furcation Involvement
Hypersensitivity Vitality
Restoration / Filled Teeth
Mobility
Migration
Contact Relation
Food Impaction

V) Pockets : (Depth in mms)

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

VI) Probable Etiological Factors

Local
Systemic

VII) Diagnosis

VIII) Prognosis

Individual
Overall

IX) Any Special Investigations / Consultation / X-ray required

X) Treatment Plan

Treatment Record Form

I) Investigations

i X-Rays
ii Blood
iii Serology
iv Biopsy
v Any other

II) X-Ray Report

III) Differential Diagnosis

IV) Histopathology Report

V) Final Diagnosis

VI) Treatment Plan

a Emergency Treatment
b Planned Treatment

a. Emergency Treatment

b. Planned Treatment

Maintaining accurate and detailed dental records is crucial for providing high-quality patient care, ensuring legal compliance and supporting effective communication among healthcare professionals.

Here are some advisor/instructions for dentists regarding dental record-keeping:

1. Patient Information:

Collect comprehensive patient information, including personal details, contact information, and relevant medical history.

Update patient records regularly to reflect any changes in health status or contact details.

Ensure accurate patient identification by recording full names, date of birth, contact details, and any relevant identification numbers.

2. Medical History:

Document the patient's medical history, including any existing medical conditions, medications, allergies, and past surgeries.

Regularly update the medical history to ensure it remains current and accurate.

Record comprehensive medical and dental histories, updating them regularly to reflect any changes in the patient's

health or dental status.

3. Dental History:

Record the patient's dental history, including previous treatments, surgeries, and any ongoing dental issues.

Document the dates and details of previous dental procedures, restorations, and radiographs.

4. Treatment Plans:

Develop and document comprehensive treatment plans for each patient, outlining proposed procedures, estimated costs, and alternatives. Update plans as needed.

Include details such as proposed treatments, alternatives, risks, benefits, and estimated costs.

Obtain informed consent from the patient for any major procedures.

5. Clinical Notes:

Maintain detailed and accurate clinical notes for each patient visit.

Record findings from examinations, diagnostic tests, and treatment procedures. Include examinations, diagnostic findings, and details of procedures performed.

Include information about the patient's complaints, symptoms, and any discussions with the patient.

6. Radiographic Records:

Keep a systematic record of radiographic examinations, including X-rays and other imaging studies.

Document all radiographs and imaging studies, specifying the type, date, and any notable findings. Ensure proper storage and accessibility of digital images.

7. Prescriptions and Medications:

Record prescriptions, medications prescribed, and any relevant details such as dosage and instructions. Keep track of any drug allergies.

8. Infection Control Protocols:

Document infection control measures and protocols followed during each patient visit.

Include details about sterilization procedures for instruments and equipment.

9. Communication:

Ensure clear and concise communication in the records to facilitate understanding among healthcare professionals. Document any referrals to specialists and communication with other healthcare providers.

10. Communication Logs:

Maintain logs of communications with patients, including phone calls, emails, and in-person discussions.

11. Follow-Up and Recalls:

Record follow-up appointments, recalls, and any necessary follow-up care. This ensures continuity of care and ongoing monitoring.

12. Legal and Regulatory Compliance:

Stay informed about local, state, and national regulations regarding dental record-keeping.

Ensure compliance with privacy laws, such as the Health Insurance Portability and Accountability Act (HIPAA).

13. Technology Integration:

Utilize electronic health record (EHR) systems for efficient and organized record-keeping. Regularly update and back up digital records.

14. Quality Assurance:

Implement a quality assurance program to periodically review records for accuracy, completeness, and compliance with established protocols.

15. Patient Access:

Provide patients. with access to their own records, respecting their right to review and obtain copies of their dental information.

16. Record Retention:

Establish a record retention policy and adhere to it. Keep records for the required duration, which may vary by jurisdiction.

17. Training and Education:

Provide ongoing training to dental staff on record-keeping practices and compliance with regulations.

Stay updated on best practices and advancements in dental ecord-keeping.

18. Patient Consent:

Document informed consent for treatments, surgeries, and procedures. Include details of discussions about risks, benefits, and alternatives.

19. Security Measures:

Implement security measures to protect patient records from unauthorized access or disclosure.

Use secure electronic systems and ensure proper backup procedures. By following these advisory/instructions, dentists can maintain accurate and comprehensive dental records, promoting patient safety, continuity of care, and legal compliance.

Maintaining dental records is a critical aspect of dental practice. Proper record-keeping not only supports patient care but also ensures legal compliance & facilitates effective communication among healthcare professionals.

By adhering to these guidelines, dental practitioners can maintain comprehensive, accurate, and secure dental records, promoting high- quality patient care and legal compliance. Regular training, audits, and updates are essential to ensuring that the record-keeping practices align with the latest standards and regulations.

CLINICAL RECORD KEEPING ABOUT SPECIALIZED DENTISTRY IS KEPT ON WEBSITE

E. ROLE OF THE DENTAL AUXILIARIES

Dr. Surekha Bhedasgaonkar

"Dental auxiliary" includes a dental hygienist or a dental mechanic or a dental operating room assistant or such other category as may be specified by the National Dental Commission Act, 2023;

The following registered Dental Auxiliaries who help the dentist before, during & after Dental treatment is delivered to patient. They can be:-

Dental Hygienist

"Dental Hygienist" means a person, not being a' Dentist or a Medical Practitioner, who scales, cleans or polishes teeth, or gives instructions in dental hygiene. He shall work under the supervision of the Registered Dentist.

Dental Mechanic

"Dental Mechanic" means a person who makes or repairs denture and dental appliances. He shall restrict his activities to purely mechanical laboratory work at the instance of the Registered Dental Surgeon. He shall not do any chair side work.

Dental mechanic" means a person qualified to perform laboratory work required for the prosthetic rehabilitation of dental and maxillofacial structures and orthodontic appliances; work at the instance of the Registered Dentist.

Dental Operating Room Assistant

Dental operating room assistant" means a person who assists the dentist in sterilising and handing over instruments as required by the dentist at the chair side. It's Dentists responsibility to train, monitor & moderate role of auxiliaries. Prevent any independent Dental Practice by your auxiliaries, outside your premises.

F. MAHARASHTRA MODEL PRESCRIPTION FORMAT

Doctor's (Prescriber's) Full Name *D1*

Qualification (eg. M.B.B.S., M.D.) *D2*

Reg. No.:(Specify alphabets Specifying Pathy) *D3*

Full Address, *D4* Contacts : (Telephone No., E-mail etc.) *D5*

Prescription Serial Number *D9* *D6* Date : dd/mm/yy

Patient's Full Name *P1*

Patient's Address and Phone Number *P2*

Sex....*P3*.....Age....*P4*....Weight ....*P5*....

Rx *D10*

1) Name of Medicine *M1* , As far as possible, genericname in capital letters.

Strength *M2* ,dosage form *M3*, dosage instruction *M4*,duration and total quantity *M5*

2)

3)

"Or any other cheaper generic medicine as per choice of patient."

Doctor's Signature & Date *D7*

Doctor's stamp *D8*

Dispensed By:
Name and Address of Medical Store,
Date of dispensing :-

If entire prescription is not dispensed, specify name or number of medicine and quantity dispensed.
Name and Address of Medical Store.
Date of dispensing :-

Minimum size of the prescription blank should be : 14x21 cm (A5 Size)

Food & Drugs Administration

A guide to the prescription format

The prescription should have following particulars pertaining to Doctor, Patient and Medicines as indicated below -

D- About Doctor/ Prescriber **P** - About Patient **M** - About Medicine

Act means - Drugs & Cosmetics Act 1940. **Rules means** - Drugs & Cosmetics Rules 1945.

Sr. No.	Particulars	Requirements & Necessities
D 1	**Doctors Full Name**	It is statutory requirement to mention name of the prescriber on cash or credit memo of the drugs under Rule 65(3) and it is also necessary to authenticate prescription. Therefore, the prescription shall bear Doctor's full name as mentioned in her / his registration certificate.
D 2	**Doctors Qualification**	To know competency and genuineness of prescriber, the prescription shall bear Doctor's primary qualification such as MBBS/BAMS followed by subsequent qualifications. For examples MBBS, MD. or BAMS MD
D 3	**Registration No**	Prescription shall bear the registration number of doctor's registration with their respective council. The registration number should be prefixed with

		registration fetters indicating the council in which doctor has registered her /his name. For example: Allo. (Allopathic), Intgrtd. (Integrated Medicine), Homeo. (Homeopathic), Dental (Dentist), Vet. (Veterinary), etc.
D 4	**Address of Doctor**	It is statutory requirement to mention the address of the prescriber on the cash or credit memo of the drugs under Rule 65 (3) and the patient and pharmacist should know where the prescriber is practicing and, therefore prescription shall bear complete address of clinic/hospital where the prescriber is practicing.
D 5	**Contacts**	The prescription shall have telephone number (Landline / Mobile) and e-mail of the prescriber. These details will help patient as well as pharmacist to contact doctor, if required.
D 6	Date of prescription	As per the Rule 65 (10) prescription shall be dated. The date of prescription is also essential to know the validity of prescription and to avoid misuse of such prescription.

D 7	Doctor's Signature & Date	As per Rule 65 (10) prescription shall be signed by the person issuing it with her / his usual signature and, therefore, the prescription shall have full signature of prescriber with date.
D 8	Doctor's Stamp	To authenticate prescription and also to avoid misuse of blank prescription and to protect patient from quacks and un qualified doctors, the prescription should have doctor's rubber stamp containing his' her full name, qualifications and registration number below his signature
D 9	Prescription serial number	For traceability and purposes of record the prescriptions must be serially numbered.
D 10	Rx Superscription	As a matter of practice the prescription may beat Rx superscription.

Sr. No.	Particulars	Requirements & Necessities
P 1	Patient's full Name	As per Rule 65 (10), prescription shall specify the name and address of the person for whose treatment it is given or name & address of the owner of the animal if the drug is meant for veterinary use. Therefore, prescription shall bear patient's / animal owner's full name.

P 2	**Patients Full Address**	As per Rule 65 (10), prescription shall specify the name and address of the person for whose treatment it is given. It is also essential for follow up of patient, or to get in touch with patient in case of dispensing or prescribing errors and also essential for recall of medicines, if required. Therefore, the prescription shall bear patient's full address.
P 3	**Patients Sex**	Ascertain drugs are gender specific, sex of the patient should be mentioned on prescription.
P 4	**Patients Age**	The drug dosages may differ with age of patient and, therefore, prescription must bear patient's age.
P	**Patients :Weight**	The drug dosages may vary with weight of the patient; therefore, prescription may bear patient's weight.
M	**Name of the Medicine**	a) The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation, 2002 under Indian Medical Council Act 1956 under Code of Medical Ethics at 1.5 prescribes as **"Every physician should as far as possible prescribe drugs with generic names and he /she shall ensure that there is a**

		rational prescription and rational use of drugs". Therefore, prescription shall bear the name of medicine as Generic name. The name of medicine should be in Capital letters in legible manner. b) If the prescriber is not sure about generic name he shall add following instructions on the prescription above her/his signature. "Or any other cheaper generic medicine as per choice of patient."
M	**Strength of Drug**	Prescription shall invariably bear strength of the medicine. eg. PARACETAMOL TABLETS 500 mg. AMOXYCILLIN CAPSULES 250 mg.
M	**Dosage Form**	Prescription shall bear proper dosage form of medicine prescribed. eg. Tablets, Capsules, Syrups, Creams etc.
M	**Dosing Instructions**	Prescription shall bear proper dosing instructions that could be easily understood by patient or owner of animal in case of veterinary drugs. (Preferably in Marathi or any other language easily understood by the patient or owner of animal.

		e.g 1 (after breakfast) .....0.....1 (after dinner) 1 (empty stomach) 0
M 5	**Total quantity of medicine and duration of medication**	Prescription shall specify duration of the treatment and total quantity of the medicine for that duration. e.g Medicine 1.....1 tab x 2 times a day for 7 days = 14 tablets Medicine 2.....1 tab per day for 3 months = 90 tablets

General guidelines for Doctors / Prescriber

Sr. No.	Suggestions
1.	**Changes in prescription:** If any changes are warranted in prescription please issue fresh prescription.
2.	**Do not use prescription pad with the name of medical store.** Doctors should not use prescription pads, with pre printed messages, like "Available at XYZ Medical Stores"
3.	**Do not print names of more than one doctor on the prescription.** One should avoid having names of two or more doctors on the

	same prescription pad (even if it is a husband and wife team).
4.	**Do not use prescription pad of another doctor.** A doctor should not use another doctor's prescription pad, even with her / his consent. Conversely a doctor should not allow other doctor to use her / his prescription pad.
5.	**Precaution about computer generated prescription.** If the doctor types or generates her/his prescription on a computer she /he must ensure that he / she issue it with her / his full, recognizable dated signature in ink. She / he must sign as close as possible to the last drug listed in the prescription.
6.	**Prescription of certain medicines by specialist** Certain medicines can be supplied on the prescription by specific specialist only. For example, Sildenafil Citrate can be prescribed only by an Urologist, Psychiatrist, Endocrinologist, Dermatologist or Venerolagist. Letrozole can be prescribed by 2 Cancer specialists only.
7.	**Recognize the services of Pharmacist** As per internationally recognized practice, especially followed in the developed world, doctors should recognize importance of services of pharmacist as they are required to supervise sale of medicines under the law and also responsible for counseling the patients. The pharmacist is trained to recognize therapeutic incompatibility, absorption incompatibility, etc of medicines in addition to various facets of pharmacological effects of medicine. In view of the above, the doctors should consider her / him as a resource person and his / her view should be considered with due regard to her / his knowledge.

G. BIOMEDICAL WASTE MANAGEMENT IN DENTISTRY

Dr. A. Kumarswamy

CATEGORIZATION OF WASTES

Category No. 1

Waste Category :

Human anatomical waste (human tissues, organs, body parts) Treatment and disposal: incineration '/deep burial.

Category No. 2

Animal waste (animal tissues. organs, body parts, carcasses. fluids, blood, experimental animals, waste generated by veterinary hospitals, colleges, discharge from hospitals, animal houses)Treatment and disposal: incineration '/deep burial.

Category No. 3

Microbiology and biotechnology waste (wastes from laboratory cultures, stocks or specimens at micro organisms, live of attenuated vaccines, human and animal cell culture and infectious agents from research and industrial laboratories. wastes from production of biological, toxins. dishes and devices used for transfer of cultures).Treatment and disposal: Local autoclaving / micro waving incineration.

Category No. 4

Waste sharps (needles, syringes, scalpels, blades, glass,

etc., that may cause puncture and cuts. This includes both used and unused sharps.

Treatment and disposal: Disinfection (Chemical treatment + utoclaving / micro waving and mutilation/shredding)

Category No. 5

Discarded medicines and cytotoxic drugs (wastes comprising of outdated, contaminated and discarded medicines)

Treatment and disposal: Incineration'/destruction and drugs disposal in secured landfills.

Category No. 6

Solid waste items contaminated with blood and body fluids including cotton, dressings, plaster casts, linen, beddings, etc

Treatment and disposal: '/autoclaving/microwaving

Category No. 7

Solid waste (wastes generated from disposable items other than the waste sharps such as tubings. catheters. intravenous sets etc.)

Treatment and disposal: Chemical treatment /autoclaving/ microwaving and mutilation/shredding.

Category No. 8

Liquid waste (waste generated from laboratory and washing, cleaning, House-keeping and disinfecting activities)

Treatment and disposal: Disinfection by chemical treatment} and discharge into drains.

Category No. 9

Incineration ash (ash from incineration of any biomedical waste) Treatment & disposal: Disposal in municipal landfill

Category No. 10

Chemical waste (chemicals used in production of biological, chemicals used in disinfection as insecticides, etc.)

Treatment and disposal: Chemical treatment} and discharge into drains for liquids and secured landfill tor solids.

TYPES OF CONTAINERS FOR SEGREGATION OF WASTE

WASTE IN THE COLOR CODED BAGS

COLOR CODING	CONTAINER TYPE	CATEGORY OF WASTE
Yellow	Plastic Bag	Human and animal waste such as body parts, placenta, body fluids and more.
Red	Plastic Bag	Infected / Non-infected waste like injections, syringes and catheters.
Blue	Plastic Bag	Glass items like bottles, broken articles and outdated medicines.
Black	Carboy	Metal articles such as blades, needles and sharps.

MERCURY CONTAINING WASTES:

Do not rinse amalgam containing traps, titers or containers in the sink.

Do not place amalgam, elemental mercury, broken or unusable amalgam capsules extracted teeth with amalgam or Amalgam containing traps and filters with medical or regular solid waste.

Recycle or manage as hazardous waste, the above mentioned materials.

Collect and store dry dental amalgam waste in a designated, airtight container. Amalgam which is designated for recycling should be labeled "Scrap Dental Amalgam" with the name, address and phone number of your office and the data on which you first started collecting material in the container. In the past, dental amalgam scrap may have been kept under photographic fixer, water or other liquid. If you should encounter amalgam stored in this manner, do not under any circumstances decant the liquid dawn the drain.

Keep a log of your generation and disposal of scrap amalgam.

Separate excess contact dental amalgam from gauze that is retrieved during restoration and place in an appropriate container.

Use chair side traps to capture dental amalgam.

Change or clean chair side traps frequently. Flush the vacuum system before changing the chair side trap.

Change vacuum pump filters and screens at least monthly or as directed by the manufacturer.

Check the trap under your sink for the presence of any amalgam containing waste.

Eliminate use of bulk elemental mercury and use only precapsulated dental amalgam for amalgam restorations.

Limit the amount of amalgam triturated to the closest amount necessary for the restoration. i.e. don't mix two spills when one spill would suffice. Keep a variety of amalgam capsule sizes on hand to ensure almost ail triturated amalgam is used.

Train staff to handle mercury containing maternal in its proper use and disposal.

METHYL METHACRYLATE:

The liquid component of the acrylic used in dental procedures is methyl methacrylate (MME) which is an extremely inflammable. Waste or spilled liquid MME Is a hazardous waste due to flammability characteristic and therefore must be disposed off as such. Any materials used to clean up a spill of liquid MME are also considered hazardous waste.

When liquid MME has been mixed with the powder component & polymerised into the acrylic, the acrylic does not exhibit the flammability characteristic & is therefore not a hazardous waste. Waste acrylic-can be discarded in the regular trash.

CHEMICALS, DISINFECTANTS, AND STERILIZING AGENTS:

The dental office utilizes many chemicals. disinfectants, and sterilizing agents that may be hazardous to the environment if they are not properly disposed. Management can be done by ensuring that staff handling these materials are trained in Workplace Hazardous Materials Information System (WHMIS),

Avoid the use of chemical sterilants whenever possible, Use steam or dry heal to sterilize your dental instruments, f using disposable plastic components, use non-chlorinated plastic (i.e. not PVC) to minimize environmental impacts, Rinse empty sterilant containers with water and place the empty containers in your solid waste stream, Avoid halogenated products (i.e. those with chlorine or iodine) since these can have detrimental effects on the environment, Do not pour ignitable substances (straight alcohols, ether, acetone, xylol, chloroform) or other solvents down the drain, Do not pour x-ray cleaning solutions containing chromium down the drain. Do not pour any used or unused chemicals down the drain that contain high concentrations of formaldehyde without contacting your municipality first, Do not pour sterilant solutions into a septic system. This may significantly disrupt the functioning of the system by killing the bacteria, which normally breakdown wastes don't pour concentrated alcohols, ethers or peroxides down the drain. These materials are flammable and could start a fire or explode13.16.

GYPSUM CONTAINING WASTE:

Though gypsum containing wastes are non infectious as they are devoid of human fluid contamination. They are considered potentially toxic to the environment. Dental study moulds contain gypsum and plaster cast which, when land filled with biodegradable waste, can produce hydrogen sulphide gas. The majority of dental study moulds are not infectious but should be segregated as a specific gypsum waste stream and be disposed of at specialist landfill sites.

MEDICALWASTE:

Regulated medical waste consists of sharps (hypodermic needles, blades, syringes) and bio-hazardous wastes (e.g. laboratory wastes, solid wastes covered with blood or other potentially infectious materials and pharmaceuticals). Waste containing mercury or contaminated with mercury should never be placed with the medical wastes as these wastes will be incinerated and there by releasing mercury into the environment.

WASTE SHARPS :

Sharps containers are designed specifically for the containment and disposal of sharps such as needles, syringes with needles, scalpel blades, clinical glass or other items capable of causing cuts or punctures. Sharps are to be placed into a puncture resistant leakproof container designed specifically for the management of sharps. If these containers are not resistant to penetration or compression, they pose a health risk to those involved in their handling and disposal.

Needle stick and puncture wound injuries and resulting infections have been recorded in situations where sharps have been improperly handled and/or disposed. All clinical sharps should be considered potentially infectious.

Disposable sharps should be placed in a proper sharps container. A sharps container should be located in each operatory and the sterilization lab.

These should be: Separated from other types of biomedical waste. Placed in a rigid, puncture resistant, leakproof container (provided by biomedical waste disposal vendors) and

labeled biohazard waste sharps."

Permanently sealed in the container (when full) and picked up by a biomedical waste disposal vendor for proper disposal. To prevent injury do not fill sharps containers past the fill line or if 90 fit Hine exists, more than three quarters.

Other types of biomedical waste including soiled rubber gloves, used swabs and other blood or body fluid saturated items. These should be Separated from waste sharps. Placed in a red bag that labeled "biohazard". Stored in a rigid leak proof container. Picked up by a biomedical waste disposal vendor for proper disposal.

Waste sharps and other types of biomedical waste must not be mixed with or disposed of as municipal garbage.

NON HAZARDOUS WASTES:

Paper, Cardboard, Aluminum, Plastics, etc. It should be minimized by using responsible suppliers, Office paper should have a high-recycled content, Minimize plastic waste by using refillable bottles for disinfecting or cleaning products and reusable devices for dental procedures where feasible, Avoid containers or packaging made of PVC plastic where feasible. This material is difficult to recycle and can produce acid gases if incinerated as part of your municipal waste treatment, Paper waste, cardboard and plastic containers (clean or rinsed) should be recycled where this service exists.

MAHARASHTRA STATE DENTAL COUNCIL
MUMBAI

LEGAL CONCEPTS OF CONSENT IN THE CONTEXT OF MEDICAL PRACTICE

Dr. Mahendra A. Lomte
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1. LEGAL CONCEPT OF CONSENT IN THE CONTEXT OF MEDICAL PRACTICE

Dr. Mahendra A. Lomte

1.1 Introduction : In order to look into legal concept of consent in the context of medical practice it is necessary to refer to some relevant legal provisions of Indian Contract Act, 1872, Indian Penal Code, 1860 with corresponding provisions of The Bharatiya Nyaya Sanhita, 2023 and some judgments of adjudicating authorities wherein necessary ingredients of the consent in relation to medical practice were enumerated for adjudicating the concerned matters. After reading this article reader can be in position to apply the necessary ingredients of the consent to the case in his or her hand as the circumstances stand for because circumstances and facts of each case may vary.

1.2 Abstract-

1) Consent is defined as Two or more persons are said to consent when they agree upon the same thing in the same sense.

2) To render the consent valid, it should be free consent of parties competent to contract (consent), for a lawful consideration and with a lawful object, and are not expressly declared to be void by law of land and with regards to IPC/BNS consent should be free from fear and misconception also

3) Competency of parties to the consent is subject to age of the parties, soundness of mind of the parties and qualifications of

the parties consenting by any law to which he is subject.

4) Section 88 of Indian Penal Code/Section 26 of BNS affords protection to doctors for act not intended to cause death, done by consent in good faith for person's benefit. Description of Good Faith in section 52 of Indian Penal Code/Section 2(11) of BNS - Nothing is said to be done or believed in "good faith" which is done or believed without due care and attention. Which means due care and attention is mandatory while doing such acts with consents otherwise protection afforded to doctor by the virtue of consent is subject to taken away.

5) Section 89 of Indian Penal Code/Section 27 of BNS affords protection to doctors for act done in good faith for benefit of child or insane person, by or by consent of guardian, provided that such person is below the age of twelve years or insane. This implies that in case of person who is above the age of twelve years and sane his or her consent is necessary to do the said act.

6) Section 90 of Indian Penal Code/Section 28 of BNS affords protection to doctors for act done in good faith for benefit of a person without consent when it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit.

7) Consent can be implied in some circumstances from the action of the patient. Except where consent can be clearly and obviously implied, there should be express consent.

8) A doctor has to seek and secure the consent of the patient

before commencing a 'treatment' (the term 'treatment' includes surgery also). The consent so obtained should be real and valid, which means that : the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what is consenting to

9) Doctor should disclose (1) nature and procedure of the treatment and its purpose, benefits and effect; (2) alternatives if any available; (3) an outline of the substantial risks; and (4) adverse consequences of refusing treatment.

10) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure.

11) The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

12) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during

the course of surgery.

13) The correctness or appropriateness of the treatment procedure does not make the treatment legal, in the absence of consent for the treatment, performance of any such an unauthorized invasion and interference with patient's body will amount to a tortious act of assault and battery and therefore a deficiency in service.

14) National Consumer Disputes Redressal Commission in Consumer Case No . 428 of 2018 held that the uniform use of pre-printed and fixed 'informed consent cum undertaking' form on the part of the hospital to be unfair trade practice within the meaning of section 2(1)® of the Act 1986. On 18/11/2020 Honorable Supreme Court of India in Civil Appeal No(s). 2993/2020 granted interim stay of Order of National Consumer Disputes Redressal Commission on Pre-Printed Consent Forms. The Civil Appeal No(s). 2993/2020 is presently pending before Honorable Supreme Court of India.

15) From the decision of Honorable West Bengal State Consumer Disputes Redressal Commission, Kolkata in Jayeeta Verma Sarkar v/s Rabindranath Tagore International Institute of Cardiac Sciences & Ors. (Sep. 19, 2016) it flows that signatures of both the consenting parties i.e. patient and treating doctor are essential on consent to render its validity along with other necessary ingredients of the valid consent.

For the sake of understanding legal concept of consent in the context of medical practice in more concise manner, essential legal ingredients have been tried to be incorporated in Annexure 1. Furthermore, it is submitted that the purpose of the said Annexure

is only an effort to display legal ingredients of the consent.

1.3 Provisions of Indian Contract Act, 1872:-

To understand the concept of consent we can refer to the relevant legal provisions of Indian Contract Act, 1872 as under:

Section 2(e)- Every promise and every set of promises, forming the consideration for each other, is an agreement;

Section 2(h)- An agreement enforceable by law is a contract;

Section 10 - What agreements are contracts.—All agreements are contracts if they are made by the free consent of parties competent to contract, for a lawful consideration and with a lawful object, and are not hereby expressly declared to be void.

Nothing herein contained shall affect any law in force in 1[India] and not hereby expressly repealed by which any contract is required to be made in writing1 or in the presence of witnesses, or any law relating to the registration of documents.

Section 11. Who are competent to contract.—Every person is competent to contract who is of the age of majority according to the law to which he is subject, and who is of sound mind and is not disqualified from contracting by any law to which he is subject.

Section 12. What is a sound mind for the purposes of contracting.—A person is said to be of sound mind for the purpose of making a contract, if, at the time when he makes it, he is capable of understanding it and of forming a rational judgment as to its effect upon his interests.

A person who is usually of unsound mind, but occasionally of sound mind, may make a contract when he is of sound mind.

A person who is usually of sound mind, but occasionally of unsound mind, may not make a contract when he is of unsound mind.

Section 13. "Consent" defined.—Two or more persons are said to consent when they agree upon the same thing in the same sense.

Section 14. "Free consent" defined.—Consent is said to be free when it is not caused by—

(1) coercion, as defined in section 15, or

(2) undue influence, as defined in section 16, or

(3) fraud, as defined in section 17, or

(4) misrepresentation, as defined in section 18, or

(5) mistake, subject to the provisions of sections 20, 21 and 22.

Consent is said to be so caused when it would not have been given but for the existence of such coercion, undue influence, fraud, misrepresentation or mistake.

1.4. Provisions of Indian Penal Code, 1860 with Corresponding Provisions of The Bharatiya Nyaya Sanhita, 2023

It will be expedient to refer to certain relevant legal provisions of Indian Penal Code, 1860 with corresponding provisions of Bharatiya Nyaya Sanhita, 2023 which afford necessary protection to the medical fraternity.

Section 88 of IPC- Act not intended to cause death, done by consent in good faith for person's benefit	**Section 26 of BNS: -Act not intended to cause death, done by consent in good faith for person's benefit**
Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied to suffer that harm, or to take the risk of that harm. Illustrations 1. A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under the painful complaint, but not intending to cause Z's death, and intending, in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence	Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied to suffer that harm, or to take the risk of that harm. Illustrations 1. A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under the painful complaint, but not intending to cause Z's death, and intending, in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence

Section 89 of IPC- Act done in good faith for benefit of child or insane person, by or by consent of guardian	Section 27 of BNS- Act done in good faith for benefit of child or person of unsound mind, by, or by consent of guardian.
Nothing which is done in good faith for the benefit of a person under twelve years of age, or of unsound mind, by or by consent, either express or implied, of the guardian or other person having lawful charge of that person, is an offence by reason of any harm which it may cause, or be intended by the doer to cause or be known by the doer to be likely to cause to that person: Provided	Nothing which is done in good faith for the benefit of a person under twelve years of age, or person of unsound mind, by, or by consent, either express or implied, of the guardian or other person having lawful charge of that person, is an offence by reason of any harm which it may cause, or be intended by the doer to cause or be known by the doer to be likely to cause to that person:
Provisos	Provided that this exception shall not extend to–
1.That this exception shall not extend to the intentional causing of death, or to the attempting to cause death;	(a) the intentional causing of death, or to the attempting to cause death;
2.That this exception shall not extend to the doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of	(b) the doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt, or the curing

death or grievous hurt, or the curing of any grievous disease or infirmity; 3.That this exception shall not extend to the voluntary causing of grievous hurt, or to the attempting to cause grievous hurt, unless it be for the purpose of preventing death or grievous hurt, or the curing of any grievous disease or infirmity; 4.That this exception shall not extend to the abetment of any offence, to the committing of which offence it would not extend. **Illustrations** 1.A, in good faith, for his child's benefit without his child's consent, has his child cut for the stone by a surgeon knowing it to be likely that the operation will cause the child's death, but not intending to cause the child's death. A is within the exception, in as much as his object was the cure of the child	of any grievous disease or infirmity; (c) the voluntary causing of grievous hurt, or to the attempting to cause grievous hurt, unless it be for the purpose of preventing death or grievous hurt, or the curing of any grievous disease or infirmity; (d) the abetment of any offence, to the committing of which offence it would not extend. **Illustration.** A, in good faith, for his child's benefit without his child's consent, has his child cut for the stone by a surgeon knowing it to be likely that the operation will cause the child's death, but not intending to cause the child's death. A is within the exception, in as much as his object was the cure of the child.

Section 90 of IPC- Consent known to be given under fear or misconception	Section 28 of BNS- Consent known to be given under fear or misconception.
A consent is not such a consent as it intended by any section of this Code, if the consent is given by a person under fear of injury, or under a misconception of fact, and if the person doing the act knows, or has reason to believe, that the consent was given in consequence of such fear or misconception; or Consent of insane person.— if the consent is given by a person who, from unsoundness of mind, or intoxication, is unable to understand the nature and consequence of that to which he gives his consent; or Consent of child.— unless the contrary appears from the context, if the consent is given by a person who is under twelve years of age.	A consent is not such a consent as is intended by any section of this Sanhita,– (a) if the consent is given by a person under fear of injury, or under a misconception of fact, and if the person doing the act knows, or has reason to believe, that the consent was given in consequence of such fear or misconception; or (b) if the consent is given by a person who, from unsoundness of mind, or intoxication, is unable to understand the nature and consequence of that to which he gives his consent; or (c) unless the contrary appears from the context, if the consent is given by a person who is under twelve years of age.

Section 92 of IPC- Act done in good faith for benefit of a person without consent	**Section 30 of BNS- Act done in good faith for benefit of a person without consent.**
Nothing is an offence by reason of any harm which it may causes to a person for whose benefit it is done in good faith, even without that person's consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit: Provided- Provisos. **Provisos** 1. That this exception shall not extend to the intentional causing of death or the attempting to cause death;	Nothing is an offence by reason of any harm which it may cause to a person for whose benefit it is done in good faith, even without that person's consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit: Provided that this exception shall not extend to– (a) the intentional causing of death, or the attempting to cause death; (b) the doing of anything which the person doing it

2. That this exception shall not extend to the doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity; 3. That this exception shall not extend to the voluntary causing of hurt, or to the attempting to cause hurt, for any purpose other than the preventing of death or hurt; 4. That this exception shall not extend to the abetment of any offence, to the committing of which offence it would not extend. **Illustrations** 1. Z is thrown from his horse, and is insensible. A, a surgeon, finds that Z requires	knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity; (c) the voluntary causing of hurt, or to the attempting to cause hurt, for any purpose other than the preventing of death or hurt; (d) the abetment of any offence, to the committing of which offence it would not extend. **Illustrations.** (1) Z is thrown from his horse, and is insensible. A, a surgeon, finds that Z requires to be trepanned. A, not intending Z's death, but in good faith, for Z's benefit, performs the trepan before Z recovers his power of judging for himself. A has committed

to be trepanned. A, not intending Z's death, but in good faith, for Z's benefit, performs the trepan before Z recovers his power of judging for himself. A has committed no offence. 2. Z is carried off by a tiger. A fires at the tiger knowing it to be likely that the shot may kill Z, but not intending to kill Z, and in good faith intending Z's benefit. A's ball gives Z a mortal wound. A has committed no offence. 3. A, a surgeon, sees a child suffer an accident which is likely to prove fatal unless an operation be immediately performed. There is not time to apply to the child's guardian. A performs the operation in spite of the entreaties of the child, intending, in good faith, the child's benefit. A has	no offence. (2) Z is carried off by a tiger. A fires at the tiger knowing it to be likely that the shot may kill Z, but not intending to kill Z, and in good faith intending Z's benefit. A's bullet gives Z a mortal wound. A has committed no offence. (3) A, a surgeon, sees a child suffer an accident which is likely to prove fatal unless an operation be immediately performed. There is no time to apply to the child's guardian. A performs the operation in spite of the entreaties of the child, intending, in good faith, the child's benefit. A has committed no offence. (4) A is in a house which is on fire, with Z, a child. People below hold out a blanket. A drops the child from the house top, knowing it to be

committed no offence. 4. A is in a house which is on fire, with Z, a child. People below hold out a blanket. A drops the child, from the house-top, knowing it to be likely that the fall may kill the child, but not intending to kill the child, and intending, in good faith, the child's benefit. Here, even if the child is killed by the fall, A has committed no offence. Explanations 1. Mere pecuniary benefit is not benefit within the meaning of sections 88 89 and 92	likely that the fall may kill the child, but not intending to kill the child, and intending, in good faith, the child's benefit. Here, even if the child is killed by the fall, A has committed no offence. Explanation.—Mere pecuniary benefit is not benefit within the meaning of sections 26, 27 and this section.

1.5. Judgments of Adjudicating Authorities:

1.5.1 Honorable Supreme Court in Samira Kohli vs Dr. Prabha Manchanda & Anr on 16 January, 2008.

Honorable Supreme Court in Samira Kohli vs Dr. Prabha Manchanda & Anr while answering the questions for consideration opined on material aspects of consents, out of which

few aspects are as under:

a) Consent in the context of a doctor-patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. Except where consent can be clearly and obviously implied, there should be express consent.

b) A doctor has to seek and secure the consent of the patient before commencing a 'treatment' (the term 'treatment' includes surgery also). The consent so obtained should be real and valid, which means that : the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what is consenting to.

c) The 'adequate information' to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment as to whether he should submit himself to the particular treatment or not. This means that the Doctor should disclose (1) nature and procedure of the treatment and its purpose, benefits and effect; (2) alternatives if any available; (3) an outline of the substantial risks; and (4) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may

persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

(d) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

(e) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(f) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in Canterbury but should be of the extent which is accepted as normal and proper by a body of

medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment.

(g) The correctness or appropriateness of the treatment procedure does not make the treatment legal, in the absence of consent for the treatment.

(h) In view of our finding that there was no consent by the appellant for performing hysterectomy and salpingo-oopherectomy, performance of such surgery was an unauthorized invasion and interference with appellant's body which amounted to a tortious act of assault and battery and therefore a deficiency in service.

1.5.2 Honorable National Consumer Disputes Redressal Commission in Consumer Case No. 428 OF 2018.

Honorable National Consumer Disputes Redressal Commission in Consumer Case No. 428 OF 2018 opined that

(a) We but note that a pre-printed and fixed 'informed consent cum undertaking' form, with blank spaces for limited select handwritten entries and for the signatures has been used. The main body of the form is preprinted and fixed. It can fit into any procedure, any doctor, and any patient, after filling up the blank spaces for the limited select handwritten entries and getting / affixing the signatures. We note this to be administrative arbitrariness and one-sided high handedness, and to be unfair and deceptive, on the part of the opposite party no. 1 (hospital), for which, though, the complainant has not been prejudiced in this particular case.

And held that

(b) We but determine the uniform use of this pre-printed and fixed 'informed consent cum undertaking' form on the part of the opposite party no. 1 (hospital) to be unfair trade practice within the meaning of section 2(1)(r) of the Act 1986 and deem it just and appropriate to impose a cost of Rs. 10 lakh on the opposite party no. 1 (hospital), to be deposited with the Consumer Legal Aid Account of this Commission within four weeks of the pronouncement of the reasoned judgment, and to direct the opposite party no. 1 (hospital) to discontinue its said unfair trade practice with immediate effect.

On 18/11/2020 Honorable Supreme Court of India in Civil Appeal No(s). 2993/2020 granted interim stay of Order of National Consumer Disputes Redressal Commission on Pre-Printed Consent Forms. The Civil Appeal No(s). 2993/2020 is presently pending before Honorable Supreme Court of India.

1.5.3 Honorable West Bengal State Consumer Disputes Redressal Commission, Kolkata in Jayeeta Verma Sarkar v/s Rabindranath Tagore International Institute of Cardiac Sciences & Ors. (Sep. 19, 2016)

It was held that

(a) It appears from the consent form being annexure 3 to the compliant that the column as to patients signature , date, time have been left blank. There is signature of the complainant being the daughter of the patient. There is no signature of the doctor although it is a duty of doctor or any of the members of surgical team to explain the risk factor to patient.

Annexure 1

1) Name of the patient .....

2) Age of the Patient ..... (In case of the patient below the age of 12 years, his/her guardian or person having lawful charge of him/her will be a consenting party)

3) Mental Status of the Patient- Sound/Unsound (In case of the patient of unsound mind , his/her guardian or person having lawful charge of him/her will be a consenting party)

Adequate Information

4) Name of the treating Doctor .....
Qualification .....

5) Provisional Diagnosis/Diagnosis .....

6) Name of the Treatment .....

7) Nature and procedure of the treatment .....

8) Purpose of the treatment .....

9) Benefits of the treatment .....

10) Effects of the treatment .....

11) Alternatives if any available .....

12) Substantial risks of the treatment .....

13) Substantial adverse consequences of refusing treatment .....

Consent for additional or further procedure

14) Name of additional or further procedure .....

15) Nature of additional or further procedure .....

16) Purpose of additional or further procedure .....

17) Benefits of additional or further procedure .....

18) Effects of additional or further procedure .....

19) Alternatives if any available .....

20) Substantial risks of additional or further procedure .....

21) Substantial adverse consequences of refusing of additional or further procedure .....

I ..... age ..... have received abovementioned adequate information provided by Dr. ..... and on the basis of that adequate information after making balanced judgment I submit myself / our patient .....

age ..... to that particular treatment of .....
and additional or further procedure of .....
and consent for the same and this consent is free from any coercion , undue influence , fraud , misrepresentation or mistake.

Name of the consenting person .....
Age ..... Signature .....

(In case of patient below the age of 12 years or unsound mind, his/her guardian or person having lawful charge of the patient should be consenting person)

Name of the treating Doctor .....
Age ..... Signature .....

Time .....
Date .....
(Consent should be secured before the commencement of the treatment)

MEDICAL NEGLIGENCE AND ITS MATERIAL INGREDIENTS

Dr. Mahendra A. Lomte
Medico-legal Consultant

2 MEDICAL NEGLIGENCE AND ITS MATERIAL INGREDIENTS

Dr. Mahendra A. Lomte

2.1 Introduction

There is no statutory codified definition of negligence and so also medical negligence. Medical negligence in the eye of law is classified as civil medical negligence and criminal medical negligence. To understand the material ingredients of the medical negligence we have to rely upon different legal provisions of Indian Penal Code, 1860 with corresponding provisions of The Bharatiya Nyaya Sanhita, 2023, Indian Evidence Act 1872, principles of the common law of torts, judicial decisions and other relevant legal provisions of regulations made by the concerned councils. The liability of the criminal medical negligence is mainly of corporal punishment and liability of civil medical negligence is mainly of civil in nature i.e. in form of monetary compensation.

2.2 Abstract

Medical negligence is of two types i.e. civil medical negligence and criminal medical negligence. The essential components of negligence are three: 'duty', 'breach' and 'resulting damage. Bolam's case has been widely accepted as decisive of the standard of care required by medical practitioner. A medical practitioner may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he

professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices.

For negligence to amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.. Certain sections of Indian Penal Code ,1860 with corresponding sections of The Bharatiya Nyaya Sanhita, 2023 content the ingredients of criminal medical negligence. Medical services come within the ambit of Consumer Protection Act, 2019 so patient can seek remedy for alleged medical negligence leading to deficiency in services under Consumer Protection Act, 2019 along with remedies available under criminal law for criminal medical negligence.

In civil proceedings, a mere preponderance of probability is sufficient, and the defendant is not necessarily entitled to the benefit of every reasonable doubt; but in criminal proceedings, the persuasion of guilt must amount to such a moral certainty as convinces the mind of the Court, as a reasonable man, beyond all reasonable doubt. Res ipsa loquitur is a rule of evidence which in reality belongs to the law of torts i.e. civil medical negligence and in criminal proceedings, the burden of proving negligence as an essential ingredient of the offence lies on the prosecution. Such

ingredient cannot be said to have been proved or made out by resorting to the said rule. it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be 'gross'.

Under vicarious liability hospitals will be liable for the negligent act committed by the doctors working for them either employed on contract basis or job basis.

By the judgment in Jacob Mathew vs State Of Punjab & Anr Supreme Court of India provided statutory guard to the doctors in relation to criminal complaints alleging medical negligence, by directing to obtain the opinion of expert doctors in order to proceed further and thereby avoiding hardship to the doctor. In Consumer Complaints Supreme Court in V. Kishan Rao vs Nikhil Super Speciality Hospital that it is not necessary to obtain the expert doctors opinion in every compliant and left it to the discretion of adjudicating authority owing to the complexity of the matter. As Judiciary encompassed the ingredients of medical negligence it also declared what is not medical negligence.

2.3 Nature of Medical Negligence:

Supreme Court of in India Laxman Balkrishna Joshi vs Trimbak Bapu Godbole And Anr on 2 May, 1968 held that A person who holds himself out ready to give medical advice and treatment impliedly holds forth that he is possessed of skill and knowledge for the Purpose. Such a person when consulted by a patient, owes certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, and a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action of

negligence against him. The medical practitioner has a discretion in choosing the treatment which he proposes to give to the patient and such discretion is wider in cases of emergency, but, he must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care according to -the circumstances of each case.

So it can be culled from the abovementioned decision of the Supreme Court of India that a medical practitioner who holds himself out ready to give advice and treatment should posses skill and knowledge for that purpose and when patient consults him then such medical practitioner owes following duties to the patient

a) A duty of care in deciding whether to undertake the case

b) A duty of care in deciding what treatment to give

c) A duty of care in the administration of that treatment

A breach of any of these duties gives a right of action of negligence against such medical practitioner.

In well celebrated judgment of Honorable Supreme Court in Jacob Mathew vs State Of Punjab & Anr on 5 August, 2005 on the most important point of holding professional liable for negligence it was held that **A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on the only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while**

undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices. (Emphasis Supplied)

On standard of care it was held that The classical statement of law in Bolam's case has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before Courts in India and applied to as touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill.

In conclusion it was held about the negligence that Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence as given in Law of Torts, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to

hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. **The essential components of negligence are three: 'duty', 'breach' and 'resulting damage'.** (Emphasis Supplied)

2.4 Civil and Criminal Medical Negligence

On point of civil and criminal negligence in Jacob Mathew case (Supra) it was held that The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

Further it was held that To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

2.5 Criminal Medical Negligence and Indian Penal Code 1860 with Corresponding Provisions of The Bharatiya Nyaya Sanhita, 2023

It will be expedient to refer to certain sections of Indian Penal Code with corresponding provisions of The Bharatiya Nyaya Sanhita which attracts the ingredients of medical negligence

Section 304 A of IPC - Causing death by Negligence	**Section 106 of BNS- Causing death by negligence.**
Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide **shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both**	(1) Whoever causes death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to five years, and shall also be liable to fine; **and if such act is done by a registered medical practitioner while performing medical procedure, he shall be punished with imprisonment of either description for a term which may extend to two years, and shall also be liable to fine.** Explanation. — For the purposes of this sub-section,

	"registered medical practitioner" means a medical practitioner who possesses any medical qualification recognised under the National Medical Commission Act, 2019 and whose name has been entered in the National Medical Register or a State Medical Register under that Act.
	(2) Whoever causes death of any person by rash and negligent driving of vehicle not amounting to culpable homicide, and escapes without reporting it to a police officer or a Magistrate soon after the incident, shall be punished with imprisonment of either description of a term which may extend to ten years, and shall also be liable to fine.

In Jacob Mathew case (Supra) Supreme Court held that The word 'gross' has not been used in Section 304A of IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be 'gross'. The expression 'rash or negligent act' as occurring in Section 304A of the IPC has to be read as qualified by the word 'grossly'.

Section 337 of IPC - Causing hurt by act endangering life or personal safety of others	**Section 125 of BNS- Act endangering life or personal safety of others**
Whoever causes hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to five hundred rupees, or with both	Whoever does any act so rashly or negligently as to endanger human life or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to three months or with fine which may extend to two thousand five hundred rupees, or with both, but— (a) where hurt is caused, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to five thousand rupees, or with both;

Section 338 of IPC - Causing hurt by act endangering life or personal safety of others	
Whoever causes grievous hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine which may extend to one thousand rupees, or with both.	(b) where grievous hurt is caused, shall be punished with imprisonment of either description for a term which may extend to three years, or with fine which may extend to ten thousand rupees, or with both.

Section 319 of IPC - Hurt	**Section 114 of BNS- Hurt.**
Whoever causes bodily pain, disease or infirmity to any person is said to cause hurt.	Whoever causes bodily pain, disease or infirmity to any person is said to cause Hurt.
Section 320 of IPC- Grievous Hurt	**Section 116 of BNS- Grievous hurt**
The following kinds of hurt only are designated as "grievous": 1.Emasculation. 2.Permanent privation of the	The following kinds of hurt only are designated as "grievous", namely:– (a) Emasculation; (b) Permanent privation of

sight of either eye. 3.Permanent privation of the hearing of either ear. 4.Privation of any member or joint. 5.Destruction or permanent impairing of the powers of any member or joint. 6.Permanent disfiguration of the head or face. 7Fracture or dislocation of a bone or tooth. 8.Any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his ordinary pursuits.	the sight of either eye; (c) Permanent privation of the hearing of either ear; (d) Privation of any member or joint; (e) Destruction or permanent impairing of the powers of any member or joint; (f) Permanent disfiguration of the head or face; (g) Fracture or dislocation of a bone or tooth; (h) Any hurt which endangers life or which causes the sufferer to be during the space of fifteen days in severe bodily pain, or unable to follow his ordinary pursuits.
Section 269 of IPC - Negligent act likely to spread infection of disease dangerous to life	**Section 271 of BNS- Negligent act likely to spread infection of disease dangerous to life.**
Whoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection	Whoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection

of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both	of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.
Section 270 of IPC - Malignant act likely to spread infection of disease dangerous to life	**Section 272 of BNS - Malignant act likely to spread infection of disease dangerous to life**
Whoever malignantly does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.	Whoever malignantly does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both

2.6 Medical Negligence vis-à-vis Consumer Protection Act.

Honorable Supreme Court in **Samira Kohli vs Dr. Prabha Manchanda & Anr on 16 January, 2008**. held that the correctness or appropriateness of the treatment procedure does not make the treatment legal, in the absence of consent for the treatment, an unauthorized invasion and interference with patient's body will amounted to a tortious act of assault and battery and therefore a deficiency in service.

When Consumer Protection Act, 1986 came in to force thereafter there was lots of confusion amongst the judiciary about medical services attracting the provisions of Consumer Protection Act , as there was no express inclusion of medical services in the definition of service provided in the said Act , in some judgments it was held that medical services come within the ambit of Consumer Protection Act, 1986 and in some judgments it was held that medical services are not within the ambit of Consumer Protection Act, 1986. This ambiguity was finally settled by Supreme Court in the year 1995 in Indian Medical Association vs V.P. Shantha & Ors on 13 November, 1995, by interpretation of relevant legal provisions of Consumer Protection Act. 1986 and other relevant laws, it was held that service rendered to a patient by a medical practitioner (except where the doctor renders service **free of charge to every patient or under a contract of personal service)**, by way of consultation, diagnosis and treatment, both medicinal and surgical, would fall within the ambit of 'service' as defined in Section 2(1) (o) of the Act.(Emphasis Supplied)

Consumer Protection Act, 1986 was repealed by the enactment of Consumer Protection Act, 2019 and with respect of

Consumer Protection Act, 2019 and medical services Supreme Court on 29/04/2022 refused to interfere with a Bombay High Court judgment (PUBLIC INTEREST LITIGATION NO. 58 OF 2021) which held that doctors and healthcare services are not excluded from the ambit of the Consumer Protection Act 2019. The definition of "Service" is wide enough under the Act. If the Parliament wanted to exclude, they would have said it expressly," remarked Justice DY Chandrachud while laying emphasis on the word, "Service of any description. (MEDICOS LEGAL ACTION GROUP Vs. UNION OF INDIA, Petition(s) for Special Leave to Appeal © No(s).19374/2021)

Supreme Court in V. Kishan Rao vs Nikhil Super Speciality Hospital ... held that this Court however makes it clear that before the consumer Fora if any of the parties wants to adduce expert evidence, the members of the Fora by applying their mind to the facts and circumstances of the case and the materials on record can allow the parties to adduce such evidence if it is appropriate to do so in the facts of the case. The discretion in this matter is left to the members of Fora especially when retired judges of Supreme Court and High Court are appointed to head National Commission and the State Commission respectively. Therefore, these questions are to be judged on the facts of each case and there cannot be a mechanical or strait jacket approach that each and every case must be referred to experts for evidence. When the Fora finds that expert evidence is required, the Fora must keep in mind that an expert witness in a given case normally discharges two functions. The first duty of the expert is to explain the technical issues as clearly as possible so that it can be understood by a common man. The other function is to assist the

Fora in deciding whether the acts or omissions of the medical practitioners or the hospital constitute negligence. In doing so, the expert can throw considerable light on the current state of knowledge in medical science at the time when the patient was treated. In most of the cases the question whether a medical practitioner or the hospital is negligent or not is a mixed question of fact and law and the Fora is not bound in every case to accept the opinion of the expert witness. Although, in many cases the opinion of the expert witness may assist the Fora to decide the controversy one way or the other

2.7 Medical Negligence vis-à-vis Revised Dentists (Code of Ethics) Regulations, 2014.

Revised Dentists (Code of Ethics) Regulations, 2014 in regulation 4.4 about patient must not be neglected provides that a dental surgeon is free to choose whom he will serve. He should,

however, respond to any request for his assistance in an emergency. Once having undertaken a case, the Dental Surgeon should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family. He shall not wilfully commit an act of negligence that may deprive his patient or patients from necessary Dental/Medical care.

2.8 Standard of Proof and Medical Negligence

In Syad Akbar v. State of Karnataka (1980) 1 SCC 30.it was held by the Supreme Court that there is a marked difference as to the effect of evidence, viz. the proof, in civil and criminal proceedings. In civil proceedings, a mere preponderance of probability is sufficient, and the defendant is not necessarily

entitled to the benefit of every reasonable doubt; but in criminal proceedings, the persuasion of guilt must amount to such a moral certainty as convinces the mind of the Court, as a reasonable man, beyond all reasonable doubt. Where negligence is an essential ingredient of the offence, the negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

Further it was held in Syad Akbar case (Supra) Res ipsa loquitur is a rule of evidence which in reality belongs to the law of torts. Inference as to negligence may be drawn from proved circumstances by applying the rule if the cause of the accident is unknown and no reasonable explanation as to the cause is coming forth from the defendant. In criminal proceedings, the burden of proving negligence as an essential ingredient of the offence lies on the prosecution. Such ingredient cannot be said to have been proved or made out by resorting to the said rule.

Res ipsa loquitur is Latin for "the thing speaks for itself." In tort law, a principle that allows plaintiffs to meet their burden of proof with what is, in effect, circumstantial evidence. The plaintiff can create a rebuttable presumption of negligence by the defendant by proving that the harm would not ordinarily have occurred without negligence, that the object that caused the harm was under the defendant's control, and that there are no other plausible explanations. (Available at

https://www.law.cornell.edu/wex/res_ipsa_loquitur)

Supreme Court in V. Kishan Rao vs Nikhil Super Speciality Hospital ... held that In a case where negligence is evident, the principle of res ipsa loquitur operates and the

complainant does not have to prove anything as the thing (res) proves itself. In such a case it is for the respondent to prove that he has taken care and done his duty to repel the charge of negligence.

2.9 Vicarious Liability

Liability that a supervisory party (such as an employer) bears for the actionable conduct of a subordinate or associate (such as an employee) based on the relationship between the two parties. (Available at https://www.law.cornell.edu/wex/vicarious_liability)

Supreme Court of India in Smt. Savita Garg vs The Director, National Heart ...cited observations of Lord Denning, J. in Gold & Ors. v. Essex County Council " " The hospital authority is liable for the negligence of professional men employed by the authority under contracts for service as well as under contracts of service. The authority owes a duty to give proper treatment _ medical, surgical, nursing and the like- and though it may delegate the performance of that duty to those who are not its servants, it remains liable if that duty be improperly or inadequately performed by its delegates."

In Smt. Savita Garg case (Supra) it was held that it is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors being employed on job basis or employed on contract basis, it is the hospital which has to justify and by not impleading a particular doctor will not absolve the hospital of their responsibilities.

2.10 Contributory Negligence

It is an unreasonable conduct or negligence on the part of the patient which is the cause of harm complained of although the attending doctor was also negligent. for example, if the patient fails to cooperate with his doctor in carrying out all reasonable and proper instruction or refuses to take the suggested treatment or fails to attend as a requested for treatment, As such, the doctors negligence is not the direct, proximate cause of the harm suffered by the patient. In such a case the defendant's negligence does not in the eye of law, materially contribute to the damage, which the plaintiff has suffered. The doctrine of contributory negligence is not recognized by law as a defense in an indictment of criminal negligence but is a good difference in case of civil liabilities and is taken into consideration by the court while awarding damages to the plaintiff

2.11 Statutory Guard for Medical Negligence .

Supreme Court of India in Jacob Mathew vs State Of Punjab & Anr held that prosecuting medical professionals As we have noticed hereinabove that the cases of doctors (surgeons and physicians) being subjected to criminal prosecution are on an increase. Sometimes such prosecutions are filed by private complainants and sometimes by police on an FIR being lodged and cognizance taken. The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to rash or negligent act within the domain of criminal law under Section 304-A of IPC. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment. He has to seek bail to

escape arrest, which may or may not be granted to him. At the end he may be exonerated by acquittal or discharge but the loss which he has suffered in his reputation cannot be compensated by any standards. we may not be understood as holding that doctors can never be prosecuted for an offence of which rashness or negligence is an essential ingredient. All that we are doing is to emphasize the need for care and caution in the interest of society; for, the service which the medical profession renders to human beings is probably the noblest of all, and hence there is a need for protecting doctors from frivolous or unjust prosecutions. Many a complainant prefers recourse to criminal process as a tool for pressurizing the medical professional for extracting uncalled for or unjust compensation. Such malicious proceedings have to be guarded against.

Further it was directed that Statutory Rules or Executive Instructions incorporating certain guidelines need to be framed and issued by the Government of India and/or the State Governments in consultation with the Medical Council of India. So long as it is not done, we propose to lay down certain guidelines for the future which should govern the prosecution of doctors for offences of which criminal rashness or criminal negligence is an ingredient. A private complaint may not be entertained unless the complainant has produced prima facie evidence before the Court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. The investigating officer should, before proceeding against the doctor accused of rash or negligent *(Modi, A Textbook of Medical Jurisprudence and Toxicology, 24th Edition 2011, p.163)* act or omission, obtain an independent and competent medical opinion preferably from a doctor in

government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying Bolam's test to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld.

. State Government of Maharashtra issued Government Resolution dated 26/03/ 2010 and 31/01/2014 making provisions to refer the criminal matters to the committee of expert doctors in cases related to allegation of medical negligence.

2.12 What is not Medical Negligence

2.12.1 Negligence cannot be attributed to a doctor so long as he is performing his duties to the best of his ability and with due care and caution. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.(Achutrao Haribhau Khodwa and Ors. v. State of Maharashtra and Ors. (1996) 2 SCC 634)

2.12.2 A mere deviation from normal professional practice is not necessarily evidence of negligence.(Jacob Mathew vs State Of Punjab & Anr)

2.12.3 Mere accident is not evidence of negligence. (Jacob Mathew case Supra)

2.12.4 An error of judgment on the part of a professional is not negligence per se. (Jacob Mathew case Supra)

2.12.5 Higher the acuteness in emergency and higher the complication, more are the chances of error of judgment. (Jacob Mathew case Supra)

2.12.6 In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.(Supreme Court in Kusum Sharma and Others v. Batra Hospital and Medical Research Centre and Others)

2.12.7. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence. *(Kusum Sharma Case Supra)*

2.12.8. A medical practitioner is not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. In the practice of medicine, there could be varying approaches of treatment. There could be a genuine difference of opinion. However, while adopting a course of treatment, the duty cast upon the medical practitioner is that he must ensure that the medical protocol being followed by him is to the best of his skill and with competence at his command. At the

given time, medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.(Supreme Court in Dr. (Mrs.) Chanda Rani Akhouri & Ors. Vs Dr MA Methusethupathi & Ors)

2.12.9 The causes for failure can well be attributable to the natural functioning of the human body and not necessarily attributable to any failure on the part of the surgeon. (Supreme Court in State of Punjab v. Shiv Ram)

MAHARASHTRA STATE DENTAL COUNCIL
MUMBAI

VARIOUS ACTS AND REGULATIONS WITH DENTISTRY

- A) Consumer Protection Act Vis-à-vis Dentistry
- B) TheBombayShopsAnd Estabilshment Act, 1948
- C) The Minimum Wages Act, 1948
- D) The Environment (Protection) Act, 1986
- E) The Labour Laws
- F) Maharashtra Fire Prevention & Life Safety Measure Act, 2006 & Rules, 2009
- G) Maharashtra Medicare Service Persons And Medicare Service Institutions (Prevention of Violance And Damage Or Loss To Property) Act, 2010
- H) The Contract Act, 1872
- I) The Drugs And Cosmetic Act, 1940

A. CONSUMER PROTECTION ACT VIS-À-VIS DENTISTRY

Dr. Mahendra A. Lomte

Question No.1- Does the practice of Dentistry fall within the ambit of Consumer Protection Act 2019?

Answer: Yes, the practice of dentistry falls within the ambit of Consumer Protection Act 2019 for following reasons:

A) The Consumer Protection Act 1986 has been repealed by The Consumer Protection Act 2019 (hereinafter referred to as "CPA"). The definition of services provided in the CPA does not specifically include the word "medical services.". In year 1995, the Honourable Supreme Court in IMA vs V.P. Shantha conclusively held that medical services fall within the ambit of CPA and defined medical services as consultation, diagnosis, and treatment, whether surgical or medicinal.

B) Consumer Protection Act, 1986 was repealed by the enactment of Consumer Protection Act, 2019 and with respect of Consumer Protection Act, 2019 and medical services Supreme Court on 29/04/2022 refused to interfere with a Bombay High Court judgment (PUBLIC INTEREST LITIGATION NO. 58 OF 2021) which held that doctors and healthcare services are not excluded from the ambit of the Consumer Protection Act 2019. The definition of "Service" is wide enough under the Act. If the Parliament wanted to exclude, they would have said it expressly," remarked Justice DY Chandrachud while laying emphasis on the

word, "Service of any description. (MEDICOS LEGAL ACTION GROUP Vs. UNION OF INDIA, Petition(s) for Special Leave to Appeal © No(s).19374/2021).

Question No.2 – What kind of medical services does not fall within the ambit of Consumer Protection Act 2019?

Answer: Honourable Supreme Court in IMA vs V.P. Shantha held that Doctors and hospitals who render service without any charge whatsoever to every person availing the service would not fall within the ambit of "service" under Section 2(1) (o) of the Act. The payment of a token amount for registration purposes only would not alter the position in respect of such doctors and hospitals.

Question No. 3- What is meant by deficiency in service in the context of Consumer Protection Act 2019?

Answer: Section 2(11) of CPA provides the definition of deficiency as: "deficiency" means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service and includes— (i) any act of negligence or omission or commission by such person which causes loss or injury to the consumer; and

(ii) deliberate withholding of relevant information by such person to the consumer;

Question No. 4- What is meant by defect in goods or product in the context of Consumer Protection Act 2019?

Answer: Section 2(10) of CPA provides the definition of defect

as: "defect" means any fault, imperfection or shortcoming in the quality, quantity, potency, purity or standard which is required to be maintained by or under any law for the time being in force or under any contract, express or implied or as is claimed by the trader in any manner whatsoever in relation to any goods or product and the expression "defective" shall be construed accordingly;

Question No. 5- Who can be a complainant under Consumer Protection Act 2019?

Answer: Section 2(5) of CPA provides the definition of complainant as: "complainant" means— (i) a consumer; or (ii) any voluntary consumer association registered under any law for the time being in force; or (iii) the Central Government or any State Government; or (iv) the Central Authority; or (v) one or more consumers, where there are numerous consumers having the same interest; or (vi) in case of death of a consumer, his legal heir or legal representative; or (vii) in case of a consumer being a minor, his parent or legal guardian;

Question No.6- What is meant by complaint under Consumer Protection Act 2019?

Answer: Section 2(6) of CPA provides the definition of complaint as: "complaint" means any allegation in writing, made by a complainant for obtaining any relief provided by or under this Act, that— (i) an unfair contract or unfair trade practice or a restrictive trade practice has been adopted by any trader or service provider; (ii) the goods bought by him or agreed to be bought by him suffer from one or more defects; (iii) the services hired or availed of or agreed to be hired or availed of by him suffer from any deficiency;

(iv) a trader or a service provider, as the case may be, has charged for the goods or for the services mentioned in the complaint, a price in excess of the price—(a) fixed by or under any law for the time being in force; or (b) displayed on the goods or any package containing such goods; or (c) displayed on the price list exhibited by him by or under any law for the time being in force; or (d) agreed between the parties; (v) the goods, which are hazardous to life and safety when used, are being offered for sale to the public—(a) in contravention of standards relating to safety of such goods as required to be complied with, by or under any law for the time being in force; (b) where the trader knows that the goods so offered are unsafe to the public; (vi) the services which are hazardous or likely to be hazardous to life and safety of the public when used, are being offered by a person who provides any service and who knows it to be injurious to life and safety; (vii) a claim for product liability action lies against the product manufacturer, product seller or product service provider, as the case may be;

Question No.7- What is the definition of consumer under Consumer Protection Act 2019?

Answer: Section 2(7) of CPA provides the definition of consumer as: "consumer" means any person who— (i) buys any goods for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any user of such goods other than the person who buys such goods for consideration paid or promised or partly paid or partly promised, or under any system of deferred payment, when such use is made with the approval of such person, but does not include a person who obtains such goods for resale or for any

commercial purpose; or (ii) hires or avails of any service for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such service other than the person who hires or avails of the services for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person, but does not include a person who avails of such service for any commercial purpose. Explanation. —For the purposes of this clause, — (a) the expression "commercial purpose" does not include use by a person of goods bought and used by him exclusively for the purpose of earning his livelihood, by means of self-employment; (b) the expressions "buys any goods" and "hires or avails any services" includes offline or online transactions through electronic means or by teleshopping or direct selling or multi-level marketing

Question No.8 – Can a patient availing medical services by using online platforms be a consumer under Consumer Protection Act 2019?

Answer: Yes, See the Explanation (b) in the answer to question no. 7.

Question No. 9- A private dentist practitioner treats a single patient free of cost and all other patients are charged by him for the treatment, can such single patient treated free of cost be a consumer under Consumer Protection Act 2019?

Answer- Yes, See the answer to question no.2. Doctors and hospitals who render service without any charge whatsoever to every person availing the service would not fall within the ambit of

"service" under Section 2(1) (o) of the Act.

Question No. 10- A dentist practising in district 'X' treats the patient came to his clinic in district 'X'. The said patient resides in district 'Z', can such patient file the complaint before District Consumer Commission in district 'Z' against such dentist alleging deficiency in service or defect in product as the case may be?

Answer- Yes- Section 34 (2) of Consumer Protection Act, 2019 provides: Section 34 (2)- A complaint shall be instituted in a District Commission within the local limits of whose jurisdiction,— (a) the opposite party or each of the opposite parties, where there are more than one, at the time of the institution of the complaint, ordinarily resides or carries on business or has a branch office or personally works for gain; or (b) any of the opposite parties, where there are more than one, at the time of the institution of the complaint, actually and voluntarily resides, or carries on business or has a branch office, or personally works for gain, provided that in such case the permission of the District Commission is given; or (c) the cause of action, wholly or in part, arises; or (d) the complainant resides or personally works for gain.

Question No. 10- What is 'product liability 'under Consumer Protection Act, 2019?

Answer- Section 2(34) of Consumer Protection Act, 2019 defines product liability as: product liability" means the responsibility of a product manufacturer or product seller, of any product or service, to compensate for any harm caused to a consumer by such defective product manufactured or sold or by deficiency in services relating thereto.

Question No. 11- What is 'product liability action' under Consumer Protection Act, 2019?

Answer- Section 2(35) of Consumer Protection Act, 2019 defines product liability action as: "product liability action" means a complaint filed by a person before a District Commission or State Commission or National Commission, as the case may be, for claiming compensation for the harm caused to him.

Question No. 12- What is misleading advertisement under Consumer Protection Act? And what remedy is available to consumer for the same under Consumer Protection Act 2019?

Answer- Section 2(28) of Consumer Protection Act 2019 defines misleading advertisement as "misleading advertisement" in relation to any product or service, means an advertisement, which— (i) falsely describes such product or service; or (ii) gives a false guarantee to, or is likely to mislead the consumers as to the nature, substance, quantity or quality of such product or service; or (iii) conveys an express or implied representation which, if made by the manufacturer or seller or service provider thereof, would constitute an unfair trade practice; or (iv) deliberately conceals important information.

Remedy is provided under section 17 of Consumer Protection Act 2019- A complaint relating to violation of consumer rights or unfair trade practices or false or misleading advertisements which are prejudicial to the interests of consumers as a class, may be forwarded either in writing or in electronic mode, to any one of the authorities, namely, the District Collector or the Commissioner of regional office or the Central Authority.

Question No. 13- What is period of limitation to file complaint under Consumer Protection Act 2019?

Answer: Section 69 of Consumer Protection Act 2019 provides that; Section 69. (1) The District Commission, the State Commission or the National Commission shall not admit a complaint unless it is filed within two years from the date on which the cause of action has arisen.

(2) Notwithstanding anything contained in sub-section (1), a complaint may be entertained after the period specified in sub-section (1), if the complainant satisfies the District Commission, the State Commission or the National Commission, as the case may be, that he had sufficient cause for not filing the complaint within such period:

Provided that no such complaint shall be entertained unless the District Commission or the State Commission or the National Commission, as the case may be, records its reasons for condoning such delay.

Question No. 14- What is the maximum compensation which can be claimed by the complainant before District/State/National Consumer Commission as the case may be under Consumer Protection Act 2019?

Answer- Under Consumer Protection Act 2019 the jurisdiction in which the complaint is to be filed is now on the basis of the value of the goods and services paid, which was not the case in the 1986 Act where it was on the value of the goods and services and the compensation, if any, claimed. So now there is no limit to claim for compensation before any of the commissions under Consumer

Protection Act 2019, however jurisdiction of every commission is regulated by the value of the goods or services paid as consideration as under:

A) Jurisdiction of District Commission- where the value of the goods or services paid as consideration does not exceed fifty lakh rupees.

B) Jurisdiction of State Commission- where the value of the goods or services paid as consideration exceeds fifty lakh but does not exceed two crore rupees.

D) Jurisdiction of National Commission- where the value of the goods or services paid as consideration, exceeds two crore rupees

See - The Consumer Protection (Jurisdiction of the District Commission, the State Commission and the National Commission) Rules, 2021.)

B. THE BOMBAY SHOPS AND ESTABLISHMENT ACT, 1948

Adv. Priyanka Patil

Object of the act: is to provide regulation of employment and other conditions of service in shops, hotels, eateries and theaters.

► Maharashtra Shops and Establishment Act applies to clinics & hospitals.

► Amended Maharashtra Shops and Establishment Act, 2017, encompasses medical practitioners, clinics, polyclinics, maternity homes, hospitals and dispensaries that employ 10 or more persons.

► It specifies that work timings should not exceed 10 and half hours a day and, in case a worker is entrusted with intermittent or urgent work, these should not cross 12 hours. It also provides for overtime wages beyond nine hours, permits employers to keep establishments open for business on all days, for weekly holidays, and mandates employers to ensure cleanliness and facilities for first- aid and water.

► Objectives and reasons of the new Act not only take into consideration the regulation of employment conditions but also provide for social security benefits to employees covered. Working hours not more than 10 and half hours a day.

► If the worker is entrusted with intermittent or urgent work,

not more than 12 hours a day.

- ► Overtime wages beyond 9 hours.
- ► Establishment can be open for all days.

C. THE MINIMUM WAGES ACT, 1948

Adv. Priyanka Patil

Object of the act: The Minimum Wages Act, 1948, was enacted in the year 1948 primarily to safeguard the interests of the workers engaged in the unorganized sector. In the unorganized sector, the workers are vulnerable to social and economic exploitation due to illiteracy, dispersed nature of operations & processes, low bargaining power, lack of institutional back-up and poor implementation of labour laws.

► The guiding principle is that the worker must be given wages which can enable him and the members of his family to lead a decent and healthy life.

► The Act provides for fixation and revision of minimum wages of the workers engaged in the scheduled employments.

► Under the Act, both central and State Governments arc responsible, in respect of scheduled employments within their jurisdictions to fix and revise the minimum wages and enforce payment of minimum wages.

► It binds the employers to pay to the workers the wages fixed or revised under the Act.

► In the absence of any standard methodology or guidelines, the norms recommended by the Indian Labour Conference held in 1957 forms the basis for fixing the minimum wages.

D. THE ENVIRONMENT (PROTECTION) ACT, 1986

Adv. Priyanka Patil

Object of the act: The objective of Environment (Protection) Act, 1986, is to protect and improve the environment and environmental conditions. To take strict actions against all those who harm the environment.

► Bio-medical waste is defined as waste that is generated during the diagnosis, treatment or immunization of human beings and is contaminated with patient's body fluids. This can be syringes, needles, ampoules, organs and body parts, placenta, dressings, disposables plastics and microbiological wastes.

► Proper disposal of waste from dental clinics is of paramount importance because of its infectious and hazardous characteristics.

► "Bio-medical waste" means waste generated during the diagnosis, treatment or immunization of human beings or animals or in research activities pertaining there to or in the production or testing of biological and including categories mentioned in the act.

► "Bio-medical waste treatment facility" means any facility wherein treatment of disposal of bio-medical waste or processes incidental to such treatment or disposal is carried out; .

► "Occupier" is any institution generating bio-medical waste, which includes a hospital, nursing home, clinic dispensary,

veterinary institution, animal house, pathological laboratory and blood bank. A person who has control over that institution and/or its premises.

► "Operator of a bio-medical waste facility" means a person who owns or controls or operates a facility for the collection, reception, storage, transport, treatment, disposal or any other form of handling of bio-medical waste; "Schedule" means schedule appended to these rules.

E. THE LABOUR LAWS

Adv. Priyanka Patil

Object of the act: The objective of Labour Laws is Protection of workers from all sorts of exploitation - mentally or physically and creating a better working environment.

► Dentists / Dental Surgeons shall not employ in connection with their professional practice any attendant who is neither registered nor enlisted under the Dentists Act and shall not permit such persons to attend, treat or perform operations upon patients wherever professional discretion or skill is required.

► These include right to work of one's choice, right against discrimination, prohibition of child labour, just and humane conditions of work, social security, protection of wages, redress of grievances, right to organize and form trade unions, collective bargaining and participation in management.

► WSIB (Workplace Safety and Insurance Board) allows dentists to apply to have their employees covered under the Workplace Safety Insurance Act.

► A dentist can buy Workplace Disability coverage with WSIB by filling out an application form, and paying monthly premiums based on the number of their employees.

► WSIB benefits are paid on a no fault basis.

► To receive compensation workers must be covered under

the WSIB scheme, and the worker must be injured in the course of their employment.

► WSIB allows dentists to apply to have their employees covered under the Workplace Safety Insurance Act.

► A dentist can buy Workplace Disability coverage with WSIB by filling out an application form, and paying monthly premiums based on the number of their employees.

► No fault protection from lawsuits by employees for work related injuries or illness.

► Protection for your employees from the costs related to work related injuries including income loss and health costs.

► Any workplace accident where the employee is injured through the fault of the dentist or his or her other employees.

Examples:

i. Filing Cabinet falls on employee's foot.

ii. Employee trips over a carpet or chair and breaks their ankle.

iii. Employee is jabbed with a needle used on an HIV positive patient.

iv. Employee gets sick from mould in building.

► Most dentists have liability insurance which covers them for claims for injuries arising in the workplace.

F. MAHARASHTRA FIRE PREVENTION & LIFE SAFETY MEASURE ACT, 2006

Adv. Priyanka Patil

Object of the act : for the prevention, control and fighting of fire and for ensuring the safety of life and property in case of fire.

The Maharashtra Fire Prevention and Life Safety Measures Act, 2006, applies to all buildings, including dental clinics, in the state. It aims to ensure effective fire prevention and life safety measures in various types of buildings. This includes requirements for fire safety equipment, emergency exits, and other measures to protect occupants in case of fire.

The Act covers all buildings within Maharashtra, including dental clinics.

Fire Safety Measures:

It mandates the installation and maintenance of fire safety equipment, such as fire extinguishers, sprinkler systems, and smoke detectors.

Emergency Exits:

Buildings must have adequate emergency exits, clear pathways, and proper signage to ensure safe evacuation in case of fire.

Inspections:

The Maharashtra Fire Services conducts inspections to

ensure compliance with the act.

Penalties:

Violations of the Act can result in fines, penalties, and even closure of the establishment.

Compliance:

Dental clinics must comply with the Act's requirements, including fire safety equipment installation and maintenance, emergency exit planning, and regular inspections.

Specific Considerations:

Dental clinics, with their potential for flammable materials and specialized equipment, may require specific fire safety considerations.

Occupant Safety:

The Act ensures that patients and staff are protected from fire hazards in dental clinics.

Applicability:

The Act is applicable to all dental clinics.

Local Regulations:

Local municipal authorities may also have their own regulations regarding fire safety, which may complement the Act.

In summary, the Maharashtra Fire Prevention and Life Safety Measures Act, 2006, is a crucial piece of legislation for ensuring fire safety in all buildings, including dental clinics, in Maharashtra and dentist must comply with the Act's requirements to protect their patients and staff in the event of a fire.

Appointment of fire officer or fire supervisor in certain buildings: There shall be appointed by every owner or occupier, a fire officer or fire supervisor for every building of the following description, namely:-

Building with height more than 30 meters such as used for hospital.

The qualifications and duties of such fire officer or fire supervisor shall be such as the Director may, with the approval of the State Government, by order in the Official Gazette, specify.

Always Have an Escape Plan.

Install Smoke Alarms in Your Place.

Stay on Top of Your Electrical Wiring System.

Keep Your Heating Equipment in Check.

Learn to Use a Fire Extinguisher.

Have a Workplace Fire Safety Checklist.

MAHARASHTRA FIRE PREVENTION & LIFE SAFETY MEASURES RULES, 2009

Object of the act: An Act to make more effective provisions for the fire prevention and life safety measures in various types of buildings in different areas in the State of Maharashtra.

G. The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2010

Adv. Priyanka Patil

Object of the act:

An Act to provide for the prevention of violence against Medicare Service Persons and prevention of damage or loss of property of Medicare Service Institutions in the State of Maharashtra and for matters connected therewith or incidental thereto.

· Registered Medical Practitioner, Practitioner or Registered Practitioner (including a person having provisional registration) working in a Medicare Service Institution other than the public servant within the meaning of section 21 of the Indian Penal Code.

Maharashtra Act (2010):

This act, passed by the Maharashtra state legislature, aims to address the increasing incidents of violence and damage to property in healthcare settings, impacting the safety and well-being of medical personnel.

Penalty:

Under the Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2010 and similar acts in other states like Rajasthan, Delhi, Punjab and Karnataka, offenders can

be punished with imprisonment for up to three years, a fine of up to fifty thousand rupees, or both, for violating the provisions of the act. Additionally, offenders are liable to pay compensation for any damage or loss to property caused, which may include a penalty of twice the amount of the purchase price of damaged medical equipment.

H. THE CONTRACT ACT,1872

Adv. Priyanka Patil

Object of the act: to ensure that the rights and obligations arising out of a contract are honored and that legal remedies are made available to those who are affected.

The doctor–patient relationship is when a professional duty attaches to the opinions and actions of the doctor. The basis of this relationship is in contract law. Contract law has three elements that must be fulfilled: the offer, the acceptance, and the consideration.

In a doctor–patient relationship, the intention of the doctor is to provide services. It must have certain and definite terms. The doctor offers to provide services for an ailment in return for consideration, that which the person accepting the offer will give to the doctor for the services rendered. And it must be made to the person who can accept the offer.

The acceptance is the voluntary act of accepting the offer. It must not be coerced or made under duress. The person accepting the offer must have the authority to accept it and must have an understanding of what is contained within the offer.

The consideration is the bargained-for exchange. It may include an act, a forbearance to act, or a promise to act. That act may include an exchange of money, goods, or services. For

example, a patient may pay personally or through an insurance policy, provide the doctor with a service such as landscaping for the doctor's office, or bring the doctor food. Without consideration, the offer becomes a gift to the person accepting the offer. Even if you decide to provide your services as a gift, you may still be sued for malpractice. Although your intentions were honorable to not charge the patient, you must still provide treatment within the standard of care. Being a nice person and helping another out, which most often happens when someone is in pain, does not preclude you from being sued.

There are two types of contracts: express and implied. The express contract may be made orally or in writing. It is when the parties involved have a distinct, explicit, and understandable agreement as to what each party must do per the contract. An express contract must also be a direct, positive, and unequivocal agreement. Preferably, the contract should be in writing that includes all the terms of the agreement to prevent miscommunication and/or misunderstanding. The implied contract occurs when the actions or the conduct of the parties involved implies that the consideration has been mutually agreed upon. Many times, through the actions of one person, another may rely on those actions as an assent to proceed with treatment with the expectation of consideration (payment).

The relationship between the Contract Act and dentistry in India is primarily governed by the Dentists Act, 1948 and the National Dental Commission Act, 2023. These laws regulate the profession of dentistry, including the registration, training, and ethics of dentists, which implicitly impacts contractual

obligations. The Indian Contract Act, 1872, outlines the general principles of contracts, which are relevant to agreements between dentists and patients, or between dentists and other professionals.

ELABORATION:

Dentists Act, 1948:

This Act establishes the regulatory framework for dentistry in India, including the formation of state dental councils and the Dental Council of India. It sets standards for dental qualifications, training, and registration, which indirectly influences the contracts dentists enter into with patients and others.

National Dental Commission Act, 2023:

This Act aims to regulate the dental profession, provide for quality dental education, and ensure accessibility to oral healthcare. It further strengthens the regulatory environment for dental professionals, influencing the nature and scope of contractual agreements.

Indian Contract Act, 1872:

This Act provides the general legal framework for contracts in India. It covers aspects like offer, acceptance, consideration, and performance, which are relevant to agreements between dentists and patients, such as treatment plans, fees, and warranties.

Examples of Contractual Relationships:

Treatment Agreements: The agreement between a dentist and a patient to provide dental services is a contract. This agreement implicitly includes promises about the quality of care,

treatment goals, and payment terms.

Employment Contracts: Agreements between dentists and their employees, such as dental assistants, also fall under the Indian Contract Act.

Professional Services: Contracts between dentists and other professionals, such as labs or specialists, also require adherence to the principles of the Contract Act.

Code of Ethics:

The Dental Council of India has established a code of ethics for dentists, which emphasizes patient interests and prohibits certain contractual practices, such as "no cure - no payment" agreements.

Implication for Patients:

Patients have the right to make informed decisions about their dental treatment, and dentists have a duty to provide competent care.

Implication for Dentists:

Dentists need to be aware of the Contract Act and the Dentists Act to ensure their practice complies with legal and ethical standards.

I. DRUGS AND COSMETICS ACT, 1940

Adv. Priyanka Patil

Object of the act: to ensure that the drugs and cosmetics sold in India are safe, effective and conform to state quality standards.

The term "drug" as defined in the act, includes various substances, diagnostic, and medical devices.

The act defines "cosmetic" as any product that is meant to be applied to the human body for the purpose of beautifying or cleansing. The definition however excludes soaps.

The Section 16 of the act defines the standards of quality for drugs. The Section 17 defines "misbranding". A drug is considered misbranded if it claims to be of more therapeutic value than it actually is. The manufacturer of such a drug may be asked to suspend the manufacture of the drug under Section 18. Section 27 deals with fake and adulterated drugs. The act requires more of that ingredients of the drugs should be printed on the label.

The Section 22 defines the powers of the drug inspectors and Section 23 defines the strict procedure which should be followed by the inspectors during any raids.

The Drugs and Cosmetics Act, 1940, is a crucial piece of legislation in India that regulates the import, manufacture, distribution, and sale of drugs and cosmetics. Dentists are directly impacted by this Act as they handle various drugs and cosmetics in

their practice. The Act ensures the safety, quality, and efficacy of these products, protecting public health.

Key points regarding the Drugs and Cosmetics Act and dentists:

Compliance with the Act:

Dentists are obligated to adhere to the provisions of the Drugs and Cosmetics Act, 1940, including the Dentists Act, 1948, and its amendments.

Safe Handling of Drugs:

Dentists must ensure that all drugs and cosmetics used in their practice are of high quality and have been properly manufactured, distributed, and stored according to the Act's regulations.

Prescription of Drugs:

Dentists need to follow the guidelines for prescribing Schedule H and Schedule X drugs, which require special precautions and storage conditions.

Sanitary Regulations:

Dentists should be cooperative in observing and enforcing sanitary laws and regulations, including those related to the handling and disposal of medical waste, as outlined in the Bio-Medical Waste (Management and Handling) Rules, 1998.

Ethical Practices:

The Dental Code of Ethics requires dentists to adhere to all relevant laws, including the Drugs and Cosmetics Act, 1940, and

to cooperate with authorities in enforcing these regulations.

Preventing Adulteration:

The Act aims to prevent the sale and distribution of substandard, adulterated, or spurious drugs and cosmetics, and dentists have a responsibility to be aware of these regulations.

Public Health:

By adhering to the Drugs and Cosmetics Act, dentists contribute to the overall public health by ensuring that drugs and cosmetics used in their practice are safe and effective.

Thank you.

J. THE MAHARASHTRA NURSING HOMES REGISTRATION ACT, 1949 AND DENTISTRY

Dr. Mahendra A. Lomte

Question No.1: Are The Maharashtra Nursing Homes Registration Act 1949, provisions are applicable to Dental Establishments?

Answer: Yes. Revised Dentists (Code of Ethics) Regulations, 2014 in its regulation 8.10 Naming and Styling of Dental Establishments provides that a dental Surgeon or a group of Dentists/ Dental Surgeons shall refer to their establishment as a dental clinic. It may however be referred to as a dental hospital if the practice involves surgical treatment of oral and dental diseases under local or general anaesthesia and if the patients need to be maintained as an in-patient for part of a day or for several days for post operative care provided the hospital fulfils the statutory requirements for such hospitals or establishments in the respective states.

Question No.2: When did the title of the Bombay Nursing Homes Registration Act, 1949 amend to the title Maharashtra Nursing Homes Registration Act, 1949?

Answer: The short title was amended by Mah. 24 of 2012, s. 2, Sch, entry no. 36, w.e.f. 1-5-1960.

Question No.3: Is Clinical Establishment Act (Registration and Regulation) Act, 2010 at present applicable to the dental

hospitals/hospitals established in the State of Maharashtra?

Answer: No. As per section 56 of Clinical Establishment Act (Registration and Regulation) Act, 2010: Section 56 Savings.—(1) The provisions of this Act shall not apply to the States in which the enactments specified in the Schedule are applicable: Provided that the States in which the enactments referred to in sub-section (1) are applicable, and such States subsequent to the commencement of this Act, adopts this Act under clause (1) of article 252 of the Constitution, the provisions of this Act shall, subsequent to such adoption, apply in that State. (2) The Central Government may, as and when consider necessary, by notification amend the Schedule.

THE SCHEDULE [See section 56] 1. The Andhra Pradesh Private Medical Care Establishments (Registration and Regulation) Act, 2002. 2. The Bombay Nursing Homes Registration Act, 1949. 3. The Delhi Nursing Homes Registration Act, 1953. 4. The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbabdu Sthapamaue (Ragistrikaran Tatha Anugyapan) Adhiniyam, 1973. 5. The Manipur Homes and Clinics Registration Act, 1992. 6. The Nagaland Health Care Establishments Act, 1997. 7. The Orissa Clinical Establishments (Control and Regulation) Act, 1990. 8. The Punjab State Nursing Home Registration Act, 1991. 9. The West Bengal Clinical Establishments Act, 1950.

Question No.4- What is the purpose of Maharashtra Nursing Homes Registration Act, 1949?

Answer: An Act to provide for the registration and inspection of nursing homes in the 2[State of Bombay] and for certain purposes

connected therewith. (2- These words were substituted for the words "Province of Bombay" by Bom. 42 of 1959, s. 3.)

Question No. 5 – Where to make application for registration under Maharashtra Nursing Homes Registration Act, 1949?

Answer: To "local supervising authority". And "local supervising authority" means- "local supervising authority" means, — (i) in the areas falling within the jurisdiction of the Municipal Corporation—the Health Officer of the concerned Municipal Corporation; (ii) in the areas falling within the jurisdiction of the Municipal Council—— the Civil Surgeon of the District in which such Council is situated; (iii) in the areas falling within the jurisdiction of a Cantonment— the Health Officer of the concerned Cantonment; (iv) in the areas not falling in sub-clauses (I), (ii) and (iii) above—the District Health Officer of the concerned Zilla Parishad. (See Section 2 (2) of Maharashtra Nursing Homes Registration Act, 1949)

Question No.6- What is the validity of the registration certificate issued under Maharashtra Nursing Homes Registration Act, 1949?

Answer: As per Section 3(2) of Maharashtra Nursing Homes Registration Act, 1949- A certificate of registration issued under this section shall, subject to the provisions of section 7, be in force and shall be valid until the 31st day of March of the third year next following the date on which such certificate is issued or renewed, as the case may be.

Question No. 7- What is the penalty for non-registration under Maharashtra Nursing Homes Registration Act, 1949?

Answer: As per Section 6 of Maharashtra Nursing Homes Registration Act, 1949- Whoever contravenes the provisions of section 3, shall, on conviction, be punished with imprisonment which may extend to six months or with fine which may extend to ten thousand rupees or with both

MAHARASHTRA STATE DENTAL COUNCIL
MUMBAI

TAXATION

CA Manish Somani

CA Navin Gupta

- Goods & Service Tax
- Professional Tax
- Income Tax

GOODS AND SERVICES TAX ACT 2017

Goods and Services Tax (GST) Act, 2017 was implemented in India from 1st July 2017.

GST is applicable on supply of all goods and services except those which are specifically exempted.

Notification no. 9/2017 of integrated Tax (Rate) dated 28th June 2017 has exempted health care services vide entry no 77 which is reproduced as under

"Health care Services by a Clinical Establishment or Authorized Medical Practitioner or Para medics are exempt from Goods and Service tax."

1. Health care services

The said notification defines Health Care services as any service by way of Diagnosis or treatment or care for

- Illness,
- Injury
- Deformity,
- Abnormality or
- Pregnancy
- In any recognized system of medicines in India and includes services by way of transportation of the patient to and from a clinical establishment

- But does not include
- Hair transplant or
- Cosmetic or
- Plastic surgery,
- Except when undertaken to restore or to reconstruct anatomy or functions of body affected due to congenital defects, developmental abnormalities, injury or trauma.

As per the above notification and definition of Health care services, it is clear that services supplied by dentists or orthodontists are exempt from the levy of Goods and Services Tax to the extent they comprise health care.

However, in case of cosmetic dentistry or beauty treatments done by dentists except in the case when undertaken to restore or to reconstruct anatomy or functions of body affected due to congenital defects, developmental abnormalities, injury or trauma.

So, in case a dentist is performing cosmetic dentistry for a person only for beautification which is not required medically, it will be chargeable to tax under GST @18%. In this case dentist will have to obtain registration under GST Act and file returns regularly.

The dentist needs to maintain proper records of patients including case paper, X rays etc. So as to determine whether a case if for cosmetic dentistry is out of medical requirement or not in case GST notice is received in future.

PROFESSION TAX

Profession Tax is applicable as per
The Maharashtra State Tax on Professions, Trades, Callings and Employments Act, 1975 (Profession Tax Act).

Under Profession Tax, there are two ways in which tax may be applicable for a Dentist who is running his own clinic.

a. **Profession Tax EC**- In this case, proprietor or owner has to pay Profession tax for self. This falls under Sr. No 2 (b) of the Schedule 1 of Profession Tax Act which reads as under.

b. Medical Practitioner including Medical Consultants and Dentists;

The amount payable under this clause is Rs. 2500/- per annum from the date of commencement practice as dentist.

Profession Tax EC is required to be paid every year before 30th June of the year. e.g for 2026-27, Profession Tax EC payment are to be made by 30 June 2026.

c. **Profession Tax RC**- in this case, proprietor or owner has to pay tax on behalf of employees by deduction from Salaries of the employees as per Sr. No 1 of Schedule 1 of Profession Tax Act. Here Profession Tax is deducted as per below Slabs:

Salary and Wages earns-such persons whose all salaries or wages :-	
(a) do not exceed Rs. 7,500/-	Nil
(b) (i) in case of male, exceed Rs. 7,500/- but do not exceed Rs. 10,000/-	Rs. 175/- per Month
(b) (ii) in case of female, do not exceed Rs. 25,000/- for female	Nil
(c)Exceed Rs. 10,000/- for Male and Rs. 25,000/- for female	Rs. 2,500/- per annum to be paid in following manner (a) Rs. 200/- per month except for the month of February (b) Rs. 300/- for the month of February

It may be noted that as per Profession Tax Laws, even interns are considered as employees and employers are liable to deduct Profession tax from their payments as per above slabs.

Employers are liable to deduct and pay profession tax from the first employee they engage. This is required to be paid by 30th of the next month for which the salary is given to the employee. E.g Salary for April 2026, Profession Tax to be paid by 30th May 2026.

After payment of tax deducted from employees, the employer is also required to file a return for the same every month in the first year of registration and from next year, either annually or monthly based on the Profession tax paid during the previous year.

If tax paid in previous year is below Rs. 50000/-, annual

payment and return will be applicable from next year.

Otherwise the payment and return will be required to be filed monthly.

However, an important point to be noted is that the period to be mentioned for challan and return is the next month i.e May 2026. E.g if the salary from which tax is deducted is for April 2026, the period to be mentioned on the challan will be 1st May 2026 to 31st May 2026, The return for salaries of April 2026 will' also be 1st May 2026 to 31st May 2026.

INCOME TAX

Basic Tax Slabs for F.Y. 2025-26

For Taxable Income in case of Individuals other than senior citizen (old Regime)

Income Level	Tax rates (including surcharge)
Up to Rs. 2.5 Lakhs	NIL
2.5 Lakhs to 5 Lakhs	5%
5 Lakhs to 10 Lakhs	20%
10 Lakhs to 50 Lakhs	30%
50 Lakhs to 1 Crore	33% (Including Additional Surcharge of 10%)
1 Crore and 2 Crore	34.5 % (Including Additional Surcharge of 15%)
2 Crore to 5 Crore	37.5% (Including Additional Surcharge of 25%)
Above 5 Crore	41.1% (Including Additional Surcharge of 37%)
● In addition to above a 4% Health and Education Cess is applicable on the amount of tax	

Tax Saving Investments and Other expenses deductible under Income tax except business expenditure for Self Employed Professionals:

Sr. No.	Section	Investments / Expenditure Eligible	Conditions for Deduction	Maximum Limits
1	80 C	ELSS - Tax saving Mutual Funds Provident Fund, Public Provident Fund Sukanya Samruddhi Scheme, Tuition fees for children taxpayer Repayment of Housing Loan Principal portion Kisan Vikas Patra, National Savings Certificate	Investment of payment must be made during the financial year	1,50,000/-

Sr. No.	Section	Investments / Expenditure Eligible	Conditions for Deduction	Maximum Limits
2	80 D	1. Medical Insurance of Self/Spouse 2. Medical Insurance of parents 3. Medical Expenditure on health of assessee / family member or parents	Payment must be made by cheque / Online / Credit Card / Cash payment not eligible. For 3. Person whose expenditure is paid should not have medical insurance policy and must be a senior citizen.	For 1 and 2, 25,000/- each if non senior citizen and 50,000/- if senior citizen. For 3. 50,000/-
3	80 GG	House rent paid	Assessee should not be in receipt of House rent allowance	Lower of 60,000/- or Amount of rent paid in excess of 10% of Total income
4	80 E	Interest on Education Loan paid during the financial year	Loan must be for higher education (after SSC) for Self, Spouse or children of student for whom assessee is legal guardian. Also allowed for education outside India	No Limit prescribed.

For Taxable Income in case of Individuals other than senior citizen (New Regime)

Income Level	Tax Rates (Including Surcharge)
Up to Rs. 4 Lakhs	Nil
4 Lakhs to 8 Lakhs	5%
8 Lakhs to 12 Lakhs	10%
12 Lakhs to 16 Lakhs	15%
16 Lakhs to 20 Lakhs	20%
20 Lakhs to 24 Lakhs	25%
24 Lakhs to 50 Lakhs	30%
50 Lakhs to 1 Crore	33% (Including Additional Surcharge of 10%)
1 Crore and 2 Crore	34.5% (Including Additional Surcharge of 15%)
2 Crore to 5 Crore	37.5% (Including Additional Surcharge of 25%)
Above 5 Crore	41.1% (Including Additional Surcharge of 37%)
● In addition to above a 4% Health and Education Cess is applicable on the amount of tax	

SOME INFORMATION FOR SELF EMPLOYED DENTISTS

Basic records to be maintained by Dentists/ Doctors in practice.

1. Daily collection register- A register containing details of fees collected from patients on a daily basis. This would include payments received in Cash as well as Bank payments through card, Cheques or any other digital mode of payment.

2. Details of Expenses made for purchase of material, consumables.

3. Details of payments made to other professionals for specialized treatments.

4. Payment cannot be accepted from a single patient of more than 2 lakhs in cash.

5. In case of foreign patients, it is advisable to keep a copy of passport and visa. This would help in proving that it has actually been paid by the foreign patient and clear suspicion of benami funds.

Under Section 44AA, Professionals are required to maintain proper books of accounts to enable assessing officer to compute the Income of the assessee. The above records along with records as required by Medical Regulations would constitute proper accounts.

Scheme of Simplified taxation for Professionals: (44ADA)

Eligibility

1. The Assessee must be a Professional like Doctor, Lawyer, Chartered Accountant etc.

2. Gross receipts for financial year must not exceed 75 Lakhs.

Benefits of the Scheme

1. Assessee need not maintain records of any expenses of consumables or payments to professionals.

2. Assessee can directly show minimum 50% of the professional receipts as profit from Business or Profession. (Depreciation on Vehicles or instruments is assumed to be included in 50%)

3. Advance Tax to be paid only in the last instalment of the year i.e by 15th March.

Who Should Opt

1. Professionals who are working with hospitals or clinics as consultants.

2. Professionals whose practice is established and expenditure including Depreciation is less than 45%.

INFECTION CONTROL OCCUPATIONAL HAZARDS AND IMMUNISATION

- A) Infection Control in Dentistry
- B) Modalities to Prevent Spread of Communicable Disease
- C) Dental Clinic Related Occupational Hazards & their Prevention
- D) Risk of Occupationally Acquired Blood Borne Infections Among Dental Workers and its Management in Dental Clinic
- E) Immunization Protocol For Dental Health Care Workers
- F) Radiation Hazards

A. INFECTION CONTROL IN DENTISTRY

Dr. A.Kumarswamy

The unique nature of dental procedures, instrumentation, and patient care settings requires specific strategies directed to prevention of transmission of diseases among dental health care workers and their patients. The following guidelines are important and must be followed to ensure safety of all dentists and dental health care workers.

ROUTINE PRECAUTIONS

Transmission of infection within the setting of dentistry may occur from the dental health care worker to the patient, from the patient to the health care worker or from patient to patient. Documented cases show transmission of human immunodeficiency virus (HIV) or hepatitis B virus (HBV) was transmitted from dental health care workers to their patients and vice Versa. Although Patient-to patient transmission has only been reported in medical settings, it could also occur in dental practices.

The major documented routes of transmission of HIV and HBV in dental settings are (i) percutaneous inoculation and (ii) contact with an open wound, non-intact (e.g. chapped, abraded, weeping or dermatitic) skin, or mucous membranes to blood, blood contaminated body fluids or concentrated viruses. Blood is the single most important source of HIV and HBV in dental practice. Protective measures against HIV and HBV should focus

primarily on preventing these types of exposures to blood as well as on delivery of Hb vaccination.

Since it is now known that persons carrying blood-borne viruses, including both health care workers and patients, may not have been identified and are thus not aware of their own condition, EVERY patient must be considered as potentially infected and adequate precautions must be taken to ensure the prevention of cross- infection.

Despite advancements in technology, the risks of accidental percutaneous injury during dental procedures cannot be completely eliminated. While HBV transmission can be prevented through immunization, exposure to blood from HIV-infected individuals remain a significant concern for dental health care workers. It is considered justifiable to apply additional infection control measures when performing invasive procedures on individuals with known HIV infection.

PROTECTIVE MEASURES

Protection involves as a combination of immunization, barrier techniques, and adherence to infection control protocols.

IMMUNISATION

All dental health care workers are advised to be immunized against HBV unless immunity from natural infection or previous immunization had been documented.

UNIFORMS: APRONS

Uniforms should be changed daily or immediately when soiled. Gowns or aprons should be worn during procedures like

surgery, scaling, or extractions that may cause spattering or splashing of blood.

HAND PROTECTION

Gloves must be worn for procedures involving contact with blood, saliva or mucous membrane. A new pair of gloves should be used for each patient. If a glove is damaged, it must be replaced immediately. Hands should be washed thoroughly with an antimicrobial liquid soap before and after glove use. Disposable paper towels are recommended for drying of hands. Any cuts or abrasions on the hands or wrists should be covered with adhesive waterproof dressings at all times.

PROTECTIVE GLASSES, MASKS, OR FACE SHIELDS

Protective glasses, masks or face shields should be worn by operators and close-support dental surgery assistants to protect the eyes against the spatter and aerosols which may occur during cavity preparation, scaling and the cleaning of instruments.

SHARP INSTRUMENTS & NEEDLES

Sharp instruments and needle should be handled with great care to prevent unintentional injury. Needles should never be recapped by using both hands in direct contact or by any other technique that involves moving the point of a used needle towards any part of the body. Needles can be recapped using one of the following methods: laying the cap on a tray and guiding the needle into it, placing the cap in a recapping device, or holding the cap with forceps to avoid direct contact.

FIRST AID & INOCULATION INJURIES

In the event of a skin puncture by a contaminated instrument, The wound should be allowed to bleed freely and thoroughly washed under running water with soap or an antiseptic.

Where there is reason to be concerned about the possible transmission of infection, Advice on serologic testing, medical evaluation, and follow-up should be sought from an infectious disease specialist or occupational health clinic.

SURFACE DISINFECTION

Surfaces that are likely to become contaminated may be decontaminated after treatment or protected with disposable coverings before they become contaminated:

Effective cross-infection control is aided by a strict system of zoning and the use of sterilizable trays. Procedures should be adopted which limit the areas touched and contaminated each time a patient is treated.

Between clinical sessions work surfaces should be thoroughly cleaned and decontaminated with ethyl alcohol (70%). If there is visible blood or pus the surface should be cleaned and disinfected with sodium hypochlorite (0.5%), followed by water rinse.

ASPIRATION AND VENTILATION

High-volume aspiration reduces the risk of cross-infection from aerosols. The risk is further reduced by good ventilation. The tubing of high- volume aspirators and saliva ejectors should be flushed with water between patients and disinfected regularly with sodium hypochlorite (0.1%) or as per manufacturer guidelines.

ADDITIONAL PRECAUTIONS FOR HIV-INFECTED INDIVIDUALS

- Double-gloving for invasive procedures.
- Use of puncture-resistant containers for sharp instruments.
- Thorough disinfection of all instruments and surfaces after treatment.
- Limiting aerosols during procedures involving known HIV patients.

(a) If possible, schedule the patient surgery at the end of the list.

(b) The team should be limited to essential members of staff and the procedures should be performed by experienced, fully trained staff.

(c) The operator should wear two pairs of gloves. Plastic gown, cap mask and protective eye wear should be worn.

(d) All procedures should be performed in a way which minimizes the formation of droplets, spatter and aerosols, utilizing high volume vacuum aspirators, rubber dams where appropriate and proper patient positioning. Ultrasonic scalers should be avoided.

(e) Avoid the use of instruments which cannot be easily decontaminated. Instruments and tools used should be handled and cleansed by experienced staff before autoclaving.

(f) After the operation, all surfaces inside the surgery and equipments should be cleaned and decontaminated with appropriate disinfectants.

Item	Recommended Method	Alternative Method
Amalgam / composite carriers	Wipe with 70% ethyl alcohol	
Articulators	Wipe with 70% ethyl alcohol	
Attachments dental units	Wipe with 2% glutaraldehyde, rinse	Wipe with 70% ethyl alcohol
Bracket tables	wipe with 70% ethyl alcohol	
	If there is visible blood or pus, clean and disinfect with 0.5% sodium hypochlorite, rinse	
Burs - diamond	Clean with metallic brush and detergent, autoclave	
Burs - steel tungsten - carbide	Clean with metallic brush and detergent, rinse, dry and dry heat	Clean with metallic brush and detergent, rinse, dry immerse in 2% glutaraldehyde for 10 hours, rinse
Dental Chairs	Clean with detergent and water	
	If there is visible blood or pus, clean and disinfect with 0.5% sodium hypochlorite or 2% glutaraldehyde, rinse	
Dental Mirrors	Clean with detergent and water, autoclave, store in covered pack or container	

Item	Recommended Method	Alternative Method
Denture	Clean with detergent and water	
	If contaminated with blood, immerse in 0.1% sodium hypochlorite for 10 mins. and rinse	Wipe with 70% ethyl alcohol
Extraction Forceps	Clean with detergent and water, autoclave, store in covered pack or container	
Gloves	Disposable	
Handpiece Air motor for slow speed handpieces	Flush for 30 sec., Clean with detergent and water, oil and autoclave	Flush for 30 sec., Clean with detergent and water, oil, surrounding the handpiece by a gauze pad soaked in 2% glutaraldehyde for 10 mins., rinse with water
Impressions - Alaginate : (Plastic trays)	Rinse, get rid of excess water, spray with 0.1% sodium hypochlorite, put in closed container for 10 mins.	
Zine-oxide eugenol paste : Alginate : (Metallic trays)	Rinse, get rid of excess water, spray with 2% glutaraldehyde, put in closed container for 10 mins.	
Rubber base :	Rinse, immerse in 2% glutaraldehyde for 10 mins. rinse	

Item	Recommended Method	Alternative Method
Injection needles for local anaesthetic	Disposable	
Instrument trays	Clean with detergent and water, autoclave	
Orthodontic bands	Clean with detergent and water, autoclave	
Orthodontic pliers	Clean with detergent and water, autoclave	
Polishing stones	Clean with detergent and water, autoclave	
Prophylactic cups and brushes	Disposable	Clean with detergent and water, autoclave
Protective plastic glasses and shields	Wipe with 0.1% sodium hypochlorite	
Root canal instruments	Clean with detergent and water, autoclave, store in covered container	
Rubber dam clamps	Clean with detergent and water, autoclave	
Rubber dam froceps	Clean and autoclave	Clean, immerse in 2% glutaraldehyde for 10 mins., rinse
Rubber dam punches	Clean with detergent and water	
Saliva ejectors	Disposable	

Item	Recommended Method	Alternative Method
Saliva ejectors, metallic	Clean with detergent and water, autoclave	
Scalpel blades	Disposable	
Stainless steel cups	Clean with detergent and water, autoclave	
Stainless steel instruments	Clean with detergent and water, autoclave, store in covered pack or container	Dry heat
Suction tips	Clean with detergent and water, autoclave	
Suction tube adaptors	Wipe with 70% alcohol after each use. Autoclave weekly	
Surgical instruments	Clean with detergent and water, autoclave, store in covered pack or container	Dry heat
Syringe - local anaesthetic	Clean with detergent and water, autoclave, store in covered pack or container	Dry heat
Syringe tips - detachable 3 - way	Clean with detergent and water, autoclave	
Ultrasonic scaler tips and inserts	Clean with detergent and water, autoclave, store in covered pack or container	
Wax bite block, wafer	Rinse, immerse in 0.1% sodium hypochlorite for 10 mins., rinse	

Item	Recommended Method	Alternative Method
X-ray films : (with disposable plastic cover)	Dispose the cover and change gloves	Remove Plastic Packet and drop the film with non-touch technique in red light, Change gloves before processing
X-ray films : (without disposable plastic cover)	Rinse, immerse in 0.1% sodium hypochlorite for 2 mins., rinse	

B. MODALITIES TO PREVENT SPREAD OF COMMUNICABLE DISEASES

Dr. Surekha Bhedasgaonkar

1. Screening of patients
2. Creating Triage Area (Temporary Isolation till confirmation of healthiness) glass / acrylic Screen fitting
3. Use of Barrier Techniques
4. Adequate cleansing & Disinfection between patients
5. Following Entire Immunization protocol for Dental Man Power
6. Biomedical waste management
7. Waterline & waste line management
8. Use of TLD Badges & lead shields for x-rays
9. Slips / Trips / fall / cuts / sharp / stabs / Burns / explosions / imitations / shocks / electrocution
10. Dental materials related chemical Hazards
11. Use of Air Ventilation System
12. Physical & mental stress relief programme necessary

C. DENTAL CLINIC RELATED OCCUPATIONAL HAZARDS

Dr. Surekha Bhedasgaonkar

All the Dentists & Dental Auxiliaries are constantly at Risk to their own health. So, a judicious use of every possible safety measure is most warranted Hazards are of various types

HAZARDS

- Biological Hazards
- Chemical Hazards
- Physical Hazards
- Psychological Hazards

TRANSMISSION OF COMMUNICABLE DISEASES

- Cytomegalovirus
- Hepatitis B
- Hepatitis C
- HIV
- Mycobacterium
- Staphy lo
- Strepto
- URT

ROUTES OF CONTACT

- ► Direct contact with Blood / Body fivids
- ► Indirect contact with contaminated instruments
- ► Airborne Transmission thro Aerosols
- ► Droplet splatter

D. RISK OF OCCUPATIONALLY ACQUIRED BLOOD BORNE INFECTIONS AMONG DENTAL WORKERS AND ITS MANAGEMENT IN DENTAL CLINIC

Dr. Abhay Kolate

A general increase m serious transmissible disease over the last few decades has created global concern and grossly influenced the treatment approaches adopted by all the health care Practitioners. Health care workers have the added risk of contracting such infections with hepatitis B virus GHBV) and hepatitis C virus (HCV) and HIV due to their respective occupational needs.

HIV/ACQUIRED IMMUNO DEFICIENCY SYNDROME (AIDS)

Available data indicate that the risk of transmission of HIV in dental settings is very low. About 85% of the exposures which resulted in HIV seroconversion among these workers were percutancous injuries. HIV seroprevalence studies among dentists and other dental workers, such as hygienists and assistants, indicate very low rates of HIV infection. The extent of HEV exposure (both occupationally and non-occupationally) among the dental workers tested, however is unknown. In addition, some of these rates may be underestimated as persons who believe they are HIV-infected and who have non- occupational risks may not volunteer to be tested. Nevertheless, studies to date have not indicated a high rate of previously undetected HIV infection

among the dentists sampled.

A case of AIDS is defined as reliably diagnosed opportunistic diseases in an adolescent or an adult at least moderately indicative of underlying cellular immunodeficiency and with no other known cause of any reduced resistance reported to be associated with secondary immunodeficiency and associated with immunosuppressive therapy, Lymphoreticular malignancies, or starvation.

Human Immunodeficiency Virus is an infection that afflicts globally arid the end point of it being AIDS. According to the statistics in India HIV estimations 2015 report, the total number of people living with HIV in India is estimated at 21.17 lakhs, among which children (<5 years) accounting for 6.54% and 40.8% of infections are among females. Patients infected with HIV are medically complicated and their health status can change rapidly making it especially important that dental professionals obtain a thorough health history Careful assessment of the patient's health can aid in determination of the potential influences of HIV disease stage on dental treatment planning.

Health-care workers are key players in the prevention & management of HIV infection This includes oral health-care workers COHCWs) who have a significant role to plays in the overall health-care delivery to patients with HIV- AIDS, Poor knowledge about HIV transmission among health care workers will lead to potential stigma and lack of treatment for people living with HIV.

TRANSMISSION AND ETIOPATHOGENESIS

Blood, blood products factor VHI, infected semen, urine. faecal materials, and rarely through saliva because only small minority of individuals harbours the virus in saliva. Immunoglobulin A (1gA) antibody which present in saliva neutralize the infectivity of virus (HIV loses its infectivity when it is exposed to mixed saliva for 30 min.

The clinical features in HIV infections are not primarily due to the virus but secondary to immunosuppression. According to WHO. an individual diagnosed as HIV positive exhibit least two major signs with one minor sign, provided there are no other known secondary causes of immunosuppression. The major sign includes weight loss of >10% of body weight and chronic diarrhoea of >1 - month duration, prolonged fever, and minor sign includes recurrent oropharyngeal candidiasis persistent generalized lymphadenopathy, persisted cough for >1 month, generalized pruritic dermatitis. recurrent herpes zoster, and progressive disseminated herpes simplex infection.

BARRIERS IN PROVIDING DENTAL TREATMENT TO HIV/AIDS INFECTED PATIENTS

Previous studies have suggested that knowledge may affect attitudes towards treatment of HIV/ AIDS patients. A thorough understanding of these barriers can help reduce the stigma of treating HIV/AIDS infected patients. The main barriers involved are :

1. Infection control procedures required for treating patients with HIV/AIDS can be cumbersome, time consuming, and

financially burdensome for the practice.

2. Lack of awareness regarding the ethical responsibility to treat patients with HIV.

3. Fears related to cross infection.

Procedures to prevent transmission between patients and dental care workers, as well as from one patient to another should always be followed, regardless of a patient's HIV status. Dentists should be taught that universal precautions should be used with all patients, since dentists and patients themselves will not always be aware of who is HIV- positive.

STEPS TO OVERCOME THE BARRIERS

To prevent HIV/AIDS, standard precautions are mandatory when treating all patients. Proper infection control practices must be implemented alongside improving practitioners' knowledge through intervention programs. The following recommendations should be adopted to mitigate the barriers,

Reducing the probability for disease transmission

A major concern for any clinician treating HIV-infected patients is to minimize the risk of exposure for themselves, their staff and other patients. Dental procedures frequently cause bleeding and exposure to infected blood is a known means of HIV transmission. Saliva has not been shown to transmit HIV in a dental setting, but the potential for exposure to bloody saliva does exist.

Possibility of infection after exposure with infected blood

The type of occupational blood exposure most likely to transmit bloodborne infection is a percutaneous exposure. Prospective studies of several thousand HCWs indicate that the risk of seroconversion from a single percutaneous exposure to HIV infected blood is approximately 0.3%. Laboratory studies suggest that during an exposure, less blood is transferred by needles that pass through latex gloves; are of smaller gauges; or are solid rather than hollow-bore.

To reduce the risk of disease transmission, the American Dental Association ADA, the Occupational Safety and Health Administration (OSHA), and the CDC have set standards of infection control for dental health care personnel (DHCP)

a) **Standard Precautions:** These include use of protective attire (e. g. gloves, masks. protective eye wear or face shield and gowns) considered to prevent skin and mucous membrane exposures. Other protective equipment (e.g. finger cots or similar protective coverings for additional safety) might also reduce injuries during dental procedures wearing of double gloves. Face masks, caps and other protective equipment contaminated with blood splatter should be replaced immediately. Gloves should be removed at last after removing mask, cap and gowns. Using a rubber dam for restorative and endodontic procedures can help reduce splatter and the risk of cross-contamination.

b) **Preventing sharp and needle stick injury:** Engineering controls are the primary method to reduce exposures to blood and OPIM (other potentially infectious material) from sharp instruments and needles. These controls 'are frequently technology-based and often incorporate safer designs of

instruments and devices to reduce percutaneous injuries. Percutaneous exposure of blood was reported among dental workers with cutting devices such as sealers, burs; smaller gauge hollow-bore needles and explores and also during use of device or afterward during clean-up or recapping. Adhering to current recommendations for safe handling of needles and other sharp instruments can prevent such injuries.

Work-practice controls help to protect DHCP (Dental health care professionals) whose handle, assemble, or processing sharp devices. (e.g. needles. sealers, laboratory utility knives, burs, explorers. and endodontic files) or sharps disposal containers. Work-practice controls such as removing burs before disassembling the handpiece, reduce the risk of accidental injuries from the dental unit, restricting use of fingers should be avoided for tissue retraction or palpation during suturing and anaesthesia administration. Additionally movements of instruments like scalers or laboratory knives should be controlled. Sharp instruments should not to be handed directly to the operator, but are required to be delivered via kidney tray. All sharp instruments should be stored in clearly labeled, puncture proof plastic containers to ensure safe disposal and handling.

c) **Careful evaluating the patient's health:** Can help access how the stage of HIV disease might influence dental treatment planning. Patients are generally well-informed about their health status, including medications, CD4 counts, and viral loads. To complete medical assessment, dentists may need to obtain details from the patient's primary physician, ensuring a signed, HIV-specific consent from is in place.

In general, the evaluation of the patient's health allows for:

a) Identifying and investigating for medical problems.

b) Calculating the risks to the patient associated with the provision of dental treatment and

c) Assessment of conditions and diseases that may require modifications in dental treatment.

In evaluating the HIV- infected patient, concerns can be generally classified as being related to issues of -

a) Hemostasis.

b) Infections.

c) Drug interactions.

d) Tolerance to treatment.

Patients may refrain from providing necessary medical information either because they are unaware, ill or do not realize its relevance to dental care. As a result dental health care providers often must probe for information in order to ensure that all relevant health information is gathered.

Prior to requesting any medical information, dentists should obtain a signed consent from the patient (a consent form that is specific for requesting information on HIV-infected patients).

d) Sterilization and disinfection of dental instruments:

Sterilize surgical instruments that penetrate soft tissue or bone using autoclaves at recommended parameters. Instruments that are not meant to penetrate oral or hard tissues but that may

come into surface contact with oral tissues should also be sterilized after each use, if possible; however, if sterilization is not feasible, the latter instruments should receive high-level disinfection.

Before high-level disinfection or sterilization, instruments should be cleaned to remove debris. Cleaning May be accomplished by a thorough scrubbing with soap and water or a detergent, or by using a mechanical device (e.g. an ultrasonic cleaner), Persons involved in cleaning and decontaminating instruments should wear heavy-duty rubber gloves prevent hand injuries. Metal and heat-stable dental instruments should be routinely sterilized between use by steam under pressure (autoclaving), dry heat, or chemical vapor. Reusable instruments must be cleaned, autoclaved, and if needed, re-autoclaved. Then washed with soap and water & Re-autoclaved. The hand piece needs to be sterilized by ethylene oxide gas. This gas is used to clean both external and internal surfaces. This type of sterilization takes several hours to overnight. The hand pieces with metal bearing turbine are best sterilized by autoclaving. The contaminated instruments are adequately sterilized by dipping them in 2% glutaraldehyde for 10-30 min or 10% formaldehyde. Impressions made with alginate or rubber base materials should be disinfected with suitable solutions and sealed in an bag for transport. The rubber base impressions are rinsed with dilute hypochloric solutions or chlorine compound. The adequacy of sterilization cycles should be verified by the periodic use of spore-testing devices and chemical indicators in each cycle. Heat- and steam-sensitive chemical indicators may be used on the outside of each pack to confirm that it has been exposed to a sterilizing cycle.

At the completion of work activities, countertops and surfaces that may have become contaminated with blood or saliva should be wiped with absorbent towels to remove extraneous organic material, Heat-stable instruments must be cleaned & sterilized by autoclaving, dry heat, or chemical vapor. Non-autoclavable instruments should be immersed in 2% glutaral-dehyde for the manufacturer-recommended time, cleaned with warm water. Verify sterilization efficacy with sporetesting devices and chemical indicators in each cycle. Laboratory specimen should be placed in 10% formalin jar, with tight leak proof cork. It is kept in a bag and tightly closed and sealed, before transportation to laboratory a solution of sodium hypochlorite (household bleach) should be prepared fresh daily as it is an inexpensive and very effective germicide. Concentrations ranging from 5.000 ppm (a 1:10 dilution of household bleach) to 100 ppm (a 1:100. dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g. blood. mucus, etc.) present on the surface to be cleaned and disinfected. Caution should be exercised, since sodium hypochlorite is corrosive to metals, especially aluminum. In case of spillage of blood or body fluid, it should be mopped up using gloves and old linen/paper towel or news paper and the area is to be covered with 1% sodium Hypochlorite. Floor is wiped with soap and water followed by 1% sodium hypochlorite.

The waterlines are best sterilized by iodophor or diluted sodium hypochlorite. All waterlines that could become contaminated during normal use such as hand pieces, ultrasonic scalars and three-way syringes should be flushed for 1-2 min after each patient, before practitioner leaves the office und preparing

system for next day. Suction bottle should contain 30 ml of 2% glutaraldehyde or 60 ml of 1% sodium hypochlorite. It is carefully emptied out, rinsed and autoclaved after surgery.

Post exposure prophylaxis

Prospective studies of HCW's (Health care workers) have estimated that the average risk for HIV transmission after a percutaneous exposure to HIV-infected blood is approximately 0.3% and that after a mucous membrane exposure it is 0.09%. After an occupational blood exposure, first aid should be administered as necessary.

Puncture wounds and ether injuries to the skin should be washed with soap and water: mucous membranes should be flushed with water, No evidence exists that using antiseptics for wound care or expressing fluid by squeezing the wound further reduces the risk of blood bone pathogen transmission; however, use of antiseptics is not contraindicated. The application of caustic agents (e.g.. bleach) or the injection of antiseptics or disinfectants into the wound is not recommended.

Exposure of any kind should immediately be informed to the infection-control coordinator or other designated person, who should initiate referral to the qualified health care professional and complete necessary reports. Information from a retrospective case-control study of HCWs suggest that ZDV (Zidovudine) PEP may reduce the risk for HIV transmission after occupational exposure to HIV infected blood. ZDV and other reverse transcriptase inhibitors may be important for PEP by preventing early viral dissemination.

Conclusion

Irrespective of the degree of disorder that happens in the human body, it manifests itself in the oral cavity too. We us dentists, the guardians of oral cavity must not fail in our duty to prevent identity, diagnose, and manage this foray of orally manifested disorder to our level best which post a major threat to our society and humanity.

HEPATITIS

Viral hepatitis is a global public health condition affecting millions of people every year, causing disability and death. Dental health care professionals are said to be at a risk of the infections caused by various microorganisms including Mycobacterium tuberculosis, hepatitis B and hepatitis C viruses (HBV and HCV, respectively), streptococci, staphylococci, and herpes simplex virus type 1, HIV, influenza, and rubella. HBV and HCV infections are the major causes of liver disease worldwide and the health policy makers try to control these infections to a greater extent. Chronic hepatitis caused by HBV and HCV is a major health care problem with an estimated worldwide prevalence of hepatitis B being 28% and of hepatitis C being around 3%.

Transmission of infection

Most investigators believe that dental health professionals may acquire the virus through a cut in the fingers contaminated by the patient's blood or saliva other cause is the nasopharyngeal secretions that carry the virus may be acquired by aeresol, although the possibility is remote. Dental surgeons have a great risk of exposure to hepatitis because of their numerous encounters

involving the use and disposal of sharp. Every health care specialty that involves contact with mucosa, blood, or blood contaminated with body fluids should have the goal of implementing compliance with standard precautions and other methods to minimize infection risks.

General picture of types of viral hepatitis

Infectious hepatitis (hepatitis A) was thought to be orally acquired, with a short incubation Period of about 50 days and tending to occur primarily in children and young adults. sporadically and in epidemics. 'The course runs from 6 to 8 weeks and the disease normally resolves with no sequelae.

Serum hepatitis (hepatitis B) was thought to be parenterally transmitted, with an incubation period of 0-100 days. It occurs sporadically in any age group, but older individuals are more affected.

HCV was identified as the causative agent of 95% of cases of non-A non-B hepatitis in 1989. The exact mechanisms by which the HCV causes liver damage are not completely understood. However, it appears that a person's own immunological response to the HCV contributes significantly to this process. The incubation period is variable, ranging from 3 to 20 weeks with a mean of 7 weeks. Most infected individuals have a transient alanine aminotransferase (ALT) level elevated greater than tenfold before the symptoms develop.

Hepatitis D virus (HDV) is an RNA defective virus which has no independent existence. It requires HBV for replication and has the same sources and modes of spread as HBV. It can infect

simultaneously with HBV or it can superinfect those who are already chronic carriers of HBV. Thus, prevention of HD infection is similar to prevention for HBV and relies strongly on HBV vaccination.

Hepatitis E virus (HEV) is an RNA virus which is excreted in the stools and spreads by the faecal-oral route. The clinical illness resembles acute Hepatitis A virus (HAV) infection and recovery is the rule. Chronic infection does not occur. Hepatitis G virus (HIG) is an RNA Virus that rarely occurs as a solitary infection and usually appears as a co-infection with hepatitis A. B. or C. IIGV is known to be transmitted through the blood and has frequently been associated with transfusions.

Hepatitis and Dental Professionals

In a dental office, infections can be transmitted through several routes, including direct contact with blood, oral fluids, or other secretions: indirect contact with contaminated instruments, operatory equipment, or environmental surroundings; or contact with airborne contaminants present in either droplet splatter or aerosols of oral and respiratory fluids. HBV is the major etiologic agent of acute and chronic liver infection, cirrhosis, and primary hepatocellular carcinoma worldwide.

There are more than 300 million carriers of the virus globally, and about 90% of these live-in developing countries. Among the global carriers, 75% are from the Asian continent; where between 8% and 15% of the population carries the virus. It has been documented that HBV infection is the most important infectious occupational hazard in the dental profession.

A number of reports suggest that a significantly higher incidence of HBV infection may be acquired by the dental professionals, and amongst them the oral surgeons, periodontists, and endodontists are more vulnerable to be affected with such infections.

Vectors of infection with HBV in periodontal practice are blood, saliva, and nasopharyngeal secretions. Intraorally, the greatest concentration of hepatitis B infection is in the gingival sulcus. Also, periodantal disease, severity of bleeding, and bad oral hygiene is said to be associated with the risk of HBV.

Blood is very often found in the aerosols produced by the dental equipment's such as ultrasonic scalar or other high-speed equipment's. Ultrasonic scaling is obviously associated with increased air contamination levels, confirming the results reported by several other studies showing that this procedure. Is the main executer of airborne contaminants in dentistry.

Patients with periodontal disease showed higher detectability rate of surface antigen of HBV (HBsAg), anti-HBc, anti HCV, or both anti-HCV and anti-HBC in whole unstimulated saliva than the controls. No undisputed case of HCV salivary transmission has been documented. However, the existence of other routes of transmission is possible. HCV-RNA has been detected in the saliva and salivary glands of patients with sialadenitis, Most HCV patients (77%) had higher HCV RNA levels in their gingival sulcus than in their saliva, and HEV- RNA was found in toothbrushes of hepatitis C patients. Sharing these objects by their household members could be a theoretical risk of infection.

Prevention and management of Hepatitis in Dental clinic

To decrease the burden of hepatitis in dental health professionals, it is recommended that they should invariably receive immunization against hepatitis virus and should use individual protective equipment's to barrier them and their patients against infections.

Despite the availability and recommendations on hepatitis B vaccination, the vaccination rate among dental professionals has remained absolutely low in developing countries.

It has also been found that 5-10% of normal subjects do net produce the anti-hepatitis B surface antibody (anti-HBs) after receiving a standard course of HBV vaccine. Thus, a post-vaccination testing, 1-3 months following the third dose of vaccine, is recommended for health care workers, who have contact with blood,

Exposure that might place a dentist at risk of hepatitis infection includes percutaneous injuries (needles tick or cut with a sharp object) and/or contact with potentially infectious blood, tissues, or other body fluids, mucus membranes of the eye, nose, or mouth or non-intact skin.

Diagnosis of the disease

The disease can be dingnosed by quantifying the levels of HBV DNA, HBs Ag, and the antigen/antibody ratio by means of immuno- enzymatic assays. Different enzyme-linked immunosorbent assay and recombinant immunoblot assay techniques have been developed for the diagnosis, though the diagnostic gold standard remains detection of the viral genome

using real time- polymerase chain reaction (RT-PCR) technology. When the disease has developed and the infection is well established, a liver biopsy must be performed to establish the amount of fibrosis and the severity of the inflammation. These findings help the hepatologist determine the treatment needs of the patients and help establish wise treatment decisions.

Recommendations for treating hepatitis patients

1) Dental treatment other than urgent care should be avoided in patients with acute viral hepatitis.

2) Hepatitis B is of primary concern to the dentist. Individuals still carry the virus up to 3 months after the symptoms have disappeared, so any patient with a recent history of hepatitis B should be treated for dental emergency problems only.

3) For patient with a past history of hepatitis, consult the physician to determine the type of hepatitis, course and length of the disease, mode of transmission, and any chronic liver disease or viral carrier state.

4) For recovered HAV or HEY patients' routine dental procedures can be undertaken. However, far recovered HBV and HDV patients consult with the physician and proceed as per the advice.

5) Patients who are anti-HBs positive or HBsAg negative may be treated routinely.

If a patient with active hepatitis, positive-HBsAg (HBV carrier) status, or positive HCV status requires emergency treatment, use the following precautions

► Consult the patient's physician regarding status.

► If bleeding is likely during or after treatment, measure prothrombin time (PT) and bleeding time. Hepatitis may alter coagulation process in such individuals which may require modifications in the treatment accordingly.

► It has been found that HBV and HCV exist on various surfaces in the dental operatory even many days after treating patients positive with hepatitis B and C. HCV can remain stable at room temperature for over 5 days therefore all personnel in clinical contact with the patient should use full barriers to protect themselves.

► All disposable items should be placed in a lined waste basket. After treatment, these items and all disposable covers should be bagged, labeled, and disposed of following proper guidelines for bio-hazardous waste.

► Aseptic techniques should be followed at all times. Minimize aerosol production by not using ultrasonic instrumentation, air syringe, or high-speed handpieces. Remember that saliva contains a distillate of the virus and pre-rinsing with chlorhexidine gluconate for 30 seconds is highly recommended in such patients.

► When the procedure is complete, all equipment's should be scrubbed and sterilized. If an item cannot be sterilized of disposed of it should not be used. All working and environmental surfaces should be wiped with 2% activated glutaraldehyde.

Post exposure prophylaxis

To avoid the risk of possible infection, the World Health

Organization introduced guidelines for prevention of possible infection caused by hepatotropic viruses and HIV. Mandatory prototol PEP is implemented in six steps discussed below

Step one: Management of the site of exposure

The site of exposure to potentially infectious fluids should be washed as soon as possible using soap and water only, while tie exposed mucus membranes should be washed with water only. Eyes should be flushed with water and saline solution (if there was contact with potentially infectious fluids). The rationale behind these measures is to reduce the number of viral units to lower the threshold count required to cause infection. In this sense, dilution with water may lower the viral count to lower this threshold.

Step two: Report and documentation

Occupational exposure should be reported immediately. Details of the exposure and the administered prophylaxis should be recorded in the employee's medical record. The documentation should include Date and time of exposure, details of the accident, (where and how the exposure happened, what was the site or sites of exposure on the body, if the exposure was associated with a sharps- type and brand of sharp), details of exposure accident (type and amount of fluid or material a person was exposed 10), severity of injury (or different kind of exposure), and details about the source of infectious material, The following should be checked.

► Does the source of potentially infectious material have HBV, HCV or HIV infection?

► If a patient the source of material, is HIV positive, the stage of disease or the level of infectious particles in the blood

should he determined.

► It is important to note the history of taking antiretroviral therapy, or antiretroviral resistance (if known)

► It is necessary to record the details of the exposed person (HBV vaccination, the response to vaccination und other medical conditions).

Step three: Assessment of exposure

The potential for spreading the infection of HBV, HOV, or HIV should be evaluated based on the type of infective material, the site of entry into the body of the exposed person, and the severity of exposure. Significant exposure may be a risk for further transmission of pathogens by blood and requires further evaluation of body fluids: Blood, sperm, vaginal secretions, cerebrospinal, synovial, Pleural, peritoneal, pericardial, and amniotic fluid. Body fluids that do not present the risk of transmitting infectious agents of this type, unless they clearly contain blood, are urine, sputum, saliva, stool, vomit, nasal excrete, tears and sweat.

Step four: Evaluation of sources

When the patient source of infectious material is known, it is necessary to follow these:

► Test the patient for anti-HBsAg. HCV and HIV antibodies

Evaluation of "viral load" (the level of infectious particles in the bleed) for routine control of a patient source is NOT recommended.

Test the patient by rapid HIV test, if the patient is NOT

infected with either of these viruses after primary lest of the exposed person, further control monitoring is not required.

Step five: Specific prophylaxis

Primary testing of all exposed persons to HBV, HCV and HIV should be done after each exposure to potentially infectious fluids. If the exposed person had previous infection caused by any of those viruses and did not know about it, he/she should receive the antiviral treatment rather than prophylaxis.

Management of exposures to hepatitis B virus

Any blood or body fluid exposure to an unvaccinated person should lead to the initiation of the hepatitis B vaccine series (Recombivax HB® 10 meg. or Energix- B® 20 meg. 1M at 0, 1 and @ months), When hepatifis B Immune Globulin (HBIG) is indicated, it should be administered as soon as possible after the exposure (preferable within 24h. but it is recommended up to 1 week following an occupational exposure). Hepatitis B vaccine can he administered simultaneously with HBIG but at a separate site. Test for antic HBs must be performed 1-2 months after the last dose of vaccine. Anti HBs cannot be ascertained if HBIG has been administered within the previous 6 weeks.

Management of exposures to hepatitis C virus

On exposure to HCV test for antic HCV must be carried out for the source. Baseline testing a for anti-HCV and Alanine aminotransferase activity (ALT) should be carried out for the exposed person. The most recent assays arc based on the use of RT-PCR) as they can detect minute amounts of HCV RNA and accurately quantify HCV RNA levels up to approximately 107

Wan. Follow- up testing for anti; HCV and ALT activity and HCV RNA by PCR at 4-6 weeks must be carried out for early detection. Results reported positive by enzyme immunoassay with supplement test should be confirmed.

Step six: Control surveillance

If any of medical staff was exposed to hepatitis, it would be necessary to do control testing for HBV including man datary counseling. This considers the following:

Testing for anti-HBs antibodies 1-2 months after the last dose of vaccine [anti- HBs antibodies cannot be tested 6-8 weeks after the administration of anti-HBs immunoglobulin (HBIG) because of the possibility for false-positive results] .

Advising the exposed person not to donate blood, plasma, organs, tissue, sperm, and to abstain from risky behavior.

Conclusion

Celebrating World Hepatitis Day every year for increasing awareness in the community is also an opportunity for the people and health policy makers globally for more knowledge sharing and finding better approaches for control of HBV and HCV infections. The role that a dentist can play in prevention of hepatitis is by considering each and every patient as a potential carrier of hepatitis. Proper infection control and sterilization protocols should be followed in order to reduce the risks of infection Dental surgeons are at a greater ad of 4 exposures than the other specialists in the medical fields because of their exposure to aerosols during routine dental procedures. So, they should Jay special emphasis on prevention and protection against hepatitis.

E. IMMUNIZATION PROTOCOL FOR DENTAL HEALTH CARE WORKERS

Dr. Maya Indurkar

The dental environment is associated with a significant risk of exposure to various organisms. The infectious agents may be transmitted by direct, indirect and airborne route. Dental health care workers may be exposed to a variety of microorganisms via blood or respiratory secretions.

CDC recommends that all dental health care workers who are at risk of exposure be vaccinated for:

1. Hepatitis
2. HIV
3. Influenza
4. Tetanus

1. HEPATITIS:

Viral hepatitis is currently divided into five primary types:

A, B, C, D, E

► **Hepatitis A:**

Most infections are subclinical with no known carrier state.

Incubation period is 2 to 6 weeks

► **Hepatitis C:**

Incubation period is 2-25 weeks

► **Hepatitis D (Delta hepatitis):**

It can occur clinically only if the individual has been simultaneously infected with HBV or is a carrier of Hepatitis B.

Hence, immunization with Hepatitis-B vaccine will prevent infection of Hepatitis D

► **Hepatitis B:**

Incubation period is 45 to 160 days (average being 60-120 days).

The onset of disease is generally insidious, prodromal phase begins suddenly with anorexia, malaise, nausea, vomiting and fever.

Modes of transmission of hepatitis B:

HBV is transmitted both percutaneously and non-percutaneously.

Percutaneous transmission occurs through injury by contaminated small, sharp instruments. Non-percutaneous transmission occurs by transfer of infectious bodily secretions such as saliva, blood, and crevicular fluid.

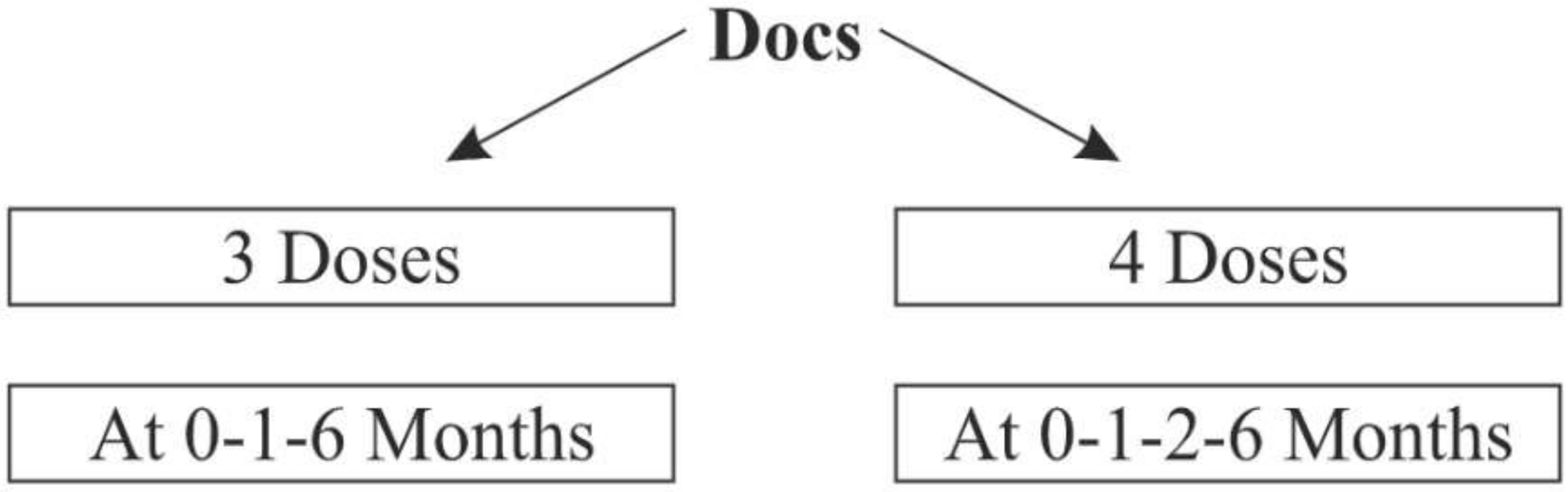
Treatment of hepatitis B:

Sub-cutaneous administration of interferon alfa-2a was effective in inducing a sustained loss of viral replication.

- Prevention of transmission of hepatitis B:
- Plasma derived vaccine

- Recombinant DNA vaccine

Primary HBV vaccination for adults:



- Highly effective in preventing acute infection after exposure if given within 7 days ideally within 48 hours.

Management of hepatitis B post exposure:

Test the exposed person: Baseline testing of the exposed person Should be done at the time of exposure or soon after Follow up testing again at 2- and 6- manths post exposure Check Anti HBs and HBsAg .

Drugs for antiviral treatment of HBV:

a. Pepylated Interferon alfa-2a (Immunomodulator):

180gm once a week by subcutaneous route for 48 weeks

b. Entecavir (Nucleoside analogue):

Preferred drug 0.5mg OD

(1mg OD in Lamivudine resistant case)

c. Thnofovir (Nucleotide analogue):

Preferred drug. 300mg OD Can be given in pregnancy

Prevention of hepatitis B and HIV infection

- If you pierce or puncture your skin with a used needle, follow this first aid advice immediately:
- Encourage the wound to bleed, ideally by holding it under running water
- Wash the wound using running water and plenty of soap
- Do not scrub the wound while you're washing it
- Do not suck the wound
- Flush mucous membrane well with water / saline (at least 1000ml.), if eye, nose, mouth is involved
- Dry the wound and cover it with a waterproof plaster or dressing

2. Treatment of HIV infection

- If your healthcare professional thinks you're at low risk of infection, you may not need any treatment.
- If there's a high risk of infection with HIV, healthcare professional may consider treatment called post-exposure prophylaxis (PEP), Prophylaxis should be started immediately with a single dose of both zidovudine (2DV) 250mg, lamivudine (3TC) 150mg and Kaletra 2 tablet (i.e.,400mg lopinavir + 100mg ritonavir} and prophylaxis should be continued with zidovudine 250mg twice per day and Lamivudine 150mg twice per day and Kaletra* 2 tablets twice per day The full course of PEP is 4 weeks.

3. INFLUENZA

Prevention and control of seasonal influenza vaccines:

For most persons who need only one dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue throughout the season as long as influenza viruses are circulating.

4. TETANUS

Vaccination protocol for tetanus:

For adult who have never received Tdap, a single dose of tdap can be given at any time regardless of when they got last Tdap followed by boosters every ten years thereafter.

If tetanus immunoglabulin is not available, Human Normal Immunoglobulin (HNIG) may be used as an alternative.

Conclusion:

Immunization reduces risk of getting an infectious disease by working with body's natural defenses to build protection. In conjugation with infection prevention and control, vaccination is an effective way of minimizing the impact and spread of infectious disease.

F. RADIATION HAZARDS

Dr. Sunil Sahuji

Medical use of X-rays for diagnosis and treatment has proven to be immensely beneficial to the society at large. However, unsafe use of X -ray radiation has risk associated with it. Therefore it is required that proper care is exercised throughout the lifecycle of equipment, te. from manufacture, supply, installation, use, maintenance, servicing, and lastly its decommissioning. The ionizing radiation has certain radiological hazards which have potential to cause severe injury to health or environmental contamination unless handled safely. Therefore the radioactive sources and the radiation generators are required to be handled safely throughout their life cycle to prevent any undue risk to health and the environment in view of the above, radiation facilities are required to be regulated for ensuring that the use of ionizing radiation does not cause undue risk to the health and environment. The radiological safety review and regulation of such facilities using ionizing radiation in India are carried out by Atomic Energy Regulatory Board (AERB). It is a statutory requirement in accordance with the Atomic Energy (Radiation protection) rules 2004, issued under Atomic Energy Act 1962, to obtain a requisite license from AERB, which is issued after ensuring overall safety in handling the radiation sources. **It is mandatory for all users / owners of medical diagnostic x-ray equipments to obtain license / registration from AERB for**

operation of the equipment as per Atomic Energy (Radiation Protection) Rules 2004 To make this process easy and approachable to the large number of radiation facilities spread throughout the nation, | AERB has taken the initiative to implement the state of art e-governance system e LORA (e - Licensing of Radiation Applications) through an automation of regulatory process associated with the use of ionizing radiation in India. e- LORA is a web-based I & CT (Information and Communication Technology) automated system application establishing direct communication channel between AERB and its stakeholders for exchange of information and communication transaction for its regulatory services as well as for higher efficiency, reliability and transparency in dealing, targeted to a large number of facilities involved in use of ionizing radiation as well as radiation workers working with them for safe service. The process developed in e-LORA system is as pet statutory requirements given by Government of India. Atomic Energy (Radiation Protection) Rules, 2004) and technical documents developed by AERB (viz. Regulatory Codes-Manuals and Standards).

GUIDELINES FOR OBTAINING LICENCE / REGISTRATION FOR OPERATION OF MEDICAL DIAGNOSTIC X- RAY EUVIPMENT THROUGH e-LORA

STEP-1: Registration of your institute: Visit the web site www.aerb.gov.in and click on the button e-LORA. It will redirect you to the e-LORA home page. Use the "Register Institute" option to submit the application for your institute registration (Username and Password will be sent to your e-mail address after

processing of application) detail guidelines for institute registration are available on e-LORA homepage.

STEP - 2 (A): Obtain license for existing medical / dental X-ray equipment (existing / installed prior to January 2015)

1) Click on "Declare existing equipment" and declare all existing equipments one by one.

2) Record of License / Registration against any of the declared equipment, click on "Record License for operation of X-ray equipment" and record the same by uploading scanned copy of License / Registration.

3) Apply for license/ registration - If you have not obtained license / registration from AERB for any equipment, apply for the same by clicking License for operation of existing equipment

STEP -2 (B): License for operation of new medical / dental diagnostic X-ray equipment

1) Obtain procurement permission from AERB for procurement of new X-ray equipment.

2) Apply for license / registration for its operation. You will be able to apply for the license registration, as soon as the supplier submits the installation report to AERB through-LORA. (This is to ensure the purchase of AERB type approved X-ray equipment only.)

Detailed guidelines for obtaining regulatory consents through e- LORA available in the "Help" menu, which can be accessed when you Log in to your e-LORA account.

PRACTICAL TIPS IN ENSURING RADIATION SAFETY IN THE USE OF DENTAL DIAGNOSTIC X-RAY EQUIPMENT

The owner / employer / radiation safety officer need to know the following.

1) Only AERS type of approved X-ray equipment shall be installed / used.

2) Display AERB registration certificate at prominent place for public information

3) Quality assurance tests of dental X-ray equipment is to be carried out periodically and after any maintenance. The records thereof to be maintained

4) TLD badges are provided to all the operators and workers involved during X- ray examination.

5) During non-working hours, TLD badge must be stored along with Control TLO badge outside the X-ray room (in the radiation free area)

6) Sufficient number of lead aprons 1 0.25 mm lead equivalent) and thyroid collars are to be provided for use with dental X-ray equipment. (Minimum 3 sets one for operator, one for patient and one for the assistant.)

7) Lead aprons should be stored either on a hanger or on a flat surface without crumpling.

8) Consistency of lead aprons shall be checked once in two years, qualitative check can be done by taking radiograph of lead aprons.

9) Routine maintenance of dental X-ray equipment are carried out.

10) Radiation: symbol and warning placards in local languages are placed outside the dental k-ray room.

11) Mobile protective barrier: 1.5 mm lead equivalent screen/ partition or fixed protective partition such as concrete / brick wall of minimum 6 inches thickness shall be provided.

12) Room door shall be 1.7 mm lead equivalent and should be closed while carrying out any radiological investigation/ procedure.

13) Display a placard / notice at the prominent place in the reception area for the pregnant women that they must inform the operator about their pregnancy status, so that necessary precautions can be taken by the operator during dental! X-ray examination.

14) Display the necessity of bringing the old X-ray records for the patients.

The personnel (Dentists / Radiographers) who are operating the equipments need to follow:

1) While operating dental X-ray equipment, operate from a distance of minimum 2 meters (6.67 feet) away from the equipment. This can be achieved by extending the switch wire and fitting the switch at desired distance and place.

2) Always use the TLD badge at the chest level while dental X-ray unit is being operated.

3) Always use lead apron (0.25 mm lead equivalent) above /

over the TLD badge.

4) For any radiographic procedure, the angle of emission should be so adjusted that the patient's eyes / thyroid should not come in the primary X-ray beam. Patent's body should be covered by lead apron and the thyroid should be covered by thyroid collar during the X-ray procedure.

5) Provide a lead apron and a thyroid collar to the person assisting to 3 pediatric patient or holding the film / sensor with his figures

6) In any circumstance, the operator should not hold the film / sensor with his figures.

7) Use collimator or long cone to limit the area of interest in order to minimize the radiation: exposure to other organs

8) Portable X-ray equipments should always be positioned on the stand and not to be hold by hands during exposure.

9) The operator must wear an apron and the thyroid collar during the procedure.

10) If the digital sensors are to be used for IOPA X-rays, the operator must use the lead apron and thyroid collar in any circumstances, operator should not hold the sensor with his fingers. He can ask the patient's assistant to-hold the sensor. Patient's assistant should wear the lead apron and thyroid collar.

11) In case of pregnant female patient, patient should be covered with lead apron and the thyroid collar.

THE OCCUPATIONAL EXPOSURE OF ANY WORKER (MALE / FEMALE) SHOULD NOT EXCEED THE FOLLOWING LIMITS.

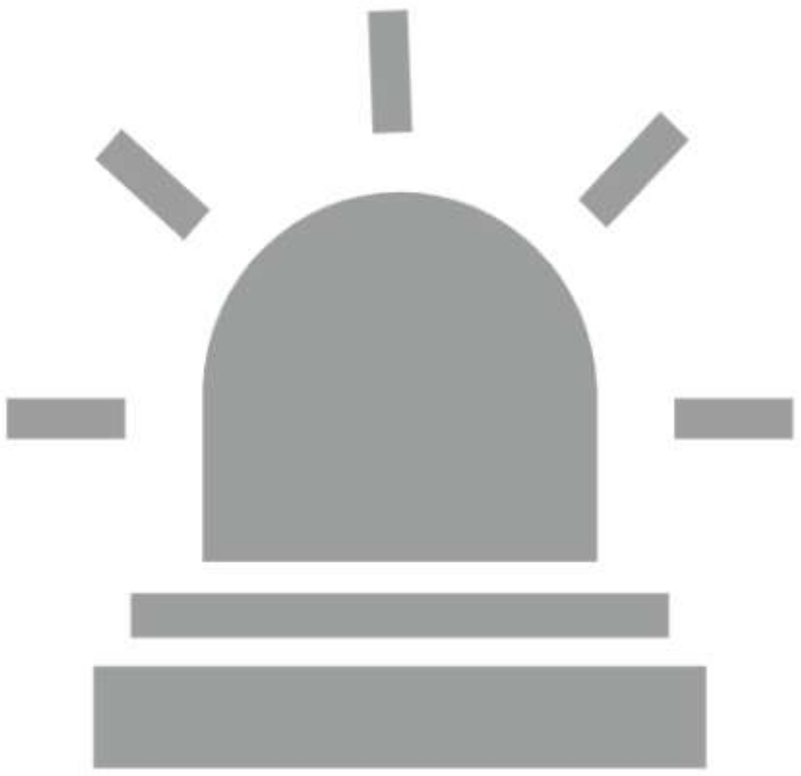
1) An effective dose of 20mSv / yr. averaged over 5 consecutive years.

2) An effective dose of 30mSv / yr. in any one year.

3) An equivalent dose to the lens of the eye of 150mSv in a year

4) An equivalent dose to the extremities (hands and feet) of 500mSv in a year.

MAHARASHTRA STATE DENTAL COUNCIL
MUMBAI



EMERGENCIES IN DENTAL PRACTICE

Dr. Vijay Deshmukh

EMERGENCY IN DENTAL PRACTICE

Sr. No.	Emergency	Features	Drugs
1	Syncope	Fainting Cold-Clammy Skin Sweating Low Pulse	Stimulants - topic, oral If Pulse < 40 - Inj. Atropine 0.6 mg. i.v. If BP < 80 mm - IVF If no pulse, respiration - Cardiopulmonary arrest Start CPR
2	Anaphylaxis	Skin rash Urticaria Agnioneurotic edema Asthama Circulatory collapse Unconsciuosness	Inj. Hydrocort. 100 mg IV Inj. Adrenaline 0.5 mg IV Dexamethasone 8-12 mg IV Inj. Avil 25-50 mg IV Oxygen
3	IHD-Angina Pectoris	Chest pain Breathlessness Pollar, cold Perspiration	Rest and reassurance One or two SL Sorbitrate (0.6 mg) Oxygen if no relief
4	IHD-Acute Mycardial Infarction AMI	Chest pains >>>> Sweating, Vomiting Weakness Unconsciousness	Supine position Oxygen Pain relief - Inj. Fortwin 30 mg IV slow Hospitalization
5	Cardiac Arrest	Unconsciousness No Pulse, BP Respiration Cyanotic Appearance	Inj. Adrenaline 1 mg IV Inj. Soda - bicard 3-4 gm. (7.5%) IV IVF Start CPR

Sr. No.	Emergency	Features	Drugs
6	▸ Hyploglyncemia Insulin Shock	▸ Unconsciousness ▸ Confusion ▸ Weak, Hunger Sweating-cold Skin Blurred Version	▸ Oral Sugar / Dextrose 25% If unconscious ▸ IV Dextrose 25%, Fast
7	▸ Hypertensive Crisis	▸ Chest Pains ▸ Breathlessness ▸ Headache Syncope / Collapse	▸ Supine position and ▸ reassurance Oxygen ▸ SL Sorbitrate or Depin 5-10 g
8	▸ Asthama	▸ Wheezing Air Hunger ▸ Prolonged Expiration	▸ Asthama Spray 2 deep inhalations ▸ Inj. Deriphyline 2 cc IM / IV ▸ Oxygen
9	▸ LA Toxicity	▸ Cortical Stimulation ▸ Cortical Depression ▸ Medullary Stimulation ▸ Medullary Depression	▸ Mild Stimulation - No Treatment ▸ Moderate Stimulation - Inj. Medazolam 2 mg IV ▸ Oxygen ▸ Covulsions - Inj. Succinylcholine 20-40 mg / IV
10	▸ Adrenal Insufficiency	▸ H/O Prolonged Steroid Intake ▸ Hypotension Collapse ▸ Weakness ▸ Cold Clammy Skin	▸ Inj. Hydrocortisone (Effcorlin) 100-200 mg IV ▸ IVF >> BP ▸ Inj. Dexamethasone 4-12 mg IV

A PRACTICAL APPROACH TO MEDICAL EMERGENCIES

Drugs Must in Clinic

- Adrenaline
- Atropine
- Aminophyline
- Avil
- Asthaline
- Dexamethasone
- Dextrose 25%
- Diazepam
- Depin
- Deriphyline
- Sorbitrate
- Oxygen
- Mephentine
- Hydrocortisone
- Soda-bicarb
- Fortwin
- IVF-RL, DNS

Armamentarium

- Scalp vein set
- IV canula
- IV set
- Ambu bag
- Face mask
- Airway
- BP apparatus
- Stethoscope

MEDICALLY COMPROMISED PATIENTS

Sr. No.	Condition	Precautions	Remarks
1	▸ Blood Pressure	▸ History ▸ Medicaments ▸ Physician Opinion 180/110 mmHG ▸ LA	▸ Tab. Nifedepline 5-10 mg SL
2	▸ Myocardial infarction	▸ H/o -1m,^1m, 3m Stent, CABG ▸ Tab. Disprin, Clopodogrel ▸ LA	▸ Tab. Sorbitrate SL ▸ Painless Procedure
3	▸ Anti Platelet Therapy	▸ Drugs-aspirin, Dipyridamole, Clopidogrel ▸ Problem Tests - BT- < 20 min. ▸ PT - 2.5 or < ▸ INR - 3.5 or <	▸ Stop Drug ▸ Consult physician
4	▸ Diabetes	▸ Type ▸ Duration ▸ Problem BSL- < = 180 mg %	▸ Antibiotic cover ▸ LA

Sr. No.	Condition	Precautions	Remarks
5	▸ Hepatic Hepatitis - A, B, C, D, E Alcoholic	▸ Bleeding Tendency ▸ Metabolism - Protein, Carbohydrate, Fat, Vitamins ▸ Factors, Calcium ▸ Unpredictable metabolism ▸ Impaired healing	▸ LFT ▸ Bleeding tendency ▸ PT, BT, CT ▸ Drug, Dose, Inj. Vit K 10 mg IM ▸ Antifibrinolytic agents ▸ FFT, PRP
	▸ Hepatic Hepatitis - A, B, C, D, E Alcoholic		▸ LA-Xylocaine, bupivacaine mepivacaine. ▸ Analgesics-Paracetamol, Ibuprofen ▸ Sedative-Diazepam ▸ Antibiotics-Ampicilin, Tetracycline, Metronidazole, Ciprofloxacin
6	▸ Allergic	▸ History ▸ Xylocaine Skin Test ▸ Drugs	▸ ?Allergy to LA ▸ Allergist referral PDT provocative dose testing ▸ Inj. Diphenhydramine with epinephrine 1:100000 as LA, 1% sol. 1 to 4 ml

Sr. No.	Condition	Precautions	Remarks
7	▸ Renal	▸ Disorders, Transplant ▸ Problem - Excretion Immunosuppressant ▸ Drugs doses - GFR ▸ 50 ml/hr, 1050, 10 ml/hr KFT ▸ Precautions	▸ LA Lignocaine - n/a ▸ Paracetamol - IIBD Ibuprofen - n/a ▸ Penicillins - IIBD Doxycycline Clindamycin - n/a ▸ Diazepamna - n/a ▸ Metronidazole IIBD - d/a
8	▸ Thyroid	▸ TFT-T3T4, TSH ▸ Hyperthyroidism Hypothyroidism ▸ Medicaments	▸ Precautions ▸ Drugs
9	▸ Pregnancy	▸ Trimester ▸ Procedure - type, Necessity, Complications, Benefits over Complications... ▸ Anesthesia ▸ Medicine ▸ Gynecologists opinion	Drugs in Pregnancy ▸ Antibiotics ampicillin, Amoxicillin, Cephalexin, Cefedroxil, Cerfotaxim, Ceftriaxone ▸ Analgesis - Paracetamol ▸ Sedatives - Medazolam ▸ Antiemetics - Ondensetrone, Domperidon ▸ To be strict up to 18 weeks
10	▸ Asthma	▸ Acute asthmatic Attack ▸ Type, PPT, factors ▸ Prior Inhalation ▸ Anti-anxiety drugs ▸ Atmosphere ▸ Allergy	▸ Avoid aspirin, ibuprofen ▸ Enquire drug ▸ Steroid Prophylaxis

Sr. No.	Condition	Precautions	Remarks
11	▸ Epilepsy	▸ Type ▸ Frequency ▸ PPT, Factors ▸ Avoid Pain, Flickering light, Hypoglycemia, Hypotension	▸ Medication Control ▸ To proceed - proper drug intake
12	▸ Chronic Steroid Therapy	▸ Problems ▸ Double Dose	▸ Inj. Hydrocortisone 100 mg IV
13	▸ Cancer Chemotherepy	▸ Bone marrow suppression ▸ Problems counts-RBC, WBC, Platelet	▸ RCT, SF ▸ Avoid oral surgery, sc/p
14	▸ Purpura	▸ Platelet level -^^ 60000 cmm ▸ Fresh blood transfusion ▸ PRP - Platelet rich plasma	▸ Hemostatic Inj. EACA, Ethamsyl ▸ Botropase Inj. Corticosteroids, Gamma globulin

SABE Prophylaxis

Cap. Amoxicillin or Cephalexin 2gm, 30-60 min. Prior to procedure (Children, 50mg/kg dose)

Clindamycin in c/o allergy, 600mg. stat. (Children 20mg/kg)

Azithromycin, Clarithromycin 500mg (15mg/kg)

Inj. Ceftriaxone 1gm IV

BASIC LIFE SUPPORT

Dr. Hemant Dhusia
Dr. Rajesh Gaikwad

BASIC LIFE SUPPORT

Dr. Hemant Dhusia
Dr. Rajesh Gaikwad

Basic life support (BLS) is a level of medical care which is used for victims of life- threatening illnesses or injuries until they can be given fill medical care at a hospital. It can be provided by trained medical personnel, including emergency medical technicians, paramedics, and by qualified bystanders.

Basic life support promotes adequate blood circulation in addition to breathing through a clear airway:

Circulation: providing an adequate blood supply to tissue, especially critical organs, so as to deliver oxy gen to all cells and remove metabolic waste, via the perfusion of blood throughout the body.

Airway: the protection and maintenance of a clear passageway for gases (principally oxygen and carbon dioxide) to pass between the lungs and the atmosphere.

Breathing: inflation and deflation of the lungs (respiration) via the airway

These goals are codified in mnemonics such as ABC and CAB.

Healthy people maintain the CABs by themselves. In an emergency situation, due' to illness (medical emergency) or trauma, BLS helps the patient ensure his or her own CABs, or

assists in maintaining for the patient who is unable to do so.

For airways, this will include manually opening the patients airway (Head tilt Chin lift or jaw thrust) or possible insertion of oral (Oropharyngeal airway) or nasal (Nasopharyngeal airway) adjuncts, to keep the airway unblocked (patent). For breathing, this may include artificial respiration, often assisted by emergency oxygen.

For circulation, this may include bleeding control or cardiopulmonary resuscitation (CPR) techniques to manually stimulate the heart and assist its pumping action.

The AHA-recommended steps for resuscitation are known as DRS CABCDE:

Check for Danger

Check for a Response

Send or shout for help

C directs rescuers to first attend to Catastrophic hemorrhage (life-threatening bleeding) and to stop the bleeding if possible.

A directs rescuers to open the Airway and look into the mouth for obvious obstruction. Also to apply a 'head tilt chin lift' or jaw thrust to open the airway.

B directs rescuers to check Breathing for 10 seconds by listening for breathe at the patient's nose and mouth and observe the chest for regular rising and falling breathing movements

C directs rescuers to maintain Circulation which may be through administration of chest compressions for Cardio Pulmonary Resuscitation (CPR).

D directs rescuers to identify Disabilities (e.g. diabetic or any allergies), Damage (identify broken bones or any minor bleeding), Devices (including use of AED devices available and fellow prompts} and Dry (if casualty is very wet, an AED device will pass current through body surface water and will harm the casualty).

E directs rescuers to take the environment into consideration for weather, location and crowds.

If the patient is unresponsive and not breathing, the responder begins CPR with chest compressions at a rite of 120 beats per minute in cycles of 30 chest compressions to 2 breaths. [f responders are unwilling or unable to perform rescue breathing, they are to perform compression-only CPR, because any attempt at resuscitation is better than no attempt. For children, for whom the main cause of cardiac arrest is from breathing related issues, 5 initial rescue breaths is highly advised followed by the same 30-2 cycles. (SOURCE: https: "en.wikipedia.org/wiki/Basic life support)

Drug	Indication	Initial Adult Dose
Oxygen	Almost any medical emergency	100% inhalation
Epinephrine	Anaphylaxis Cardiac arrest Asthma unresponsive to salbutamol	0.1 mg IV. or 0.3 - 0.5 mg IM 1 mg IV 0.1 mg IV or 0.3 - 0.5 mg IM
Nitroglycerine	Pain of angina	0.3 - 0.4 mg sublingual
Antihistamine (Chlorphniramine / Diphenhydramine)	Allergic reactions	25 - 50 mg IV IM 10 - 20 mg IV IM
Salbutamol	Asthmatic bronchospam	2 Sprays, inhalation
Asprine	Myocardial information	160 - 325 mg

ADDITIONAL EMERGENCY DRUGS

Drug	Indication	Initial Adult Dose
Glucagon	Hypoglycemia in unconscious patient	1 mg IM
Atropine	Clinically significant bradycardia	0.5 mg IV or IM
Ephedrine	Clinically significant Hypotension	5 mg IV or 10 to 25 mg IM
Hydrocortisone	Adrenal insufficiency recurrent anaphylaxis	100 mg IV or IM
Morphine or Nitrous oxide	Angina - like pain unresponsive to nitroglycerin	Titrate 2 mg IV, 5 mg IM - 35% inhalation
Naloxone	Reversal of opioid overdose	0.1 mg IV
Lorazepam or Midazolam	Status epilepticus	4 mg IV or IM 5 mg IV or IM
Flumazenil	Benzodiazepine overdose	0.1 mg IV

CARDIOPULMONARY RESUSCITATION (CPR)

Dr. Hemant Dusia

Dr. Rajesh Gaikwad

BLS IN DENTAL PRACTICE

Life-threatening emergencies can occur anytime, anywhere and to anyone. Such situations are more likely to be encountered in the dental clinics due to increased levels of stress and anxiety which is so often present and also because of ever increasing number of medically compromised patients seeking dental treatment.

Sudden cardiac arrest is a real medical emergency, all collapsed patients should be considered as cardiac arrests, unless otherwise proven. This is a medical emergency where the time and the presence of mind are very crucial. Cardio pulmonary cerebral resuscitation (CPCR) is the most effective management strategy to save the life of a collapsed patient in any setting

Needless to say, all dental surgeons must be able to recognize, prevent, and manage such emergencies till advanced medical help is sought.

This talk will focus on the areas which are considered vital to a proper understanding of medical emergencies and discuss basic steps for CPCR (BLS) and automated external defibrillation (AED) for adult patients

Basic Life Support, or BLS, generally refers to the type of care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing cardiac arrest, respiratory distress or an obstructed airway. It requires knowledge and skills in cardiopulmonary resuscitation (CPR), using automated external defibrillators (AED) and relieving airway obstructions in patients of every age.

Step by Step Guidelines for Basic Life Support

SEQUENCE/ACTION	TECHNICAL DESCRIPTION
SAFETY	•Make sure that you, the victim and any bystanders are safe
RESPONSE Check for a response	•Shake the victim gently by the shoulders and ask loudly: *"Are you all right?"*
AIRWAY Open the airway	•If there is no response, position the victim on their back •With your hand on the forehead and your fingertips under the point of the chin, gently tilt the victim's head backwards, lifting the chin to open the airway
BREATHING Look, listen and feel for breathing	•Look, listen and feel for breathing for **no more** than 10 seconds •A victim who is barely breathing, or taking infrequent, slow and noisy gasps, is not breathing **normally**
ABSENT OR ABNORMAL BREATHING Alert emergency services	•If breathing is absent or abnormal, ask a helper to call the emergency services or call them yourself •Stay with the victim if possible •Activate the speaker function or hands-free option on the telephone so that you can start CPR whilst talking to the dispatcher
SEND FOR AED Send someone to get an AED	•Send someone to find and bring back an AED if available •If you are on your own, **DO NOT** leave the victim, but start CPR
CIRCULATION Start chest compressions	•Kneel by the side of the victim •Place the heel of one hand in the centre of the victim's chest - this is the lower half of the victim's breastbone (sternum) •Place the heel of your other hand on top of the first hand and interlock your fingers •Keep your arms straight •Position yourself vertically above the victim's chest and press down on the sternum at least 5 cm (but not more than 6 cm) •After each compression, release all the pressure on the chest without losing contact between your hands and the sternum •Repeat at a rate of 100-120 min-1

Step by Step Guidelines for Basic Life Support

Correct technique of chest compression in an adult victim. Notice the shoulder of the rescuer is directly above the chest of the victim. The wrist, elbows and shoulders are locked. The chest compression movement is from the hip joint. Quality chest compressions can only be provided on a hard surface.

Step by Step Guidelines for Basic Life Support

SEQUENCE/ACTION	TECHNICAL DESCRIPTION
COMBINE RESCUE BREATHING WITH CHEST COMPRESSIONS 	• **If you are trained to do so,** after 30 compressions, open the airway again, using head tilt and chin lift • Pinch the soft part of the nose closed, using the index finger and thumb of your hand on the forehead • Allow the victim's mouth to open, but maintain chin lift • Take a normal breath and place your lips around the victim's mouth, making sure that you have an airtight seal • Blow steadily into the mouth whilst watching for the chest to rise, taking about 1 second as in normal breathing. This is an effective rescue breath • Maintaining head tilt and chin lift, take your mouth away from the victim and watch for the chest to fall as air comes out • Take another normal breath and blow into the victim's mouth once more to achieve a total of two rescue breaths • Do not interrupt compressions by more than 10 seconds to deliver the two breaths even if one or both are not effective • Then return your hands without delay to the correct position on the sternum and give a further 30 chest compressions • Continue with chest compressions and rescue breaths in a ratio of 30:2
COMPRESSION-ONLY CPR 	• **If you are untrained, or unable to give rescue breathes,** give chest-compression-only CPR (continuous compressions at a rate of 100-120 min-1)
WHEN AED ARRIVES **Switch on the AED and attach the electrode pads** 	• As soon as the AED arrives switch it on and attach the electrode pads to the victim's bare chest • If more than one rescuer is present, CPR should be continued whilst the electrode pads are being attached to the chest
FOLLOW THE SPOKEN/ VISUAL DIRECTIONS 	• Follow the spoken and visual directions given by the AED • **If a shock is advised,** ensure that neither you nor anyone else is touching the victim • Push the shock button as directed • Then **immediately** resume CPR and continue as directed by the AED

Step by Step Guidelines for Basic Life Support

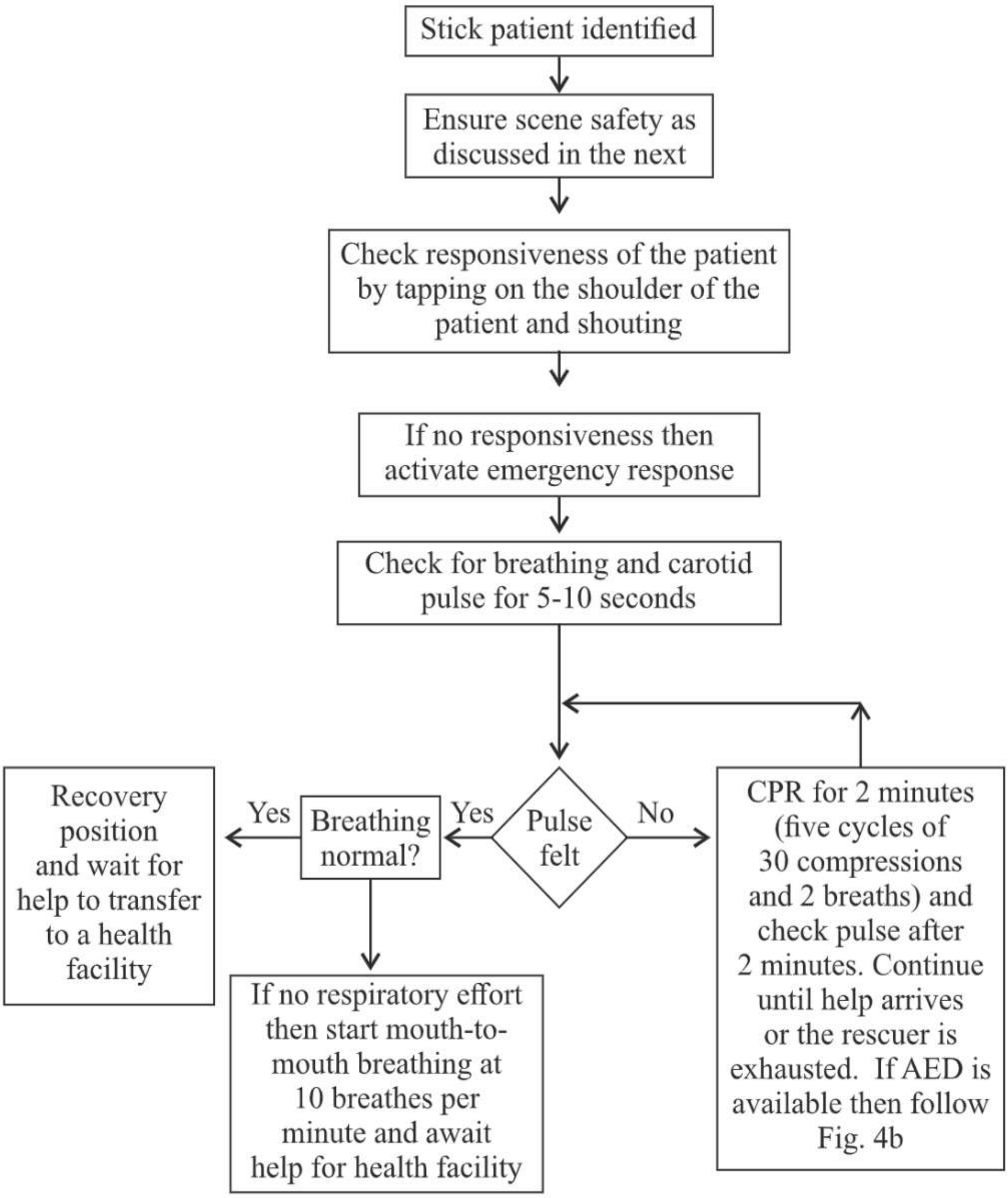
SEQUENCE/ACTION	TECHNICAL DESCRIPTION
IF NO SHOCK IS ADVISED Continue CPR 	• **If no shock is advised,** immediately resume CPR and continue as directed by the AED

IF NO AED IS AVAILABLE
Continue CPR
 	
	• If no AED is available, **OR** whilst waiting for one to arrive, continue CPR
	• Do not interrupt resuscitation until:
	  • A health professional tells you to stop OR
	  • The victim is definitely waking up, moving, opening eyes, and breathing normally
	  • OR
	  • You become exhausted
	• It is rare for CPR alone to restart the heart. Unless you are certain that the victim has recovered continue CPR
	• Signs that the victim has recovered
	  • Waking-up
	  • Moving
	  • Opening eyes
	  • Breathing normally

IF UNRESPONSIVE BUT BREATHING NORMALLY Place in the Recovery Position 	• If you are certain that the victim is breathing normally but still unresponsive, place them in the recovery position **SEE FIRST AID SECTION** • Be prepared to restart CPR immediately if the victim becomes unresponsive, with absent or abnormal breathing

Algorithm for basic life support (BLS) when an automated external defibrillator or AED is not available,

If no responsiveness, then activate emergency response



FOREIGN BODY AIRWAY OBSTRUCTION OR CHOKING

- A patient who has a foreign body in his or her airway can have hypoxic arrest and die within minutes.
- On choking, the patient usually places both hands on the neck, also known as the universal choking sign.
- In this situation, he or she will not be able to breathe, talk, cry or even cough. Sometimes, patients may have stridor or high-pitched noisy breathing.
- The rescuer must be quick to identify these patients, which often happens on the dining table after food is stuck in the airway.
- Having confirmed that the patient is choking, the rescuer should stand behind and encircle the patient using his arms, keeping his fists on the abdomen between umbilicus and the xiphoid process of the sternum.
- Having set his position, the rescuer must give upward and backward thrust in the abdomen. The abdominal thrusts must continue until the object is expelled and the patient can breathe, cough or talk. This technique is popularly known as the Heimlich manoeuvre.
- If the patient becomes unresponsive, the patient has to be laid on the floor and assessed as in cardiac arrest. In unresponsive state, the airway must be opened using the head-tilt chin-lift technique and the rescuer must look inside the mouth and remove any food or foreign body from the mouth if present.
- Blind sweep using a finger should be avoided.

Conclusion

In the event of a cardiac arrest in the dental practice, dental professionals should ensure a swift, effective, and safe resuscitation response to help optimize the chances of the patient surviving.

MAHARASHTRA STATE DENTAL COUNCIL
MUMBAI

ORAL CANCER AWARENESS & ROLE OF DENTISTS

Dr. Namrata Patil

ORAL CANCER AWARENESS & ROLE OF DENTISTS

Dr. Namrata Patil

Introduction

Oral cancer is emerging as a major public health challenge in India, driven primarily by widespread tobacco use. Although screening and early detection can drastically lower mortality, the absence of organized programs often results in diagnosis delays averaging 9 months. This problem is worsened in rural areas, where access to diagnostic facilities and pathology services is limited.

At the heart of this challenge lies the General Dental Practitioner (GDP), who serves as the first point of contact for most patients. However, inadequate training in identifying suspicious lesions, performing systematic oral examinations, and initiating timely referrals means that many opportunities for early detection are missed.

The consequence is clear: delayed diagnosis, poor prognosis, and increased cancer burden.

The way forward is to empower GDPs by:

- Enhancing knowledge of early potentially malignant lesions.
- Strengthening examination and referral skills.

► Reforming dental curricula to place greater emphasis on oral cancer detection and prevention.

By bridging this knowledge gap, GDPs can transform from passive observers into active gatekeepers against oral cancer.

IMPORTANT ORAL POTENTIALLY MALIGNANT DISORDERS (OPMDS)

1. Leukoplakia – most common white patch; risk factors: tobacco, alcohol, betel quid.

► Can be homogeneous (uniform white) or non-homogeneous (mixed, speckled, nodular).

► Diagnosis: visual exam + palpation + biopsy.

2. Erythroplakia – fiery red patch not attributable to any other cause.

► Sites: soft palate, ventral tongue, floor of mouth.

► High risk of malignant transformation (much higher than leukoplakia).

► Management: habit cessation, biopsy essential, surgical/laser excision if dysplasia present.

3. Erythroleukoplakia (red + white lesion) – also high-risk.

► Requires the same approach as erythroplakia (biopsy + removal if needed).

4. Oral Submucous Fibrosis (OSMF) – due to areca nut/betel quid chewing.

► Causes mouth stiffness, reduced opening, fibrosis.

- High risk of malignant change.

RED FLAG SIGNS (NICE GUIDELINES)

Dentists should suspect malignancy if they see:

- Non-healing ulcer > 2 weeks
- Red (erythroplakia) or mixed red-white lesion
- Induration (hardening)
- Exophytic growth (lump)
- Persistent tooth mobility (without gum disease)
- Non-healing extraction socket
- Cervical lymph node swelling

In Case of Red & White Lesions

- Always consider erythroplakia (since it has the highest malignant potential).
- Any red, white, or mixed lesion persisting >2 weeks should be investigated.

ERYTHROPLAKIA – DIAGNOSIS & REFERRAL

Diagnosis

Clinical appearance

- Bright red patch, flat or slightly depressed, irregular outline.
- Common sites: floor of mouth, ventral tongue, soft palate.
- Lesion cannot be wiped off (unlike candidiasis).

Symptoms

- May be asymptomatic.
- Sometimes burning, tingling, or sensitivity to spicy food.

Diagnostic steps

1. History – tobacco, alcohol, betel quid use.

2. Clinical examination – inspect entire oral mucosa for additional lesions.

3. Adjuncts – toluidine blue staining, autofluorescence (optional).

4. Biopsy (incisional) – gold standard.

5. Histopathology – confirms dysplasia or carcinoma (seen in majority of cases)

Nearly 90% of erythroplakia shows epithelial dysplasia or carcinoma → hence considered the most dangerous oral potentially malignant disorder.

Referral (Whom Should Dentist Approach?)

If a general dentist identifies a suspicious red lesion:

- **Immediate referral is mandatory** (do not wait for spontaneous healing).
- The patient should be referred to:

1. Oral & Maxillofacial Surgeon – for biopsy and surgical/laser excision.

2. Oral Medicine & Radiology Specialist – for diagnosis, biopsy planning, and follow-up.

3. Oral & Maxillofacial Pathologist – for histopathological

evaluation and definitive diagnosis.

4. ENT / Head & Neck Oncologist – if lesion is extensive, malignant, or requires advanced cancer management.

Conclusion

General Dental Practitioners are the frontline warriors in the fight against oral cancer. With proper knowledge of potentially malignant lesions, they can recognize danger signs early and guide patients toward life-saving care. Their role extends beyond detection—they provide preventive education, timely referrals, and personalized care that directly influence patient outcomes.

By strengthening their skills, we can ensure earlier diagnosis, reduced morbidity and mortality, and improved quality of life for countless individuals. Continuous education, collaboration with specialists, and access to diagnostic resources will empower GDPs to practice confidently.

Ultimately, when dentists are informed and proactive, they become the key to a healthier, cancer-free future, where oral cancer is detected early, managed effectively, and prevented whenever possible.

DIETARY COUNSELING IS A "MUST DO" IN PEDO PATIENTS & PREGNANT LACTATING WOMEN

Dr. Surekha Bhedasgaonkar

DIETARY COUNSELING IS A "MUST DO" IN PEDO PATIENTS & PREGNANT LACTATING WOMEN

Dr. Surekha Bhedasgaonkar

As it has been proved beyond doubt, that systemic health is directly affected by periodontal health, a constant vigilance becomes a moral duty of every dentist to monitor & maintain optimist. Life style modification & behabioural changes are easier said than done a very rigorous motivation is required to attain both.

So every dentist-should take it as a challenge and perform it as our pious moral duty.

Every aspect of plaque control should be promoted to patients, including,

Physical
Chemical
Probiotic
Dietary Change

In no other fraternity of medical Dental field, the Dicturm Prevention is better than cure. Turns out to be more relevant.

TAPPING INTO YOGA AND MEDITATION FOR HEALING IN THE DENTIST'S ARSENAL

Mrs. Archana Amalapure

TAPPING INTO YOGA AND MEDITATION FOR HEALING IN THE DENTIST'S ARSENAL

Mrs. Archana Amalapure

Dentists, who must focus on precision and patient care, often find themselves overwhelmed by the demands of their profession, Long hours, complex procedures and the need for continual recently can take a toll on both their physical and mental health. Yoga and meditation, both ancient practices, can prove to be invaluable assets in a dentist's toolkit, as they offer a holistic approach to improving posture, managing stress, and promoting overall well being. Let us explore in more detail how these timeless disciplines .can be integrated into a dentist's life.

Perfecting Your Posture:

Dentists can benefit from practicing yoga to improve their posture and reduce the risk of musculoskeletal issues. Yoga poses such as Tadasana (Mountain Pose) and Sukhasana (Easy Pose) can help to create a strong foundation for the body, and promote body awareness and alignment. This can help to reduce strain on the spine, and minimize the effects of long hours spent hunched over patients.

Achieving Balance:

Dentists are tasked with a multitude of obligations, such as caring for patients, managing the staff, and taking care of administrative duties. To help them in achieving balance, dentists

can utilize mindfulness meditation. This practice enables them to stay focused in the present moment, aiding their concentration and promoting a sense of peace even amidst the challenges of juggling multiple tasks Techniques like focused breathing or meditation can be highly beneficial in managing the delicate balance of a dental practice and personal life.

RELIEVING NECK & SHOULDER PAIN: SYRACUSE ORTHOPEDIC SPECIALISTS:

Dental professionals often find themselves in static postures for extended periods, which can cause strain in the neck and shoulder areas. To reduce tension in these areas, yoga stretches and poses can be implemented. Neck stretches, shoulder roils, and poses such as Cat-Cow or Child's Pose can help to reduce stress and prevent chronic pain and musculoskeletal disorders.

Harmonizing the Mind and Body:

To be a successful dentist, it is essential to have a good understanding of different types of patient personalities and be able to communicate effectively. To help with this, yoga and meditation can be used to increase emotional intelligence and self-awareness These mindfulness practices can help dentists to communicate more effectively with their patients. Creating a more positive and compassionate relationship.

Methods to Reduce Stress:

Stress is an unavoidable part of being a dentist, and long-term stress can lead to physical and mental health issues. Meditation is an excellent way to reduce stress and improve

wellbeing. Incorporating breathing exercises, muscle relaxation techniques, and guided meditation sessions into daily routines can help dentists better manage their stress levels.

Environments Other Than the Treatment Room:

Practicing yoga and meditation not only enhances the performance of dentists in their professional lives, but also has a positive effect on their overall wellbeing. Dentists who make these practices a part of their daily routine have reported better sleep, better concentration and higher levels of energy. Such benefits help them to be more resilient when faced with difficult situations.

The Last Word: Concluding Insights:

Dentistry is a field that demands precision and compassion from practitioners. To help they maintain optimal posture and resilience in the face of stress, the dental community is turning to the ancient practices of yoga and meditation. This integration of science and mindfulness is resulting in healthier and more balanced approaches to dentistry, leading to a more rewarding and fulfilling professional journey.

DENTAL SLEEP MEDICINE – A BOON TO DENTAL PROFESSION

Dr Chandrakant Shivkumar Shete

Dental Sleep Medicine – A Boon to Dental Profession
What is Dental Sleep Medicine?

Dr. Chandrakant Shete

- Dental Sleep Medicine is an area of specialization for dentists which focuses on treating Snoring and Obstructive sleep apnea. This field is known as dental sleep Medicine.
- Dentist are often the first Healthcare professionals to suspect the condition based on s igns and symptoms they see in their patients.
- Dentists trained in dental sleep medicine can diagnose and treat Successfully the Snoring and Obstructive Sleep apnea through oral appliance therapy.

Sleep related breathing disorders (SRBD)

- SRBD are disorders characterized by disruptions in normal breathing patterns. SRBDs are potentially serious medical conditions caused by anatomical airway collapse and altered respiratory control mechanisms.
- **Common SRBDs include Snoring, upper airway resistance syndrome (UARS) and obstructive sleep apnea (OSA).**
- OSA has been associated with metabolic, cardiovascular, respiratory, dental and other diseases. In children, undiagnosed and/or untreated OSA can be associated with cardiovascular problems, impaired growth as well as learning and behavioral

problems.

- OSA is also associated with Bruxism, MyoFacial Pain , TMJ pain and Dentofacial Deformities in children.

Dental Sleep Medicine Scope in India

- Approximately 104 million Indians of working age suffer from OSA, of whom 47 million have moderate-to-severe OSA. This represents a major public health problem in India with important implications for the global burden of the disease.

- The dental sleep medicine market has witnessed significant growth in recent years, driven by rising awareness of sleep-related breathing disorders such as obstructive sleep apnea (OSA) and an increasing preference for non invasive treatment options. This market encompasses a range of oral appliances and therapies designed to manage OSA and other sleep disorders through dental interventions.

- The demand for dental sleep medicine solutions is fueled by factors such as the growing prevalence of sleep apnea worldwide, coupled with advancements in dental technology that enable more precise and effective treatment options.

- In addition, collaborations between dental professionals and sleep medicine specialists have enhanced diagnostic capabilities and treatment outcomes, further boosting practice expansion.

- As the field continues to evolve with ongoing research and technological innovations, the dental sleep medicine practice is expected to continue its growth trajectory, offering promising opportunities for manufacturers, dental clinics, and healthcare

providers globally.

People are Becoming Aware of the Risks of Untreated Sleep Apnea

People are becoming more aware of the financial effects of untreated sleep apnea. If left untreated, obstructive sleep apnea (OSA) is a dangerous condition that can seriously harm the heart. Long-term untreated sleep apnea can also result in several linked illnesses, including congestive heart failure, type 2 diabetes, stroke, other sleep disorders, cognitive and memory deficits, and cardiovascular disease or even congestive heart failure. Healthcare industry participants are encouraged by growing knowledge of the financial costs associated with untreated sleep apnea.

In United Sates there are Separate Dental Sleep Clinics for treatment of Obstructive sleep Apnea.

Global Dental Sleep Medicine Market Size was valued at USD 4.9 Billion in 2023. The Global Dental Sleep Medicine industry is projected to grow from USD 5.6 Billion in 2024 to USD 9.1 Billion by 2032, exhibiting a compound annual growth rate (CAGR) of 7.40% during the forecast period (2024 -2032).

Restraints/Challenges in Practicing Dental Sleep Medicine in India

- Lack Of Education about Sleep Apnea in Dental and Health Professional
- Lack Of Authentic Dental Sleep Medicine Course Provider

- Lack Of Authentic Dental Labs which fabricate Customised Oral Appliance
- Lack of public awareness about Snoring and Sleep Apnea side effects in India

My Experience with Dental Sleep Medicine Practice

I did my 3 years research on Obstructive Sleep Apnea during Post graduation in GDCH Nagpur orthodontic department (2012 -15) and the resarch article was Published in **American Journal Of Orthodontics (AJODO) on 2017. I am the only Indian who received 2018 Helen E Dewel award for the best clinical research by AJODO at Washington DC.** I have successfully treated almost more than 900 sleep apnea patients. I give lectures in different CDE activities and Associations on Dental Sleep Medicine. I have innovated different Oral Appliance designs according to patient conditions and having Complete Lab Set Up to provide the Oral Appliance for sleep apnea Patients. My main practice now a days along with orthodontics is treating Snoring and Sleep Apnea Patients. **You Can also Upgrade your Dental Parctice with name and Fame as Dental Sleep Apnea Specialist.**

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HANDBOOK OF DENTAL PRACTICE MANAGEMENT

ISBN
978-81-991517-8-9

Price : Rs. 500/-