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Special Ethical and Legal Issues in Healthcare: Excessive Disclosure, HIV/AIDS Confidentiality and Neonatal Intensive Care

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Abstract : *Healthcare is not limited to diagnosing illnesses and providing treatment, it also involves protecting the privacy, dignity and rights of patients. People share their personal and medical information with healthcare professionals because they trust that such information will be handled with care and used responsibly. However, situations arise in medical practice where this trust may be affected, particularly when information is disclosed without proper justification, when a person's HIV status is revealed, or when difficult treatment decisions have to be made for newborns who cannot express their own wishes. These concerns form the central focus of this study, which examines three important areas: excessive disclosure of patient information, confidentiality in HIV/AIDS-related healthcare and the ethical and legal challenges arising in Neonatal Intensive Care Units (NICUs). The study explores how unnecessary or unauthorised disclosure of medical information can affect a patient's privacy and dignity, and why confidentiality requires greater protection in cases involving HIV/AIDS, where disclosure may expose individuals to stigma, discrimination and social difficulties. It also examines the challenges faced in NICUs, where healthcare professionals and parents must make decisions concerning the treatment and well-being of newborns, often under difficult and urgent circumstances. Such decisions require careful consideration of the child's best interests, parental consent and the responsibilities of medical professionals. Using a doctrinal method of research, the study examines relevant Indian constitutional provisions, statutory laws, professional medical regulations and judicial decisions, along with selected American and international standards. It also considers the extent to which healthcare professionals and institutions can be held accountable when they fail to protect patient information, disregard consent requirements or fall short of their professional duties. The study distinguishes ethical shortcomings from violations that may attract professional disciplinary action, civil liability, consumer remedies or criminal consequences, depending on the applicable law. Finally, the study highlights the need for stronger confidentiality practices, clear consent procedures, effective institutional supervision, proper handling of medical records and accessible grievance-redressal mechanisms. It argues that accountability should not rest only on individual doctors but should also extend to healthcare institutions responsible for creating and maintaining safe and ethical systems of care. Ultimately, healthcare must protect patients not only through treatment but also through respect, responsibility and accountability.*

Keywords: Healthcare Ethics; Patient Confidentiality; Excessive Disclosure; HIV/AIDS Confidentiality; Informed Consent; Neonatal Intensive Care; Medical Accountability; Patient Rights; Medical Negligence.

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I. INTRODUCTION

Healthcare is built on trust, responsibility and the expectation that every patient will be treated with dignity and care. When people approach hospitals, they often share personal information, depend on medical professionals for important decisions and place their lives in the hands of those responsible for their treatment. This creates a duty on healthcare professionals and institutions not only to provide proper medical care but also to respect patients' rights and protect them from unnecessary harm. However, ethical and legal concerns arise when this responsibility is not properly fulfilled. Some of the important concerns in this regard are the excessive disclosure of patient information, the protection of confidentiality in HIV/AIDS-related healthcare and the safety and treatment of newborns in Neonatal Intensive Care Units (NICUs). The disclosure of medical information is sometimes necessary for treatment, consultation or other legally recognised purposes. However, sharing such information beyond what is necessary or legally permitted can seriously affect a patient's privacy, dignity and personal life. This concern becomes even more sensitive in cases involving HIV/AIDS, as the disclosure of a person's HIV status may expose them to stigma, discrimination and rejection by family members or society. Although confidentiality is an important professional and legal obligation, healthcare providers may also face situations where disclosure is permitted or required by law. Maintaining a proper balance between these responsibilities is therefore essential. NICUs present a different set of challenges because newborns are entirely dependent on others for their safety and medical care. While doctors make important treatment decisions, nurses and other healthcare personnel often remain directly involved in the newborns' day-to-day care and supervision. Apart from concerns relating to consent, medical negligence and emergency treatment, incidents such as newborn swapping, kidnapping, trafficking, deliberate harm and other criminal activities raise serious questions about hospital security and professional responsibility. Such incidents make it necessary to examine not only the responsibility of the individual offender but also the possible accountability of hospital management and other persons whose negligence or involvement may have contributed to the incident. These concerns demonstrate that healthcare accountability must extend beyond the delivery of treatment. Against this background, this article examines the ethical and legal dimensions of the three selected areas, identifies the responsibilities of different healthcare personnel and institutions, and considers the legal consequences that may arise from misconduct, negligence or criminal acts. It also highlights practical measures needed to strengthen patient protection, hospital supervision and institutional accountability.

II. EXCESSIVE DISCLOSURE

2.1 Meaning and Nature of Excessive Disclosure

Confidentiality is a basic duty in healthcare.1 Excessive disclosure occurs when identifiable patient information is shared beyond what is necessary for treatment or another lawful purpose, without valid consent or legal authority. It may result from deliberate conduct, curiosity, commercial motives, careless conversations or weak control of medical records. Not every exchange of information is improper: necessary communication among treating professionals and disclosures required by law may be legitimate. The central questions are whether the recipient had a proper need to know, whether disclosure had a lawful basis and whether only the necessary information was shared.

2.2 Common Situations Leading to Excessive Disclosure

Disclosure to relatives without authority: Family relationship alone does not give relatives a right to access an adult patient's diagnosis or treatment details.

Public conversations and displays: Discussing a patient's condition in corridors, reception areas or lifts, or displaying diagnoses on bed charts and doors, may expose information to visitors and unrelated persons.

[1] WORLD MED. ASS'N, *INTERNATIONAL CODE OF MEDICAL ETHICS* (2022), Principle 29 (requiring physicians to respect patient privacy and confidentiality, including after death).

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Digital and social-media sharing: Circulating reports, prescriptions, photographs, scans or treatment videos through messaging applications or social platforms without authorisation can rapidly widen the disclosure.

Unnecessary record access: Employees who access records out of curiosity, or who leave paper files and screens visible to unauthorised persons, compromise confidentiality.

Personal or commercial use: Patient information must not be used for publicity, advertising, personal benefit or research/publication in identifiable form without an appropriate legal basis and safeguards.

These examples show that confidentiality may be breached by both intentional disclosure and ordinary failures in handling information.

2.3 Ethical Issues Associated with Excessive Disclosure

Excessive disclosure violates confidentiality and privacy by removing a patient's control over information shared for care. It may undermine autonomy, cause embarrassment or humiliation, and expose patients to discrimination, family conflict or social stigma.

It also weakens confidence in healthcare institutions: patients who fear exposure may avoid treatment or withhold information essential to diagnosis. For healthcare professionals, unjustified disclosure may amount to professional misconduct and call into question their fitness to handle confidential information.2

2.4 Legal Framework Governing Patient Information

Constitutional protection

Article 21 of the Constitution protects life and personal liberty, including the right to privacy recognised in Justice K.S. Puttaswamy (Retd.) v. Union of India, (2017) 10 SCC 1. Medical records and health information fall within the sphere of personal privacy.3 Articles 14 and 21 also support protection against arbitrary or degrading treatment.

Indian medical professional regulations

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 require professional secrecy. Regulation 2.2 addresses secrecy and confidentiality; Regulation 7.14 restricts disclosure of professional secrets, subject to recognised exceptions such as court orders, serious and identified risks, and notifiable diseases. Regulation 7.17 restricts publication of identifiable patient photographs or case reports without permission.4 Breach may lead to disciplinary proceedings before the competent medical authority.

Information Technology Act, 2000 and SPDI Rules, 2011

Rule 3 of the SPDI Rules treats medical records and medical history as sensitive personal data or information.5 Rules 4–8 prescribe requirements concerning privacy policies, collection, disclosure, transfer and reasonable security practices. Sections 43A, 72 and 72A of the Information Technology Act may be relevant to negligent security failures or unauthorised disclosure, but each provision has specific statutory elements; they should not be treated as a general offence for every privacy breach.

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[2] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, regs. 2.2, 7.14 & 7.17, Gazette of India, pt. III, sec. 4 (Apr. 6, 2002).

[3] *Justice K.S. Puttaswamy (Retd.) v. Union of India*, (2017) 10 SCC 1

[4] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, regs. 2.2, 7.14 & 7.17, Gazette of India, pt. III, sec. 4 (Apr. 6, 2002).

[5] Information Technology (Reasonable Security Practices and Procedures and Sensitive Personal Data or Information) Rules, 2011, rr. 3–8, Gazette of India, pt. II, sec. 3(i) (Apr. 11, 2011).

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Digital Personal Data Protection Act, 2023

The DPDP Act establishes a framework for digital personal data, including electronic health records.6 Its substantive provisions are subject to phased commencement under the relevant notification. The commencement schedule must be checked at the time of publication; provisions not yet in force should not be described as current enforceable duties.

Consumer and comparative standards

Section 2(11) of the Consumer Protection Act, 2019 defines deficiency in service. A confidentiality breach may support a consumer claim where the facts establish deficient service and compensable harm; disclosure alone does not automatically establish liability. In Indian Medical Association v. V.P. Shantha, (1995) 6 SCC 651, the Supreme Court held that qualifying paid medical services fall within consumer law, subject to the judgment's exclusions.7 The World Medical Association's International Code of Medical Ethics (2022) and the American Medical Association's Opinion 3.2.1 also require physicians to protect patient confidentiality, allowing only limited justified disclosures.

2.5 Practical Accountability and Legal Consequences of Excessive Disclosure

Accountability should address both the person who disclosed information and the institution responsible for access controls, staff training and complaint handling.

Public display or disclosure to relatives

Displaying a diagnosis on a bed chart or telling relatives without authority may expose a patient to stigma and humiliation. The hospital should remove the display, preserve relevant records, investigate the source and take proportionate disciplinary action. For HIV-related information, the special protections and remedies under the HIV and AIDS (Prevention and Control) Act, 2017 must also be considered.

Unauthorised access and digital circulation

Where employees access records without a treatment-related need or circulate reports through WhatsApp or social media, the hospital should examine access logs, preserve electronic evidence, restrict access and investigate the employees involved. IT Act provisions may apply only where their requirements are met; professional discipline and civil or consumer remedies may also be available on the facts.

Disclosure to employers, insurers or the public

Medical certificates should contain only information necessary for their stated purpose. Unnecessary disclosure to employers or insurers may cause discrimination or loss of opportunity. Where HIV status is involved, the HIV Act's anti-discrimination provisions and complaint mechanisms are particularly relevant.

Institutional failure and large-scale leakage

A hospital that ignores complaints, fails to supervise staff or maintains inadequate security may face institutional and consumer consequences. It should contain the breach, identify affected patients, preserve evidence, review access permissions and strengthen safeguards. The DPDP Act's provisions should be invoked only to the extent they have commenced and apply to the entity and processing concerned.

2.6 Important Judicial Decisions

2.6.1 Indian decisions:

JUSTICE K.S. PUTTASWAMY (RETD.) V. UNION OF INDIA, (2017) 10 SCC 1

Facts: A nine-judge Bench considered whether privacy is a fundamental right in challenges concerning the Aadhaar scheme.

Held: The Supreme Court unanimously recognised privacy as a fundamental right under Article 21 and other Part III freedoms.

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[6] Digital Personal Data Protection Act, No. 22 of 2023, §§ 1, 4–8, Acts of Parliament, 2023 (India).

[7] *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 SCC 651 (India); Consumer Protection Act, No. 35 of 2019, § 2(11), Acts of Parliament, 2019 (India).

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Relevance: It supplies the constitutional foundation for protecting medical records and personal health information.

MR. X V. HOSPITAL Z, (1998) 8 SCC 296

Facts: A hospital disclosed a patient's HIV-positive status to the family of his prospective bride, after which the proposed marriage was cancelled.

Held: The Court treated disclosure as justified on the particular facts to protect the prospective spouse; its broader observations were later reconsidered in the 2002 proceedings.8

Relevance: The case shows that confidentiality is not absolute, but it is not a general licence to disclose information to relatives or the public.

R. RAJAGOPAL V. STATE OF TAMIL NADU, (1994) 6 SCC 632

Facts: The State sought to prevent publication of a prisoner's autobiography containing personal information.

Held: The Supreme Court recognised privacy against unauthorised publication of private facts, subject to recognised limits including matters forming part of public records.9

Relevance: Its privacy principles are relevant to identifiable patient photographs, reports and medical stories published without authority.

2.6.2 American decisions:

WHALEN V. ROE, 429 U.S. 589 (1977)

Facts: New York required collection and storage of information about people receiving certain prescription medicines.

Held: The US Supreme Court acknowledged privacy interests in avoiding disclosure of personal matters but upheld the system because safeguards protected the data.

Relevance: It illustrates that legitimate collection of health information must be accompanied by meaningful safeguards.

FERGUSON V. CITY OF CHARLESTON, 532 U.S. 67 (2001)

Facts: A hospital tested pregnant patients for drug use and shared positive results with law enforcement under a policy not based on valid consent.

Held: The US Supreme Court held that the policy violated the Fourth Amendment because the testing and disclosure served law-enforcement purposes without valid consent or an applicable exception.

Relevance: It confirms that information collected for healthcare cannot automatically be transferred to law enforcement for unrelated purposes.10

III. HIV/AIDS CONFIDENTIALITY

3.1 Meaning and Importance of HIV/AIDS Confidentiality

HIV is a virus that attacks the immune system, particularly CD4 cells. AIDS is the most advanced stage of HIV infection, not a separate virus. With timely antiretroviral treatment, many people living with HIV do not progress to AIDS. HIV is transmitted through specified body fluids, including blood, semen, vaginal and rectal fluids and breast milk; it is not transmitted through ordinary contact such as hugging, sharing food or using common toilets.11 Accurate understanding of transmission is important because misinformation fuels stigma.

HIV/AIDS confidentiality is the duty of healthcare professionals and institutions to protect a person's HIV status, test results, diagnosis, counselling details and treatment records from unauthorised access or disclosure. Disclosure may lead to family rejection, cancellation of marriage, employment discrimination and social exclusion. Fear of exposure

[8] *Mr. 'X' v. Hosp. 'Z'*, (1998) 8 SCC 296 (India).

[9] *R. Rajagopal v. State of Tamil Nadu*, (1994) 6 SCC 632 (India).

[10] *Ferguson v. City of Charleston*, 532 U.S. 67 (2001); *Whalen v. Roe*, 429 U.S. 589 (1977).

[11] WORLD HEALTH ORG., *HIV and AIDS*, Fact Sheet (July 15, 2025), WHO Fact Sheet on HIV and AIDS.

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can also discourage testing and treatment. The HIV and AIDS (Prevention and Control) Act, 2017, in force from 10 September 2018, therefore provides specific safeguards for privacy, non-discrimination and access to healthcare.12

3.2 Practical Challenges and Consequences of Unauthorized Disclosure

Family disclosure: Informing parents, spouses or other relatives without consent may lead to rejection, verbal abuse, separation or isolation. Research from South India has documented family involvement in disclosure without adequate consultation with the person concerned.

Workplaces and educational institutions: Disclosure may lead to pressure to resign, exclusion, bullying or denial of opportunities, even though HIV is not transmitted through ordinary workplace or classroom contact.

Prospective marriage partners: Disclosure may result in cancellation of marriage proposals and family conflict. The legal position concerning a sexual partner must be distinguished from unrestricted disclosure to a prospective spouse's relatives.

Hospitals and laboratories: Handing reports to unauthorised persons, discussing results openly or allowing staff to access records without a care-related purpose exposes patients to embarrassment and discrimination.

Stigma and social exclusion: Misconceptions about transmission may cause rejection by neighbours, relatives and even healthcare providers. Fear of disclosure can interrupt treatment and discourage people from seeking care.

Unauthorised disclosure is therefore not merely a breach of privacy; it can trigger discrimination across family, employment, education and social life.

3.3 Ethical Issues in HIV/AIDS Confidentiality

Patient autonomy and confidentiality: Patients should control who receives information about their HIV status. Family members do not acquire an automatic right to know merely because they provide support.

Non-discrimination and dignity: People living with HIV are entitled to equal respect and healthcare. Confidentiality helps prevent stigma, humiliation and unjust exclusion.

Duty to protect identifiable third parties: Where an identifiable sexual partner faces a significant risk, the professional should first counsel the patient and encourage voluntary disclosure. Any disclosure must follow the statutory procedure and be limited to the partner concerned.

Public-health interests: Necessary reporting to authorised public-health authorities is different from disclosure to the public. Identifying details should remain protected and access should be restricted.

3.4 Legal Framework Governing HIV/AIDS Confidentiality

The HIV and AIDS (Prevention and Control) Act, 2017 is the principal Indian statute. Section 3 prohibits discrimination against protected persons in specified areas. Section 4 addresses practices that compel disclosure or testing in circumstances prohibited by the Act. Sections 5 and 6 govern informed consent and the limited exceptions for HIV testing. Section 8 protects HIV-related information and permits disclosure only with written informed consent or within its specified exceptions.13 Section 9 creates a narrow procedure for disclosure to a sexual partner by the physician or counsellor directly responsible for the patient, subject to counselling, risk and safety conditions.14

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[12] The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, No. 16 of 2017, pmbl., §§ 3, 8–11, Acts of Parliament, 2017 (India).

[13] The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, No. 16 of 2017, § 8, Acts of Parliament, 2017 (India).

[14] The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, No. 16 of 2017, § 9, Acts of Parliament, 2017 (India).

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Section 11 requires establishments maintaining HIV-related records to adopt data-protection measures.15 Article 21, as interpreted in Puttaswamy, protects medical privacy; Articles 14 and 15 support equality and non-discrimination. Regulation 7.14 of the 2002 medical ethics regulations restricts disclosure of professional secrets, subject to recognised exceptions, and Regulation 7.17 concerns identifiable photographs and case reports. The WMA International Code of Medical Ethics (2022), paragraph 22, requires respect for privacy and confidentiality, with disclosure only on consent or in exceptional circumstances involving an overriding ethical obligation and minimum necessary information.16 The AMA Code, Opinion 3.2.1, similarly requires protection of confidential information and recognises limited legal or ethical exceptions. The AMA Code is comparative guidance, not Indian legislation.

3.5 Permissible Disclosure and Its Legal Limitations

Written informed consent: Under Section 8, disclosure may be made with the individual's informed consent recorded in writing. Consent must be voluntary.

Legally recognised circumstances: Section 8 permits specified disclosures, including necessary sharing with healthcare providers involved in care and disclosures under competent court orders or other statutory conditions. The exception must be applied only to the purpose and extent authorised.

Disclosure to a sexual partner: Section 9 permits a physician or counsellor directly responsible for the patient to disclose to an identifiable partner only after the prescribed counselling and risk-related conditions are met. The Act includes safeguards where disclosure may expose a woman or her children to violence or other serious harm.

Minimum necessary disclosure: Information must not be circulated to unrelated relatives, employers or educational institutions. Section 11 requires establishments to protect records through appropriate data safeguards.

3.6 Practical Accountability and Legal Consequences of Breach

Doctors and counsellors: Unauthorised disclosure may breach Section 8 and professional confidentiality duties, potentially leading to a complaint and disciplinary action.

Nurses, laboratory staff and other personnel: Revealing test results or discussing a patient's status with unauthorised persons may lead to institutional discipline and complaints under the Act's grievance mechanism.

Hospitals and record custodians: Unauthorised circulation or weak protection of HIV-related records may breach the establishment's duties under Section 11 and require corrective institutional action.

Discriminatory treatment: Refusal of care or unequal treatment based on HIV status may violate Section 3 and can be raised through the Complaints Officer and Ombudsman mechanisms.

Legal consequences must be stated precisely. Section 37 prescribes punishment for contravention of Section 4; it is not a general criminal penalty for every breach of Section 8.17 Section 39 concerns unauthorised disclosure of a protected person's HIV status obtained during or in relation to court proceedings. Complaints and Ombudsman remedies under the Act, professional discipline and other civil remedies may be available according to the facts.

3.7 Important Judicial Decisions

3.7.1 Indian decisions:

MR. X V. HOSPITAL Z, (1998) 8 SCC 296

Facts: A man's HIV-positive status was disclosed in connection with his proposed marriage, which was then cancelled.

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[15] The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, No. 16 of 2017, § 11, Acts of Parliament, 2017 (India).

[16] WORLD MED. ASS'N, *INTERNATIONAL CODE OF MEDICAL ETHICS* ¶ 22 (2022); AM. MED. ASS'N, *CODE OF MEDICAL ETHICS*, Op. 3.2.1, Confidentiality.

[17] The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, No. 16 of 2017, §§ 26, 37–39, Acts of Parliament, 2017 (India).

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Held: The Supreme Court justified disclosure on the particular facts to protect the prospective bride; the 2002 proceedings reconsidered broader observations.18

Relevance: It must be read narrowly and alongside the later statutory procedure in Section 9 of the HIV Act.

MX OF BOMBAY INDIAN INHABITANT V. M/S ZY, AIR 1997 BOM 406

Facts: An employee was denied regular employment after testing HIV-positive, despite being medically fit to perform the work.

Held: The Bombay High Court held that exclusion merely because of HIV status violated Articles 14 and 21 and ordered relief.19

Relevance: It protects livelihood and equality and rejects unjustified discrimination based on HIV status.

JUSTICE K.S. PUTTASWAMY (RETD.) V. UNION OF INDIA, (2017) 10 SCC 1

Facts: The case considered whether privacy is a fundamental right under the Constitution.

Held: The nine-judge Bench recognised privacy as a fundamental right.

Relevance: Its reasoning supports protection of HIV status as sensitive personal medical information.

3.7.2 American decisions:

DOE V. CITY OF NEW YORK, 15 F.3D 264 (2D CIR. 1994)

Facts: A city commission issued a press release containing details that could identify a person living with HIV despite a confidential settlement.

Held: The Second Circuit recognised a constitutional interest in confidentiality of personal medical information and allowed the claim to proceed.20

Relevance: It directly illustrates the need for public bodies to protect HIV-related information from unnecessary disclosure.

WHALEN V. ROE, 429 U.S. 589 (1977)

Facts: Patients challenged a state system collecting prescription information on privacy grounds.

Held: The US Supreme Court acknowledged privacy interests but upheld the system because safeguards were in place.

Relevance: It supports the principle that legitimate collection of medical information does not remove the duty to secure it.

IV. ETHICAL AND LEGAL ISSUES IN NEONATAL INTENSIVE CARE UNITS (NICU)

4.1 Meaning, Purpose and Functions of NICU

A Neonatal Intensive Care Unit is a specialised hospital unit for newborns who are premature, have low birth weight, congenital conditions or serious complications after birth. Incubators, ventilators and monitoring systems support care by neonatologists, nurses and other trained staff. NICUs provide respiratory and life support, infection management, treatment of jaundice and other complications, nutrition and temperature regulation, emergency monitoring, developmental support and guidance for parents.21 Because newborns cannot protect themselves or communicate their needs, NICU care requires medical competence, parental participation and strong institutional safeguards.

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[18] *Mr. 'X' v. Hosp. 'Z'*, (1998) 8 SCC 296 (India); *Mr. 'X' v. Hosp. 'Z'*, 2002 INSC 526, [2002] Supp. 4 S.C.R. 661 (India).

[19] *MX of Bombay Indian Inhabitant v. M/S ZY*, AIR 1997 Bom 406 (India).

[20] *Doe v. City of New York*, 15 F.3d 264, 267–68 (2d Cir. 1994); *Whalen v. Roe*, 429 U.S. 589, 599–600 (1977).

[21] MINISTRY OF HEALTH & FAMILY WELFARE, GOV'T OF INDIA, *FACILITY BASED NEWBORN CARE OPERATIONAL GUIDELINES* (2025).

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4.2 Major Ethical Issues in NICU

Parental consent and decision-making: Parents or legal guardians generally make treatment decisions after receiving information about benefits, risks and alternatives. Their authority is not unlimited where a decision would expose the newborn to serious preventable harm.

Best interests of the newborn: Decisions must prioritise the child's life, health, safety and welfare, without discrimination based on sex, disability or family circumstances.

Emergency treatment without prior consent: Where delay threatens life or risks serious harm, doctors may provide necessary emergency treatment without waiting for consent. Reasons should be documented and parents informed as soon as possible.

Life-sustaining treatment and end-of-life decisions: Decisions about resuscitation, ventilation or withdrawal of treatment require careful medical assessment, the child's best interests, consultation and compliance with applicable legal safeguards. Financial pressure or convenience must not determine the decision.

Confidentiality and records: A newborn's diagnosis, photographs, identity and treatment records must be protected. Access should be limited to authorised personnel, and information shared with parents or others should follow appropriate legal and ethical safeguards.

4.3 Medical Negligence and Criminal Activities Inside NICUs

Infant killing: Intentional killing may constitute culpable homicide or murder under Sections 100 and 103 of the Bharatiya Nyaya Sanhita (BNS), 2023.22

Infant swapping: Deliberate substitution or manipulation of identification may involve cheating, forgery and other offences, depending on the conduct and evidence.

Kidnapping or abduction: Removing a newborn from lawful guardianship may attract Section 137 of the BNS.

Sale or trafficking: Trafficking may attract Section 143 of the BNS; Section 81 of the Juvenile Justice (Care and Protection of Children) Act, 2015 specifically penalises sale or procurement of children.

Physical abuse: Deliberate injury may attract provisions including Sections 115 and 117 of the BNS; the precise charge depends on the injury and intention.

Poisoning or harmful substances: Section 123 of the BNS may apply where hurt is caused by poison or similar means with the prescribed intention.

Negligent supervision and abandonment: Negligent acts causing death may attract Section 106 of the BNS when its elements are established. Section 93 concerns exposure or abandonment of a child below twelve by a person having care of the child.

Falsification of records: Forgery and use of forged documents may attract Sections 336 and 340 of the BNS, depending on the document and purpose.

Theft of property or materials: Unauthorised removal of hospital property or medicines may attract Section 303 of the BNS. This should be distinguished from the separate and more serious offence of removing a newborn.

A poor outcome or ordinary medical error does not automatically amount to criminal negligence. Criminal liability requires proof of the statutory elements and the legally required degree of fault; civil or consumer negligence is assessed separately.

4.4 Legal Framework Governing NICU Care and Related Offences

Constitution of India

[22] Bharatiya Nyaya Sanhita, No. 45 of 2023, §§ 93, 100, 103, 106, 115, 117, 123, 137, 143, 303, 336 & 340, Acts of Parliament, 2023 (India).

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Article 21 protects the newborn's right to life and personal liberty and supports access to necessary medical care and dignity. Articles 14, 15(3) and 39(f) reinforce equality, special protection for children and conditions for their healthy development.

Medical professional regulations

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 require registered practitioners to maintain professional standards and confidentiality. Regulations 2.1, 2.2 and 7.14 are relevant to care, secrecy and disclosure; professional misconduct may lead to disciplinary proceedings under the applicable regulatory framework.

Bharatiya Nyaya Sanhita, 2023

Relevant provisions include Sections 93 (exposure and abandonment of a child), 100 and 103 (culpable homicide and murder), 106 (death by negligence), 115 and 117 (hurt and grievous hurt), 123 (hurt by poison or similar means), 137 (kidnapping), 143 (trafficking), 303 (theft), and 336 and 340 (forgery and use of forged documents). Their application depends on the specific facts and statutory ingredients.

Juvenile Justice Act, 2015

Section 3 sets out child-centred principles, including best interests, safety, equality and privacy. Section 75 punishes cruelty to a child by a person having actual charge or control.23 Section 81 punishes sale or procurement of children and provides enhanced punishment in specified cases involving persons entrusted with the child's care, including employees of hospitals and maternity homes.

Consumer Protection Act, 2019

Section 2(11) defines deficiency in service, and Section 35 provides for filing a consumer complaint before the appropriate Commission. Under Indian Medical Association v. V.P. Shantha, paid medical services generally fall within consumer jurisdiction, subject to recognised exclusions. A claim requires proof of deficiency and legally cognisable loss.

Child protection and hospital safety

National Health Mission newborn-care guidance addresses trained staff, essential equipment, infection control, monitoring and referral arrangements. Hospitals must also comply with applicable clinical-establishment requirements, biomedical-waste rules, fire and building safety requirements, and infection-control standards. These measures help prevent avoidable clinical and security risks.

International and American standards

The UN Convention on the Rights of the Child supports the child's best interests (Article 3), right to life, survival and development (Article 6), privacy (Article 16) and health (Article 24).24 American Medical Association and American Academy of Pediatrics ethical guidance provide comparative principles on parental decision-making, best interests and end-of-life care. HIPAA protects identifiable health information held by covered US entities; it is not applicable to Indian hospitals.

4.5 Practical Accountability for NICU Negligence and Criminal Activities

Nurses and nursing staff: Must monitor newborns, administer prescribed medicines, verify identity bands, document care and report deterioration. Medication errors, abuse or unauthorised removal may lead to discipline and, where elements are proved, civil or criminal liability. Treating doctors and paediatricians: Must diagnose and treat competently, obtain consent where required, respond to emergencies and maintain accurate records. Negligence may

[23] Juvenile Justice (Care and Protection of Children) Act, No. 2 of 2016, §§ 3, 75, 81 & 84, Acts of Parliament, 2015 (India).

[24] Convention on the Rights of the Child arts. 3, 6, 16, 19 & 24, Nov. 20, 1989, 1577 U.N.T.S. 3.

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lead to professional or compensation proceedings; intentional harm or proven criminal negligence may lead to prosecution.

Hospital management: Must provide adequate staffing, functioning equipment, infection control, identification systems, secure records and supervision. Systemic failures may expose the institution to consumer, civil and regulatory consequences.

Other employees and contractors: Attendants, housekeeping and outsourced staff must follow access and safety rules. Participation in abuse, theft, record manipulation, kidnapping or trafficking attracts individual disciplinary and criminal consequences.

Security personnel: Must monitor entry and exit, verify authorised visitors and prevent unauthorised removal. Negligent performance may lead to employment or contractual action; deliberate assistance in abduction or trafficking may result in prosecution.

Institutional and regulatory accountability: Hospitals should investigate suspicious injuries or deaths, preserve CCTV and medical records, report suspected crimes, maintain complaint systems and cooperate with regulators. Parents may seek consumer or other legal remedies where the requirements are met.

V. KRISHNAKUMAR V. STATE OF TAMIL NADU, (2015) 9 SCC 388

Facts: A premature baby suffered permanent blindness after a hospital failed to ensure timely screening and follow-up for Retinopathy of Prematurity.

Held: The Supreme Court upheld negligence and enhanced compensation, recognising the failure to provide required screening and care.25

Relevance: It highlights the duty to follow neonatal protocols and arrange timely intervention.

MAHARAJA AGRASEN HOSPITAL V. MASTER RISHABH SHARMA, (2019) 16 SCC 759

Facts: A premature child suffered blindness after failure to conduct timely ROP screening; there were also concerns about delayed access to medical records.

Held: The Supreme Court upheld the finding of negligence and compensation, recognising hospital responsibility for deficient neonatal care.26

Relevance: It demonstrates that both clinicians and hospitals must ensure proper screening, records and follow-up.

DEEP NURSING HOME V. MANMEET SINGH MATTEWAL, 2025 INSC 1094

Facts: The family alleged negligence after a mother and newborn died following delivery at a nursing home.

Held: The Supreme Court set aside the finding against the doctor where the material did not establish the required negligence, reiterating that an adverse outcome alone is insufficient.

Relevance: It clarifies that liability must be based on evidence of breach and applicable medical standards, not outcome alone.27

American decisions:

IN RE BABY K, 16 F.3D 590 (4TH CIR. 1994)

Facts: A newborn with anencephaly required respiratory support; the mother sought continued ventilation while the hospital considered it medically inappropriate.

Held: The Fourth Circuit held that EMTALA required emergency stabilising treatment when the child presented with respiratory distress.28

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[25] *V. Krishnakumar v. State of Tamil Nadu*, (2015) 9 SCC 388 (India).

[26] *Maharaja Agrasen Hosp. v. Master Rishabh Sharma*, AIRONLINE 2019 SC 1757 (India).

[27] *Deep Nursing Home v. Manmeet Singh Mattewal*, 2025 INSC 1094 (India).

[28] *In re Baby K*, 16 F.3d 590, 593–95 (4th Cir. 1994).

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Relevance: It illustrates the hospital's emergency-treatment duty and the tension between parental wishes and medical judgment.

MILLER V. HCA, INC., 118 S.W.3D 758 (TEX. 2003)

Facts: An extremely premature newborn was resuscitated despite the parents' request that resuscitation not be performed.

Held: The Texas Supreme Court found that emergency circumstances justified immediate life-sustaining treatment without prior consent on the facts.29

Relevance: It illustrates the limits of parental decision-making when immediate intervention is necessary to protect a newborn's life.

VI. LEGAL RECOMMENDATIONS AND SUGGESTIONS

- Adopt clear confidentiality and information-sharing policies that define who may access records, for what purpose and on what legal basis.
- Use role-based access, audit trails, secure storage and breach-response procedures for paper and electronic medical records.
- Apply HIV-specific safeguards: written consent, confidential counselling, limited disclosure under Sections 8 and 9, and accessible Complaints Officers.
- Standardise NICU consent, emergency-treatment documentation and escalation procedures, with parental communication as soon as practicable.
- Introduce reliable newborn identification using matching mother–baby bands, verification before transfer or discharge, and documented handovers.
- Control NICU access through visitor verification, staff identification, movement logs and secure entry and exit arrangements.
- Use CCTV in appropriate common and access areas with clear retention, access and privacy safeguards; avoid intrusive recording of treatment spaces.
- Define duties of doctors, nurses, administration, contractors and security staff through written protocols and supervision.
- Require prompt reporting, preservation of evidence and independent investigation of suspicious injury, death, missing infants, substitution or record manipulation.
- Strengthen internal grievance mechanisms, external oversight and cooperation with police, child-protection authorities and medical regulators.
- Provide regular training on confidentiality, informed consent, child protection, medication safety, infection control and emergency response.

VII. CONCLUSION

Healthcare ethics and law require institutions to protect patients not only from disease but also from avoidable violations of privacy, dignity and safety. Excessive disclosure undermines trust and may expose patients to discrimination; HIV-related information requires particularly careful protection because unauthorised disclosure can have lasting social consequences. The HIV and AIDS (Prevention and Control) Act, 2017 provides a specific framework, but its safeguards must be reflected in everyday clinical and institutional practice. NICUs demand an equally strong commitment to protection because newborns are wholly dependent on others. Ethical treatment requires respect for parental participation while keeping the child's best interests central. Preventing negligence, abuse, substitution and abduction requires reliable clinical protocols, secure identification, trained staff and effective hospital

[29] *Miller v. HCA, Inc.*, 118 S.W.3d 758, 764–66 (Tex. 2003).

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supervision. Accountability must be individual where a person commits wrongdoing and institutional where unsafe systems contribute to harm. Ultimately, a trustworthy healthcare system is one that combines competent treatment with confidentiality, transparency, child protection and meaningful remedies.

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