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Disclaimer

Address for correspondence :
Dr. V. P. Singh
Professor, Forensic Medicine,
Old DMC, Civil Lines
Ludhiana, 141001. Punjab.
Email: singhvp@gmail.com
Mob.: 98154 77722

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CONTENTS

Editorial :

We Cannot Turn Back the Clock; But We can Move Forward.

Dr. Yash Paul

Received for publication : 26th May 2023 Peer review : 08th June 2023 Accepted for publication : 22nd June 2023

Key words:

Violence against doctors, Vandalizing Medical establishments.

Abstract:

For last many decades there are reports of violence against doctors and medical establishments. Such incidences were unheard till seventh decade of last century. It is the government's duty to control violence and vandalism. There are some black sheep in medical profession also, for which the whole fraternity is paying the price. There is an urgent need for the doctors to take remedial steps on their part.

The Times of India dated August 7, 2022 had 65x1.5 cm size headline which was not easy to miss. Headline was 'How India Treats Its Physicians: The Patient Is Dead: Let's Beat Up The Doctors And Go Home.' It states "Workplace violence and humiliation is a unique job hazard for India's medical profession, which seems to be a fair game for people, politicians and police. How did it come? How can we stop it? And what will happen if it doesn't stop?"

The author is compelled to quote some part of the report: "Assaulting doctors is a Pan-Indian sport now. And enraged friends and relatives of patients are not only the ones in this game. Sometimes politicians and their retinue join in, sometimes senior government officials and the police too. In other major countries, overwork, fatigue and dangers of contracting serious infections while providing care are the stress points of medical professionals. Only in India is workplace violence a job hazard for doctors. It gets worse. There is no guarantee an experienced, ageing doctor, even some-one known to the patient's kin, won't be assaulted. There is no guarantee a woman doctor won't be assaulted. There is no guarantee that a young doctor working in impossible circumstances won't be assaulted."

Here are some reports regarding assaults on doctors in the recent past :

1. A 42 years old Gynecologist in Dausa (Rajasthan) committed suicide on 29th–30th March 2022 night when she was booked for murder under section 302 of the IPC for death of a patient. In year 2021 National Medical Commission (NMC) had issued guidelines requiring police to send medical negligence criminal complaints to the District Medical Council's Medical Board. Before an arrest, experts must hear the case and the doctor's defense must he heard. But Dausa Police did not follow the correct procedure.
2. The Times of India dated May 11, 2023 had headline "Patient stabs Kerala doctor to death, Medicos go on strike: "A 25 year old House Surgeon at Kottarakkare Taluka hospital in Kallam was stabed to death with surgical scissors and scalpel by her patient when he was brought there by police for treatment of his injured legs and hands. (In this case there was no reason for any provocation).
3. The Times of India dated 22nd May 2023 reported that a doctor and two members of the medical staff from the Casualty Department of the Government Medical College in Nagpur were assaulted when a patient was wheeled in

Practicing Pediatrician, Jaipur E-mail: dryashpaul2003@yahoo.com

with a crippling stomach ache, along with an army of relatives and attendants when patients condition started deteriorating.

4. Medical Dialogue (https: emedicaldialogues. in) dated May 22, 2023 reported a case of violence in Balrampur Hospital, Lucknow. Five lawyers came with an injured person. According to the Medical Superintendant lawyers allegedly asked the Intern Doctor on duty to write more injuries in medico-legal report. When the Intern refused he was beaten up.

The author joined government service in August 1963 and was posted at Bharatpur, a small town in Rajasthan. There were limited facilities regarding investigations, medicines etc. Many patients could not be saved, but relatives of the deceased persons always thanked the doctor for all efforts done before taking away the dead body [1]. People as well as government employees including Railway staff not only used to go out of way but sometimes against the rules out of goodwill to thank the medical profession [2].

Why Has This Change Occurred?

The above mentioned four heart rending incidences were unimaginable five decades ago. The author cites here five reported incidences which were equally un-imaginable five decades earlier.

1. The Times of India dated August 11, 2022 had headline: "City doctor held for demanding Rs. 30 Lakh from a businessman. The doctor was Associate Professor in S.M.S. Medical College, Jaipur.
2. Rajasthan Patrika (A Hindi Newspaper) October 30, 2022 reported from Bharatpur: A Private hospital charged Rs. 14000/- for a Gel costing Rs. 150-00. Another hospital charged Rs. 3 lakh for 21 tablets costing Rs. 800. All bills were reimbursed under Rajasthan Government Health Scheme (RGHS).
3. The Times of India dated January 30, 2023 had headline: After Kidneys stolen by doctor, woman deserted by husband: It stated: The doctor of a private nursing home in Bihar's Muzaffarpur, stole the woman's kidneys and put her on permanent dialysis when she had gone to him with uterus infection.
4. The Times of India dated March 18, 2023 had headline: " Probe finds illegal a/cs in Mumbai Hospital to use pharma donations. An inquiry had found that heads of 11 departments of J.J. Hospital's Grant Medical College, opened and operated unauthorized bank accounts. A sum of Rs. 6 Crore was collected in these accounts and almost half of it was then used for expenses such as foreign trips without permission.
5. The Times of India dated May 19, 2023 had headline: ' Maharashtra doctor held over child-selling sacked'. It stated, "The Thane Crime Branch has cracked a five-member racket involved in selling babies in Ulhasnagar in Maharashtra. The accused include a women doctor, a mother and three agents."

These five reported incidences do not make any doctor proud.

Justice V.S. Deshpande in Foreword to Dr. R.D. Lele's book titled 'The Medical Profession and Law' had stated 'The deterioration of standards in the medical profession is but a reflection of the deterioration of standards in other professions and in the all pervading public life of our country"[3].

Dr. Farokh Erach Udwadia stated: "Today, when science and technology have pushed the frontier of medicine far ahead, enabling medicine to achieve a great deal, the respect for

the profession has plummeted and the image of the physicians is increasingly tarnished. Perhaps the underlying explanation for the decline in the ethics of contemporary medicine is a fall in the sense of values in most fields of human endeavor. A burning desire for material gain and wealth at any cost dominates life today. It is difficult for any profession to remain an island of high-mindedness and virtue when surrounded by a sea of filth and corruption"[4].

So, we are slowly drowning in a sea of filth and corruption. Should we continue to drown in this or swim out? Again answer is provided by Dr. Udwadia himself. He had stated. 'This is a possible explanation but certainly not an excuse. The answer is to reform and wipe out this cancer from the heart of medicine' [4].

What should be our response to what Justice V.S. Deshpande and Dr. Udwadia have stated?

(i) We are part and parcel of the system.

(ii) There is urgent need for soul searching.

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Review Article :

Babies Born with Congenital Defects: Medical Legal Interface

Dr. Ishita Banerji

Received for publication : 27th April 2023 Peer review : 04th May 2023 Accepted for publication : 15th May 2023

Keyword :

Congenital Birth defects, Legal implication, Fetal anomalies, Medical negligence

Abstract :

It is a dream of every parent to have a healthy baby in whom they see their future and happiness. When the baby is born with a congenital defect, this dream is shattered. Then begins the deliberation on cause of such a mishap and fault finding for their misfortune. The finger pointing soon stops at the doctors. Was the Obstetrician not careful enough? Did the Radiologist miss it in the pre-natal ultrasonography? How could it be left undetected prenatally? Why were they not given a clear picture in order to make an informed choice? The parents seek answers to the innumerable queries that play havoc in their minds, building up the psychological pressure which translates into anger, frustration and finally takes shape of a litigation. An insight into medical negligence in birth defects followed by an analysis of prenatal diagnosis of fetal anomalies is drawn up in this review article.

It is not uncommon to find children with major congenital defects. Congenital anomalies are important causes of infant and childhood deaths, chronic illness and disability. This also gives rise to the legal terms “wrongful birth” and “wrongful life”. “Wrongful birth” is a legal cause of action in which the parents of a congenitally diseased child claim that their doctor failed to properly warn of their risk of conceiving or giving birth to a child with serious genetic or congenital abnormalities. “Wrongful life” is a legal cause of action in which a congenitally-diseased child sues the doctor, claiming that but for the negligence of the doctor, the child would not have been born into a life of pain and suffering. The child claims he or she would have been better off never having been born than having been born with a congenital disease[1].

WHO defines congenital anomalies or birth defects as structural or functional anomalies including metabolic disorders that occur during intrauterine life and can be identified prenatally, at birth, or sometimes may only be detected later in infancy, such as hearing defects, still some much later in life like hemophilia. The exact cause of congenital anomaly cannot usually be identified; however, some known risk factors are:

1. **Genetic factors** such as single gene defects, chromosomal disorders, multi-factorial inheritance;
2. **Consanguinity** increases the prevalence of rare genetic congenital anomalies;
3. **Advanced maternal age** increases the risk of chromosomal abnormalities like Down's syndrome;
4. **Medical condition of mother** such as diabetes, epilepsy, hypertension during pregnancy;
5. **Maternal infections** such as Syphilis, Rubella, Toxoplasmosis, Herpes;
6. **Parent's carrier status of a genetic disorder** like thalassemia, sickle cell anemia, and metabolic disorder;
7. **Teratogenic medications** that damage the fetus directly, the placenta or umbilical cord.
8. **Lower socioeconomic status** with lack of access to sufficient nutritious food by

Practicing Pediatrician, Trained in Cardiology, Prayagraj E-mail: ibanerji70@gmail.com

pregnant women, deficiency of iodine and of folic acid with poorer access to healthcare are circumstances that predispose to birth defects.

How Does Medical Negligence Arise In Birth Defects?

1. **Existence of a doctor-patient relationship:** In antenatal care a medical diagnosis or medical advice given by the doctor is deemed to affect both the mother and her baby, assigning doctor-patient relationship amongst the three.
2. **Failure to diagnose:** Healthcare providers can miss a condition or misdiagnose the condition. It occurs for many reasons most being preventable. Failure to detect maternal infections or gestational diabetes, failure to review mother's medical history or conduct a proper physical exam, failure to order proper tests and screening, failure to diagnose and treat infant health problems, to name a few.

   Legal Implications: In a review article [2] the authors stated the study by Whang et. al. that showed that the most common cause of malpractice claim against radiologists is error in diagnosis i.e. failure to diagnose[3]. Radiologic errors in diagnosis can be of two types, cognitive and perceptual errors. Cognitive errors are those in which an abnormality is seen but its nature is misinterpreted. The perceptual errors or the radiologic 'miss' that account for 80% of cases, are the one in which a radiologic abnormality is not perceived by the radiologist. Such errors of perception are influenced by multiple factors like lack of knowledge, faulty reasoning, under reading, inadequate exposure, limitation inherent to the diagnostic test, non-communication with the referring clinician, no adequate clinical information available etc. Certain psycho-physiological factors affecting visual perception like level of observer alertness, workload and fatigue, duration of observer task, distracting factors, conspicuousness of abnormality and others also contribute to errors.

   The authors of the said review article further stated that not all missed findings represent breach in standard of care. When the radiologists review an imaging study obtained with proper technique and exposure and fails to perceive an abnormality, which, in retrospect, is apparent, such error in perception cannot be considered negligence. This was upheld by the 1992 Delaware State Supreme Court decision over a malpractice claim.

   Fall out: There are limitations to the routine screening for fetal abnormalities. Not all anomalies (e.g. some cardiac, gastrointestinal and renal abnormalities) are evident at 20 weeks, when the routine ultrasound examination for anomalies is performed; there is wide variation in both expertise of staff and quality of equipment and some fetuses are difficult to scan because of maternal habitus, reduction in liquor volume or persistent difficult position.

   There are thousands of different congenital defects making the diagnoses more complex than apparent. Prenatal diagnostic tests such as chromosomal analysis, genetic screening, fetal echo etc. are highly specialized tests, besides being very expensive. Hence, the fall out will be that in order to avoid any litigation, a practice of giving blanket advice for all pre-conception and prenatal screening may ensue; howsoever irrational it may seem in the present socio-economic scenario.
3. **Failure to disclose the risk of having a child with a genetic or congenital disease:** If the plaintiffs allege that the defendant failed to

disclose the risk of conceiving a child with an abnormality, then the plaintiffs must show that the doctor had the duty to make the disclosure at issue. Lay juries do not have the necessary knowledge of medical practice to evaluate the conduct of doctors without the assistance of an expert witness.The plaintiffs may also prove the negligence element by showing that the doctor failed to properly disclose the availability of genetic or prenatal screening procedures.

Legal Implications: Doctors are under an obligation to disclose to their patients the risks of passing on a genetic condition to their prospective children. However, the doctor need not disclose all risks or recommend all available testing procedures. For example, in the case of **Munro v. Regents of the University of California,** the court held that the doctor was not under an obligation to recommend a Tay-Sachs test when the doctor had no reason to suspect his patients were at any more at risk for Tay-Sachs than the general population.

Fall out: The detection of a structural abnormality will often lead to referral to the regional fetal medicine service for confirmation and advice on further management. Failure to offer this referral may be deemed to represent a reduced standard of care if, for example, a local hospital detects an anomaly that warrants further investigation but fails to offer such investigation or referral. However, lack of availability of fetal medicine services locally becomes a major limiting factor and referral to bigger facilities with the said facilities an additional financial burden on the patient family.

When a birth defect correctable by surgery after birth is detected prenatally, termination is not advocated, however the family, despite being counseled may choose to abort the fetus, leaving the doctor in a dilemma as to what is actually lawful - to abide by his professional understanding or respecting the patient's freedom and right over her body. Thus the major fall out will be an exponential increase in the rate of abortions. Can law afford to remain silent on this?

4. **Faulty prescriptions:** Only those medications that are absolutely necessary and safe for consumption during each particular stage of pregnancy can be prescribed. Failure to follow this medical standard may hold the medical professional responsible for any birth defect a child is born with.

   Legal Implications: If at all a medication with possible detrimental effects to fetus becomes mandatory to be given to the pregnant woman it would be prudent to first suggest a second opinion to the patient and thereafter explain the necessity of the drug for the benefit of the mother (legal entity at hand) at the cost of the fetus (legal entity by virtue of being born).

   Fall Out: Diverse medical conditions of a pregnant woman often detected during pregnancy require radiological investigation, medication or urgent intervention which may adversely affect the fetus despite all precautions, making it a challenging dilemma for the physician.

5. **Expertise:** The physician who carries out the prenatal screening tests must have appropriate qualifications having undergone sufficient training to carry out such specialized tests.

   Legal Implications: The PC PNDT Act, 1994 prescribes in clear terms as to who all can conduct these prenatal screening tests and where it can be conducted. The place where the tests can be conducted must be registered under

this Act besides the ones doing the tests. A monthly report needs to be sent to the respective CMO office besides keeping an impeccable record at the center. The CMO conducts intermittent inspection of these centers to satisfy itself.

Fall out: The stringent legal requirement often acts as a deterrent for many medical professionals from venturing into this field. The fact of the matter is that there are very few medical professionals with such expertise and the brunt falls on the existing few centers, not to mention the cost, which itself is a limiting factor. The expertise must percolate down in order to have sound, ethical, cost effective prenatal detection system.

An Analysis Of Prenatal Diagnosis Of Fetal Anomalies

1. The first line **basic investigations** advised in antenatal clinics are CBC, ABO and Rh typing, Fasting and Post Meal blood sugar, viral serology and TSH.
2. The **USG scans** routinely advised are Dating scan and Anomaly scan. While the dating scan is done in the first trimester of pregnancy, the **Anomaly scan** is done at 18 – 22 weeks to confirm the presence or absence of any structural defect in the baby. Not all congenital anomalies are detected by USG.

In **Dr. Nikhil Dattar v Union of India (2008)**,Haresh and Nikita Mehta had beseeched the Bombay High Court to allow them to abort their 26-week-old fetus, which had been diagnosed with a serious heart defect. It is during this case that the medico-legal narrative was jolted into awareness about how the advent of medical technology mandated a change in the understanding of fetus viability and amendments in the law. Their plea was struck down because of expert medical opinion. The Court suggested that changes in the law can only be affected by the legislature.

In **Murugan Nayakkar vs. Union of India and ors. W.P. N0. 749/2017** the Apex Court allowed the termination of 32-week old pregnancy of a 13-year-old rape victim. However, in **Savita Sachin Patil vs. Union of India,** termination of a 27-week pregnancy with Down's Syndrome was rejected. The Court then did not permit termination on the ground, based on the Medical Board Report. In another **landmark judgement the Supreme Court on 26 July, 2016 granted a 24 weeks pregnant woman and rape survivor the permission to go for abortion**. The judgment questioned the constitutional validity of the Medical Termination of Pregnancy (MTP) Act 1971, which until lately allowed abortion only up to the 20^{th} week.

However, in the summer of **2017, the Supreme Court of India denied permission to abort a 26-week-old fetus, detected with Down syndrome,** to a family which already had a child with special needs, on the grounds that the 20-week mark specified in The Medical Termination of Pregnancy Act of 1971 had been crossed, once again bringing into question the stringent abortion laws in India.

Similar judgments were passed by the Supreme Court in other cases where pregnancies were beyond 20 weeks and the fetuses had various medical conditions and anomalies, resulting in a high risk to the fetus and the mother **Tapasya Umesha Pisal vs. Union of India** with 24 weeks pregnancy and fetus diagnosed with severe congenital heart defects – MTP allowed; **Meera Santosh Pal vs. Union of India** with 23 weeks pregnancy with Anencephaly – MTP allowed; **Mamta Verma**

vs. Union of India with 25 weeks pregnancy with Anencephaly – MTP allowed. In all these cases the Supreme Court referred the matters to a Medical Board and gave its decision based on the opinion of the Medical Board.

Taking cognizance of above cases, the legislature revisited the abortion laws and recently The **Medical termination of Pregnancy (Amendment) Act, 2021** was passed increasing the upper limit of legal abortions to 24 weeks for rape survivors and beyond 24 weeks for substantial fetal abnormalities, however, requiring the approval of Medical Board after 24 weeks.

3. **Fetal echocardiography,** an advanced scan to detect congenital heart disease is not advised routinely but only in presence of suspicious findings on anomaly scan and sometimes in presence of maternal or family history of cardiac diseases, maternal diabetes mellitus and in bad obstetric history especially with a previous child with Congenital Heart Defect. The structure of the heart is formed by 16 – 18 weeks of gestation hence Fetal Echocardiography is done only after this period. There are some cardiac defects which are incompatible with life while some correctable, postnatally. Few require several stages of palliative and/or definitive surgery, improving the quality of life to a great extent. These cardiac defects may not be detected in the anomaly scan with the possibility of missing out if not routinely advised for Fetal Echocardiography which itself has its own limitations and may not pick up every cardiac defect, often due to shadowing from bones in advanced gestational age or due to its location.
4. **TORCH** test to rule out infection with Toxoplasmosis, Rubella, Cytomegalo virus and Herpes is not done routinely by all gynecologists. Since TORCH infections affect the pregnancy adversely and may cause fetal defects, they need to be treated if found positive. It is being advised more frequently these days.
5. The **tests for Trisomy 13, 18, 21** are **NT scan** done at 12-14 weeks while many prefer **NT scan + Double marker** at 12-14 weeks and **Quadruple test** at 16-20 weeks. NT scan is a Nuchal scan or nuchal translucency scan which is a sonographic prenatal screening scan to detect chromosomal abnormalities in a fetus during the first trimester of pregnancy. It measures the size of the clear tissue at the back of the baby's neck. NT scan is a screening tool for early suspicion of chromosomal anomaly, if any.
6. The **screening tests** like the **double marker** in the first trimester of pregnancy, **triple marker** and **quadruple marker** in the second trimester of pregnancy are done to screen out patients with high risk or low risk for chromosomal anomalies. **Down's Screening** is usually advised in elderly women (>35years of age) as it is associated with higher maternal age at conception, though it may not always spare the young mothers. The patients screened positive (high risk) are then advised specific confirmatory invasive tests like chorionic villus sampling and / or amniocentesis.
7. **Chromosomal anomalies:** The genetic make-up of an individual resides in the chromosomes. The display of these 23 pairs of chromosomes of an individual in a picture format is called Karyotype. Any aberration in this karyotype is a chromosomal anomaly as in Down's syndrome or Trisomy 21 wherein there is an extra chromosome 21 or third copy (trisomy) of chromosome 21. Antenatal

Karyotyping or chromosomal analysis calls for **invasive diagnostic tests,** such as Chorionic villus sampling (CVS) or amniocentesis. Though more reliable than screening tests they carry an increased risk of miscarriage or abortion specially CVS. The risk of procedure being greater the earlier it is performed. Hence CVS is done usually around 12 weeks (not before 10 weeks) and amniocentesis 16 weeks onwards.

8. For amniocentesis **full karyotyping** despite its higher cost is preferred over standalone FISH. FISH (Fluorescence In Situ Hybridization) is a technique that uses fluorescent probes that binds to only those parts of a nucleic acid sequence with a high degree of sequence complementarity. FISH may be quick and cost effective but it can rule out only the targeted five common aneuploidies of chromosomes 13, 18, 21, X and Y.
9. It **takes more than 2 weeks to get the results** for genetic tests. For any decision to be taken the clock of gestational age in weeks should be continuously ticking in our heads.
10. However, the above tests are **not routinely done** by patients primarily due to cost factor and lack of understanding about the anomalies.
11. The above tests are **not available at government hospitals.** They are available only at super-specialized centers. Thus adding on to burden of undetected congenital birth defects, in time, antenatally.
12. These specialized investigations are conducted in some **private labs or fetal medicine clinics** which are not locally accessible. It is a major challenge in the smaller cities and towns who need referral to higher centers.
13. That the **congenital defect is left undetected** in the antenatal period is usually due to absence of any indicator to advise special tests or due to refusal by patients to comply considering the cost factor. Unless one understands the limitations of antenatal tests, doctors will be forced to advise special tests more frequently irrespective of patient affordability or feasibility. Would it be a fair practice is a question for the legal fraternity to answer !
14. **Minor congenital anomalies are not diagnosed by anomaly scans.** Not all defects can be picked up antenatally despite special investigations. A congenital defect which is not incompatible with life or one that does not compromise on quality of life or one that is correctable postnatally would be considered minor like syndactyly, polydactyly, cleft lip, talipes etc.
15. Parents who test positive for Trisomy and other genetic syndromes or diagnosed with minor congenital anomalies often opt for **termination of pregnancy.** This raises the bigger question of morality and legality behind this. While one can give an oration questioning the morality for such a decision but managing such a child is not easy and can always be contested with the argument of quality of life one has to offer to these children. From the legal standpoint the right over one's body or right to autonomy (of mother) could be a fair argument. However, it takes the question of Right of life (of Fetus) head on.
16. The **obstetric complications attracting medico-legal issues** are usually found to be maternal mortality, stillbirth/neonatal death, operative complications and birth injuries. This calls for in-depth knowledge of late complications of pregnancy – complications for the mother and / the baby. When a complication does arise it becomes very difficult to explain why the unforeseen happened. A known hypertensive or gestational hypertensive can

proceed to develop pre-eclampsia / eclampsia despite due care. Fetal distress may ensue despite due care calling for a need of cesarean section even though a normal delivery had been planned. During cesarean sections unforeseen adverse events can occur and some difficult deliveries may lead to birth injuries which yet again leave the doctor in the dock. The prevalent opinion is that unnecessary cesarean sections are being favored by obstetricians. However, it is usually done for safe delivery of baby while taking care of the safety of the mother in equal measures. When the outcome is good, one invariably questions the need of having got the cesarean done in the first place. What one fails to see is the eventuality of prolonged trial of labor and difficult normal delivery could result in birth asphyxia in the baby which often leads to cerebral palsy – yet another reason to sue the doctor.

To have a healthy baby is every parent's dream and rightfully so. However, without a blemish – would be taking things too far. In the endeavor for the perfect baby how far are we willing to go as a society. The demands from the medical professionals remain unreasonably high by the society, administration and judiciary. Are we making room for "super-humans" making our existence in the society seem questionable? While technology is a boon it can also be devastating. Genetic tinkering to have an intelligent perfect baby can never be the answer. Living with our imperfections makes life challenging and worthwhile. In post-Covid times, today, more than ever before nature has given us this opportunity, having once brought the entire world to a halt; to stop, step back and think what does humanity really need. It would be a happier world if we could embrace our babies with some birth defects as we embrace our imperfections and defects. Taking the argument further, it is said "to err is human" then "to be perfect" is definitely not human!

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Perspective :

Good News: There will be some restraints on Pharmaceutical Industry

Dr. Yash Paul

Received for publication : 26th May 2023 Peer review : 10th June 2023 Accepted for publication : 25th June 2023

Key words:

Substandard drugs, Spurious drugs, Unapproved drugs, Irrational drugs, Potentially harmful drugs, Different prices for similar drugs.

Abstract:

In India the doctors face many problems regarding drugs, like substandard and spurious drugs, unapproved, irrational and potentially harmful drugs. The author has been raising these issues since 2012 through Pharma and Medical journals, but pharmaceutical industry has not taken any cognizance. The Drugs and Cosmetics Act 1940 has provisions for punishment for belligerent acts of pharma houses, but rarely implemented. On 25th November 2022 the author presented a petition to the Administrative Reforms and Public Grievance, Government of India. Recently there is news that the government plans to take action against unethical practices by pharma industry.

According to the Drugs and Cosmetics Act 1940 the punishment for manufacturing or trading spurious drugs that can cause death is 10 years to life imprisonment, and a fine of Rs. 10 Lakh or three times the value of the drug confiscated. Doctors caught taking gifts in cash or as foreign trips and sponsorship can be hauled up by the state medical councils or National Medical Commission (NMC) have their licenses suspended if found guilty however there is no law to prosecute pharma companies that bribe the doctors.

The Times of India dated April 26, 2018 reported: 4 years on, code to punish pharma firms for bribing doctors still in works'.

The Times of India dated September 24, 2020 titled 'Govt drops mandatary pharma ethics code plan. It stated: "For over four years the government has been maintaining that it was drafting a mandatory code on ethical marketing of pharmaceutical with penal provisions since the voluntary code had not worked. But it has now admitted in Parliament that it has no intention of making the code mandatory.

In India the doctors face following problems:

1. Substandard drugs,
2. Spurious drugs,
3. Unapproved drug formulations,
4. Irrational drug formulations
5. Potentially harmful drug formulations,
6. Different prices for similar drug formulations prepared by different pharmaceutical houses.

The author has been raising these issues through pharmaceutical and medical journals, since 2012. The author cites here some articles, even titles are self explanatory:

1. Drug formulations: Safety of patient remains the main concern [1].
2. Need for safe and doctor friendly drug formulations [2].
3. Drug formulations should be rational and uniform [3].
4. Problems associated with irrational and potentially harmful drug formulations. But who cares? [4].
5. Problems Associated with some Drug Formulations [5].
6. Medical watch: Bribes to Doctors by Pharmaceutical Industry [6].
7. Laws to Curb Unethical Practices by Pharmaceutical Industry [7].
8. What should the Doctor do in case Pharma

Practicing Pediatrician, Jaipur E-mail: dryashpaul2003@yahoo.com

Industry resorts to malpractices endangering lives of people? [8].

9. Is Pharmaceutical Industry uncontrollable or not being controlled? [9].

As there was no initiative on part of Pharmaceutical Industry, on 25th November 2022 the author presented a memorandum to the Administrator, Administrative Reforms and Public Governance, Government of India, New Delhi.

Author quotes here the first paragraph of the memorandum:

"Ministry of Petroleum and National Gas takes all necessary steps to ensure that petrol supplied all over the country is of uniform and high quality so that no damage occurs to engines of the vehicles. Pharmaceutical Industry comes under the Ministry of Health and Family welfare. This industry makes and sells products which are for human consumption. Pharmaceutical houses obtain license to manufacture drugs from Drugs Controller General of India (DCGI). Many times case of spurious and substandard drugs have been reported. Many medicines made in India are irrational and potentially harmful. As these irrational and potentially harmful drugs are produced after obtaining the license from appropriate government authority, it may be said that the government has knowingly permitted production and sale of such drugs". (Registration No. DHLTH/E/2022/16931)

The Hindustan Times dated April 25, 2023 reported under title 'Centre begins process to revamp drug regulation: "To assure better quality of drugs it was decided by the ministry to amend the archaic Drugs and Cosmetics Act. Health is a state subject but as part of amendment, it has been decided that the centre will have to take control of certain power to maintain quality of drugs being produced in the country. The Union Health Ministry is in the process of finalizing amendments to the Drugs and Cosmetics Act 1940."

Medical Dialogue (http://medicaldialogue.in) dated 16th May 2023 reported that the Central Government has issued instructions that it may be ensured that visits of medical representative to the government hospital premises are completely curtailed. Any information about new launch may be communicated by way of e-mail only".

It is a good omen, but it will take some time to finalize the proposed amendments and some more time when it will come into force. Till then responsibility of patient's safety falls on the doctor.

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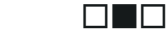

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Review Article :

Telemedicine and Telehealth - An Overview

Dr. T.N. Ravisankar

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Digital health, Telemedicine, Telehealth, Guidelines, Legal liability.

Abstract :

Digital health and Telemedicine have become the order of the day in health care services. The change in the environment and growth of science has to be adopted for the growth of the Medical Profession and Professionals. Digital technology has invaded all sectors and there has been a phenomenal growth both in services and in business prospect. Health Care Sector has adopted the technology as a diagnostic and professional tool. But it was hesitant to use the same in its professional services. COVID 19 brought in the need and necessity to use Digital Health Services enforcing the Medical Councils to issue guidelines to practice Telemedicine and Telehealth. Guidelines issued in an emergency situation need to be evaluated as the pandemic has passed over so that the practicing guidelines are best used by the professionals without any burden.

The best teacher of this country COVID -19 has metamorphosed the health care industry to adopt the ardent discovery of the past century – Digital Technology. It took nearly two decades to adopt Digital Technology for use in clinical services. The Pandemic set the humans and health care industry on a roller coaster ride. Infection became so transferable that the busiest world came to a standstill. But the services of the health care sector were in the highest demand as ever. It also had to find ways and means to safeguard itself from the most infectious Virus – COVID 19. Ministry of Health and Family Welfare drafted swift guidelines for use of Telemedicine spanning over 40 pages- Telemedicine Practice Guidelines and released them on 25th March 2020. The same have been incorporated almost in total in the National Medical Commission, Registered Medical Practitioner (Professional conduct) Regulation 2022.

Telehealth has been in existence for almost a decade prior to the COVID 19 days. Patients who are in good relationship with their Family Physicians or their Specialist have been using communication by emails, SMS, Whatsapp and in other modes expressing their symptoms and getting prescription for drugs. It has always been possible in our country to get even the schedule drugs from any pharmacy. It is highly competitive commercial establishment, that the pharmacies are always willing to bypass the minimum law of a prescription from a Registered Medical Practitioner. Here again human relationship does the final trick to get the drugs in the pharmacy violating the law. It is a well-known factor in the Indian healthcare sector that compassion and empathy always stand above the Law enabling the population to procure the necessary drugs as and when needed. Health care sector is always indicated of being non transparent, hence the service provider always takes the opportunity to be more empathetic responding to such request for drugs supply and advice evaluation online as a relationship strategy.

Telemedicine provides clinical services via the digital modes that are available to the recipient-the patients. Telemedicine is defined by WHO as

Senior Family Physician, Sudar Hospitals, Chennai Email : tnrimlindia@gmail.com

'The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.'

Telehealth was also defined as *'The delivery and facilitation of health and health-related services including medical care provider and patient education, health information services, and self-care via telecommunications and digital communication technologies.' (Scope of Telemedicine is also enlisted in 1.2)*

3.1.1 *The Registered Medical Practitioners should exercise their professional judgment to decide whether a telemedicine consultation is appropriate in a given situation or an in-person consultation is needed in the interest of the patient. They should consider the mode/technologies available and their adequacy for a diagnosis before choosing to proceed with any health education or counseling or medication. They should be reasonably comfortable that telemedicine is in the patient's interest after taking a holistic view of the given situation.*

3.1.2 *Complexity of Patient's health condition- Every patient/case/medical condition may be different, for example, a new patient may present with a simple complaint such as headache while a known patient of Diabetes may consult for a followup with emergencies such as Diabetic Ketoacidosis. The RMP shall uphold the same standard of care as in an in-person consultation but within the intrinsic limits of telemedicine.*

Clinical services of Telemedicine purely depend on the capacity of the patient to describe his symptoms. It is easy to identify if one has fever, myalgia or cough - the most common symptoms of any infection. If Telemedicine is encouraged in the community, non-communicable disease which has no accurate specific symptoms will not be detected early in the community practice. Giddiness, headache, frequent urination, pedal edema needs assessment with a Sphygmomanometer and a Glucometer to the barest minimum. Do the drafting policy experts expect the public to own a BP apparatus and Glucometer, if they opt for Telemedical consultation? Symptom analysis and clinical evaluation form the basis for any consultation. In that scope patient needs to demarcate pain, numbness, burning sensation, tingling sensation, radiating pain with clinical perfection for the Telemedicine practitioner to identify the symptoms for an accurate diagnosis.

The proposed draft nor the existing one has self-protective provision for the Telemedicine practitioners. It only stresses "The RMP should uphold the standard of case as she/he does for in person consultation within the inherent limitation of telemedicine. "What is the inherent limitation". Clinical examination is lost in total and visual evaluation is also not with the naked eye, but only through the artificial lens that the humans manufacture. The natural lens of the eye's perception of spotter diagnosis is unmatched when the brain is loaded with knowledge.

A good history is only a contributing factor for a clinical examination. Abdomen is a Pandora's box even when examined clinically, pain in the right hypochondria, epigastric region and below the left costal margin needs to be identified to differentiate between a surgical and medical abdomen. A delay in the diagnosis can have a

terrible outcome, drowning the telemedicine doctor under the domain of medical negligence.

Burning chest, recurrent belching, pricking pain in a comorbid patient has the differential diagnosis of Coronary Artery disease and advising to reach the hospital or a Diagnosis center is to be the priority to diagnose the cause and to treat within the Golden hour.

Section 3.1.1 *Telemedicine has its own set of limitations for adequate examination. If a physical examination is critical information for consultation, RMP should not proceed until a physical examination can be arranged through an in-person consult. Wherever necessary, depending on professional judgment of the RMP, he/she shall recommend: - Video consultation - Examination by another RMP/ Health Worker ; - In-person consultation - The information required may vary from one RMP to another based on his/her professional experience and discretion and for different medical conditions based on the defined clinical standards and standard treatment guidelines.*

It is going to be really difficult to convince the patient on Telemedicine to go in person for a consultation after starting a tele consultation. Even in a physical Consultation with the Family Practitioner there will always be hesitancy to do any evaluation that is advised. The symptoms, expressed, may be withheld or withdrawn by a patient if evaluation incurring expense is advised by the practitioner. If a Specialist advices evaluation they get back to their Family Doctor to get a second opinion on investigation, while losing the Golden hour for early management.

Once on Telemedicine Consultation, it is not going to be an easy option to advise the patient to go to a hospital using the clause 3.1.1. As the patients will insist for prescription loss of man hour is the only option left to the Telemedicine Doctor, which will be a better option than being enmeshed with a medical negligence case.

3.6.1 of Code of Telemedicine providers the Registered Medical Practitioner the scope of first and subsequent consultation. It is far from practical issues, since the human body depends on its environment and mental factor that can alter the symptoms and clinical status of the patient in a very short time. Also a patient's reaction to any change in environment also depends on the individuals. The varying factors from individuals and the timeline for any symptoms and recognition of such symptoms also depends on their awareness and the ability to correlate their ailment. Six months is too long a time to enable a patient to utilize his first consult with follow-up consult. Any follow-up consult cannot be more than a week or at the maximum with leverage for patient it can only be two weeks. Further be aware that the Indian patients are used to continue a doctor's prescription for years together. But blame the Doctor for any side effects or poor recovery for them even years later and for their life time. The six months' time will provide the courts to be biased towards the patients if the case reaches the court or alleged negligence on treatment or for denying a Teleconsultation as per the guidelines of the NMC.

A patient with an acute febrile illness will seek to reach the RMP until six months quoting the first consultation, though the guidelines define different symptoms or change in symptoms do not fall in the category. Fever more than once occasionally within six months is not uncommon and if one has chronic ailments such as Tonsillo-adenitits or Chronic Urinary Tract Infection or Chronic Obstructive Pulmonary Disease or terminally ill malignant patients they are bound to have repeated symptoms that can vary within six

months thus cannot fall in the category of subsequent consultation after first consult.

3.7.1.3 gives immunity for breach of confidentially for the RMP's but the social media such as Whatsapp and Facebook do have cloud base storage which can be hacked. In due course number of software are bound to be in the Digital Market with different levels of security platform. These Digital platforms must be accredited on their security facet by a common agency for the RMPs to use them without any legal accountabilities.

If such authority does come into play the guidelines or the minimal adherence details on Hardware and Software based on Information Technology act could be endorsed for better applicability.

The Indian populations' cluttered target have always been the Medical community. Telemedicine guidelines do not allow for international patients to seek any consultation. But an Indian with an Indian mobile number can call from any part of the world communicating with the Indian RMP for consultation. One cannot check on the tower to offer or deny the consultations. Indian number used by an Indian on a foreign soil cannot be detected, which could lead to violation of Telemedicine guidelines of both country. If so who is legally responsible? The Teleconsultation seeking individual or the RMP who provided consultation without been aware of the violation by the person and the legal structure? To substantiate the violation of the person or patient seeking legal consultation from abroad one need the Ministry of External affairs and Ministry of Communication to provide data to let the RMP free from legal mesh. This in our country will definitely shorten the Life span of the Doctor. Emergency vs non-emergency has been clearly guided by the NMC, but unfortunately if you respond and later request for personal consult or advice to reach the nearest hospital on a number of occasions it will be difficult to convince the patient to do so and the golden hours in the management are bound to be lost. Not adhering to Health providers' advise always are at a higher scale as related to the one that is followed in our country.

One stop solution with so many odd and unexpected reactions to Telemedicine will be in the best interest of the health sector with one act passed by the Act of Parliament. **"Patients who seek Tele consultations will not be eligible to seek legal remedy in form in any forum".** This will enable the RMPs to practice without a sword dangling on their head. It will also promote Digital health in the country reducing the cost of travel and time.

Telemedicine depends on two major tools for better implementation. A well-educated patient about his symptoms and signs of his ailment, so it becomes imperative to educate the patients to use digital mode. There is already a by law by NMC to have certificate course on use of Tele technology for Doctors within three years of enacting Telemedicine guidelines. It is 2023 and three years have vanished yet such a course is still not offered by NMC.

Telemedicine will truly depend on Diagnostic tool to follow the patient. Many times number of negative predictive investigations may be needed to rule out certain ailments rather than find a positive one. In chest pain which may be a pure reflux or gastritis, which will only need an Endoscopy, for diagnosis an ECG or ECHO will be essential in Telemedicine to rule out a Heart ailment. If the RMP overlooks and by chance the patient lands up in a cardiac event for the next six months the liability will be again on the doctor as it is a similar symptom recurring repeatedly.

CPA had lead the Doctors to defensive

practice and Telemedicine will push them for negative predictive diagnostic test as it is now evidence based medicines. It then becomes evidence based negative practice in Telemedicine escalating the cost of medicare.

5.4 of the guideline stress that Artificial Intelligence/ Machine learning are not allowed to counsel the patient as of 2022. It will only take another decade or still shorter that NMC will be issuing guidelines on AI as it is on the invading path in all fields of life. Health sector is already for adopting non patient involving arena. Days will not be far off when patients demand Artificial intelligence for their treatment or second opinion and health care sector will be forced to oblige.

Telehealth providing health education can make the society healthy in such a varied and big Democratic country. It can reach the remotest village and hills to provide early detection and care to mobilize them to the nearest health care facility for early recovery.

In the urban area after the first physical consult, Telehealth / Telemedicine will be time saving to review the reports that were advised on physical visit or access the prognosis of the treatment provided.

A word of advice on lifestyle, food habits and encouraging and confident creating words can be provided in Teleconsultation. These are less likely to be legally liable but will never be financially beneficial for the RMPs as the Indian citizens do not value such advises.

It is evident from the fact that a Doctor spotted on road / mall is often asked for a free advise by anyone, if he is recognized by the other person as a Health care facilitator be it doctor, paramedical or allied Health care provider.

Telemedicine can never replace physical medicine until Humans becomes Robots when it can be treated with adding a chip or adjusting a nut or bolt. Emotional factors needs to have consoling words with smiling and encouraging face and master communication since medicine alone does not cure. The physician's presence and communications mark an infinite and favorable outcome.

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Contribution in JIMLEA

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

Medicolegal News

Compiled by : Dr. Santosh Pande

IPC 304A: Bhopal Doctor Booked After Pregnant Patient Dies Due To Blood Transfusion

Bhopal: A doctor belonging to a Private Hospital in Bhopal has been booked under IPC 304A for the death of a pregnant woman due to alleged negligence during treatment.

Allegedly, the health of the patient deteriorated due to a reaction to blood transfusion as the transfused blood was several months old. Relying on the post-mortem report, Chhola Mandir Police have registered a case against the doctor under Section-304-A of IPC. Statements of the family members have also been recorded.

The unfortunate incident happened last year when the patient, who was a resident of Chandbadi, had been admitted to Karond-based Aadhaar Hospital for the delivery of her child. At the time of admission on October 15, 2022, the patient was 35 weeks 6 days pregnant. The treating lady doctor conducted the delivery of the child by operation and the patient delivered a baby boy. However, the next day, the condition of the patient deteriorated. Therefore, another doctor offered blood to the patient at around 2 pm. Following this, the patient died at 10.30 pm.

After this, a post-mortem of the patient was conducted. Family members of the deceased patient and the doctors of the hospital also recorded their statements. As per the latest media report by Daily Pioneer, the statements revealed that even though the blood bank had been informed about the requirement of blood at 5pm on October 15, the blood could be offered to the woman only the next day, around 21 hours later. As a result of this, the patient's condition worsened further and the blood transfusion was stopped due to this.

Relying on the Post-Mortem report, Police booked the 55 years old doctor who had given the blood to the patient. Allegedly, it was found that the patient had died because of an old blood transfusion. Commenting on the matter, a doctor told the daily that the patient had died due to a blood transfusion reaction. The transfused blood resulted in hypersensitivity and due to this, there were spots on the body.

He further mentioned that before blood transfusion and before giving any injection, sensitivity test is done and if reaction is noticed, then the doctor does not give it to the patient.

Ref.: *https://medicaldialogues.in/news/health/doctors/ipc-304a-bhopal-doctor-booked-after-pregnant-patient-dies-due-to-blood-transfusion-110234?from-login=156091 Accessed on 02/05/2023*

Patient Dies After C Section: Court Summons Doctor Charged Under IPC 304A

Ahmedabad: While considering a case of medical negligence, where the patient died after c-section delivery, a metropolitan court has recently summoned the treating doctor to answer the charges leveled against him under Section 304A of IPC (causing death by negligence).

The concerned doctor of Deep Maternity and Nursing Home, Narida had been accused of negligence as he remained absent at the maternity home and the patient's condition allegedly worsened and she ultimately died.

Even though the Police opined that there was no cognizable offense made out against the doctor, the Additional Chief Metropolitan Magistrate, D J Parmar observed that the presence of the doctor at the maternity home could have avoided such a situation altogether.

Practicing Anesthetist and President IMLEA, Amravati Branch E mail:drpandesr@gmail.com

Opining that the doctor had shown negligence in his duty, the Court also observed that the hospital staff were not responsible since they merely acted on the instructions of the doctor.

The doctor has been asked to remain present in court on May 12 to respond to the charges concerning the death of the patient back in 2014.

As per the latest media report by the Times of India, on October 5, 2014, the patient had been admitted to Deep Maternity and Nursing Home and she underwent a C-section for the delivery of her baby. After the birth of the baby boy, the condition of the patient worsened.

Since the treating doctor was not available, the staff of the hospital treated the patient after obtaining instructions from the doctor via phone. Despite repeated calls from the relatives of the patient, the doctor could not reach the hospital and when finally he reached the facility, the patient had become unresponsive and she did not have a pulse.

After being shifted to an ICU in a nearby hospital, the patient had been declared dead and the husband of the patient approached the court for relief.

Referring to the matter, the counsel for the petitioner demanded action against the doctor under Section 304 of the IPC, for culpable homicide not amounting to murder.

Following this, the court directed the police to investigate the matter and accordingly, the Sardarnagar police inspector sent his opinion to the court. After perusing the Post Mortem report, the medical record and the FSL report, the inspection had opined that no cognizable offence was made out against the doctors.

However, the court has opined that the situation could have been avoided if only the doctor would have been present at the maternity home. Accordingly, holding the doctor negligent in his duties, the court has summoned him to answer the charges against him.

Ref.: *Patient Dies After C Section: Court Summons Doctor Charged Under IPC 304A Accessed on 02/05/2023*

Negligence In Laparoscopic Cholecystectomy Results In Patient's Death: ISPAT, Apollo Hospitals, Doctors Slapped Rs 25 Lakh Compensation

New Delhi: The National Consumer Disputes Redressal Commission (NCDRC) recently held Doranda-based Ispat Hospital and Andur Razzaque Ansari Memorial Weavers' Hospital (Apollo Hospitals Group) and its doctors guilty of medical negligence while providing treatment to a patient operated for removal of the gall bladder.

Following the operation, the condition of the patient worsened and she ultimately died because of internal bleeding leading to cardio-respiratory failure.

Previously, while considering the matter, the State Commission had exonerated the Apollo Hospital. However, now the top consumer court has noted that the "doctors at ISPAT and Apollo Hospital liable for not exercising their reasonable skills and failed to provide standard of reasonable care."

"Based on the discussion above, we hold the doctors at ISPAT and Apollo Hospital liable for not exercising their reasonable skills and failing to provide standard of reasonable care. Thus, both the hospitals are vicariously liable for the acts of their employees (doctors). We find the State Commission has awarded just and adequate compensation, but erred while deciding negligence against the OP-6 (the Apollo Hospital)," read the order.

Therefore, the NCDRC bench has slightly modified the State Commission order. Even though the amount of compensation of Rs 25 lakh has been kept the same, the Apex consumer court has clarified that Apollo Hospital will also pay an equal proportion.

"Considering the entirety of the fact of the case, we affirm the Order of State Commission with the modification that the compensation awarded by the State Commission shall be paid in equal proportion by the OP-1 and OP-6 within 6 weeks from today, failing which, the entire amount shall carry interest @10% p.a. till its realization," the NCDRC bench observed.

The matter goes back to 2001 when the Complainant's wife, the patient had been operated by Dr. Agrawal for laparoscopic cholecystectomy i.e. removal of gall bladder. The operation had been conducted at Ispat Hospital. However, during the hospital stay on July 9, bile discharge was found to be abnormally high and therefore, the patient had been referred to Andur Razzaque Ansari Memorial Weavers' Hospital or the Apollo Hospital.

At the second hospital, ERCP had been performed but it remained incomplete since the doctor was allegedly unable to cannulate the Common Bile Duct (CBD). Finally, Hepaticojejunostomy operation had been performed. However, the condition of the patient worsened from July 22 and two days later, she died. The cause of death was mentioned as 'Biliary Peritonitis and internal bleeding' leading to cardiorespiratory failure. Aggrieved by the death of the patient, her husband and two sons filed a consumer complaint before the State Commission Jharkhand.

On the other hand, Ispat Hospital and its doctors denied any deficiency and medical negligence on their part. Meanwhile, Dr. Agrawal expired during the proceedings and his name was deleted from the proceedings. Dr. Mishra and Dr. Sreeniwasulu filed their replies and denied any negligence during the operation and post-operative care. It had been submitted that the treating doctors had chosen appropriate method based on the patient's condition. Further they submitted that the laparoscopic procedure is a least invasive and safe method for the patient as she was diabetic and obese.

Further, referring to the allegation of Consent taken for open surgery and changing it to laparoscopic, it was submitted that since entire preparations were ready, the procedure could not be changed abruptly with short notice. They also denied that CBD of the patient had been injured due to negligence.

Meanwhile, Apollo Hospital also denied about the removal of the drainage tube on July 11 and submitted that the drainage tube had come out on its own. Denying allegations of delayed open surgery, Apollo Hospital further submitted that the operation was not possible because of fluctuating blood sugar levels of the patient.

After considering the matter, the State Consumer Court partly allowed the Complaint and held Ispat Hospital and its doctors liable to pay Rs 25 lacs compensation along with interest @9% and Rs.1 lac towards litigation charges. However, Apollo Hospital had been exonerated by the State Commission.

Challenging the State Commission's order, the Ispat Hospital and its doctors approached the top consumer court. The counsel for the Complainants argued that the doctors at ISPAT Hospital during laparoscopic cholecystectomy had cut the CBD instead of cystic duct and wrongly clipped the lower trunk of CBD leaving upper part of duct un-clipped. It resulted in uncontrolled biliary leak in the peritoneal cavity and biliary peritonitis.

Alleging that the doctors were not serious, the counsel further submitted that the patient just got referred to Apollo Hospital for ERCP to shift their liability on Apollo Hospital. Further, it was claimed that the doctors in Apollo Hospital were also careless and they performed ERCP negligently and removed the drainage tube on July 10. It was alleged that the doctors delayed the surgery till July 17 and it

resulted into accumulation of bile in the peritoneal cavity and ultimately the death of the patient.

Meanwhile, Apollo Hospital submitted that ERCP was difficult and incomplete and it was also submitted that the hospital took all possible steps to save the life of patient.

Apart from taking note of the submissions, the NCDRC bench also perused the entire medical record, took reference from several medical literature on CBD injuries and gone through the standard textbooks on surgery.

Referring to the medical record of Ispat Hospital, the Commission noted that, "Admittedly, after the surgery, there was large drainage of bile till 09.07.2001 and no steps to investigate or stop the leakage were taken. It is pertinent to note that the patient was referred for ERCP after 9 days which was the ultimate cause of biliary peritonitis. The Appellants failed to produce the USG films in support of their case. The State Commission rightly observed."

Further perusing the biliary drainage record, the Commission observed, "On bare perusal of the table, it is clear that, the biliary leakage was significant. The USG abdomen revealed a large collection in sub-hepatic space."

The Commission noted that Dr Ali performed the exploratory laparotomy and Hepaticojejunostomy on July 17, at Apollo Hospital. In the operative notes, it was recorded that “Large amount of bile in the peritoneal cavity, CBD had been divided, leakage of bile from the cut end of CBD”.

Examining the role of Apollo Hospital, the Commission noted, "It is pertinent to note that the State Commission erred, which, despite having held that Apollo Hospital (OP-6) was negligent, dismissed the Complaint qua OP-6 as barred by limitation. We note that during first round of litigation in FA No. 860 of 2003, this Commission, vide order dated 28.04.2010, remitted back the matter to the State Commission to implead OP-6. The OP-6 never challenged that Order, thus it attained finality. Therefore, the impleadment of OP-6 was not barred by limitation."

Referring to the complaint, the NCDRC Bench also observed, "It is pertinent to note that, the drainage tube was removed, but it was not clear whether it was removed at ISPAT or APOLLO. Thus, it proves that there was leak of bile due to CBD injury."

The Commission also referred to the medical record of the Apollo Hospital, which revealed that on July 10, it was recorded as “C/o drainage tube removed”.

Taking note of this, the Commission pointed out the failure of duty by the doctors of Apollo Hospital and noted, "Thus, it confirms in Apollo Hospital that the drainage tube was removed. Thereafter, the ERCP was performed on next day. It was not successful, therefore, the decision to perform open surgery was taken. But it was not done immediately. Nothing is forthcoming as to why the patient was kept waiting till 17.07.2001. The findings of bile drainage during intervening period i.e. 11.07.2001 to 16.07.2001 were conspicuously missing. It was just mentioned that abdomen soft and there was no leakage from drain site. Since the drain tube was removed, the abdominal accumulation of bile increased. The doctors / staff on duty at Apollo Hospital failed to insert drainage tube, which could have accumulated the bile. Thus, the condition of the patient further deteriorated."

In order to discuss the laws laid down on medical negligence, the Commission referred to Supreme Court order in the case of Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole and Anr. and A.S. Mittal vs. State of UP, holding the doctors at both the hospitals negligent, the Commission observed, "Taking clue from above judgment, it is clear that at ISPAT hospital, during laparoscopy, the CBD was cut, whereas in Apollo Hospital, after ERCP, the doctors delayed the

exploratory laparotomy for a week. Thus, in our considered view, the doctors at both the hospitals (ISPAT and Apollo) failed in their duty of care. It further resulted into biliary peritonitis and death of the patient."

"We do not agree with the State Commission which dismissed the complaint against the OP-6 (Apollo Hospital) relying upon the Discover Rule as discussed by the Hon'ble Supreme Court in V.N. Shrikhande (Dr.) Vs. Anita Sen Fernandez case. However, in the case in hand, it is pertinent to note that the patient was operated in two Hospitals and sustained injuries, which led to the death. From ISPAT Hospital, she was referred to Apollo Hospital, but the Complainant raised the entire allegations on OP-1 only. Therefore, merely on such technicality, the OP-6 cannot be exempted from its liability of negligence, otherwise, it would defeat the principles of natural justice under the Consumer Protection Act, 1986." it added.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/negligence-in-laparoscopic-cholecystectomy-results-in-patients-death-ispat-apollo-hospitals-doctors-slapped-rs-25-lakh-compensation-110379 Accessed on 02/05/2023*

No Doctor Does Negligence Knowingly: NCDRC Refuses Patient's Kin Plea To Enhance Compensation

New Delhi: The National Consumer Disputes Redressal Commission (NCDRC) has rejected a revision petition seeking to enhance the quantum of compensation pronounced by the U.P State Commission in a case, wherein, the District Forum held a doctor guilty in treating a patient suffering from pleural effusion of left lung, who eventually died.

Stressing on the State Commission's remark that, 'No doctor does negligence knowingly and nor his objectives are that he will give wrong treatment', Presiding Member of NCDRC, Dr S M Kantikar observed that the death of the patient, as alleged by the patient's kin, should not be attributed to the Anti Tubercular Treatment (ATT) advised by the doctor, adding that the State Commission awarded just and proper compensation, considering the peculiar facts and the known complication of ATT.

The case is that in 1998, a patient was taken to the doctor for respiratory problems. It was diagnosed as pleural effusion on left side and he was admitted in the doctor's nursing home. The effusion fluid was removed and he was discharged. It was alleged that due to consumption of medicines prescribed by the doctor, the patient lost his appetite and developed jaundice. The patient visited the doctor repeatedly, but he allegedly ignored the patient. And again, the doctor himself admitted the mistake and did not stop Anti Tubercular Treatment (ATT), alleged the patient's kin. For jaundice, he referred the patient immediately to RML Hospital, New Delhi.

Thereafter, the patient got admitted in Safdarjung Hospital, New Delhi and diagnosed as Drug induced hepatitis. The patient was in the Safdarjung Hospital for some time. He developed kidney problems (loss of urine) and dry gangrene of both foot. Therefore, for dialysis, he was shifted to Batra Hospital. Unfortunately, the patient eventually died. Being aggrieved by the alleged negligent treatment causing death of the patient, the patient's son filed a complaint before the District Forum to claim Rs 4,40,000/-.

In response, the medical practitioner filed written version and submitted that he diagnosed the case as tubercular pleural effusion and started the best available treatment for TB. He further submitted that in the Safdarjung Hospital, the same diagnosis was made and the same medicines were given. Thereafter, it was diagnosed as drug induced hepatitis.

The District Forum, allowed the complaint and directed the doctor to pay compensation of Rs. 50,000/- and Rs. 5,000/- for mental agony with cost

of litigation amounting to Rs. 2,500/-.

Being aggrieved at the amount of compensation, the Complainant filed the First Appeal before the U.P. State Commission for the enhancement of compensation. The Appeal was dismissed with the following observation: "The appellant reiterated that the amount of compensation in passing judgement should be having enough ground to be increased and grant the compensation, as prayed in the plaint. No doctor does negligence knowingly nor his objectives are that he will give wrong treatment. Hon'ble District forum found Doctor guilty and by self-discretion compensation has also been applied. In such situation we came to the conclusion that there is no need to interfere in the decision and order taken by the Hon'ble District Forum regarding the question and the order is reasonable and lawful. The appeal deserves to be rejected."

Aggrieved, the Complainant filed the instant Revision Petition against the Order passed by U.P. State Consumer Disputes Redressal Commission in 2022. On careful perusal of the medical record of RML Hospital, Safdarjung Hospital, Batra Hospital and the prescriptions of the doctor, the Commission concluded that the patient was properly investigated by the doctor and thereafter, he started ATT for tuberculosis. The patient took ATT for one month and he was under regular follow-up of the doctor. As the patient developed jaundice, due to drug induced hepatitis, on 21.11.1998, the doctor referred him to RML Hospital. From there, the patient went to Safdarjung Hospital for further treatment, wherein he was investigated. The X-ray revealed pulmonary Koch's and the ATT was continued. The patient further developed Anuria (renal problems) and dry gangrene of right foot. The surgical opinion was also taken.

The apex consumer body noted; "In the instant case, the diagnosis and ATT treatment was necessary. The doctor treated the patient with appropriate ATT regime. I find it to be a reasonable standard of care. From the standard textbook on medicine (Harrison's Internal Medicine), it is known complication that ATT drugs cause hepatotoxicity, and it is reversible."

Subsequently, the Commission dismissed the revision petition. It held; "In the instant case, as the patient developed jaundice, he was immediately referred to higher centres for further management. In my view, the renal problem and gangrene of foot, both are not related to or resulted due to ATT treatment. Therefore, the death of the patient shall not be attributed to the ATT treatment advised by the doctor. However, the State Commission awarded just and proper compensation, considering the peculiar facts and the known complication of ATT. The same is affirmed. Based on the discussion above, there is no merit in the instant Revision Petition, same is dismissed."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/no-doctor-does-negligence-knowingly-ncdrc-refuses-patients-kin-plea-to-enhance-compensation-110438?infinitescroll=1 Accessed on 02/05/2023*

Disability Due To Non-Union Of Bones After ORIF: NCDRC Absolves Punjab Hospital Of Medical Negligence

New Delhi: Setting aside the order of the State Commission, which held a Punjab based hospital guilty of medical negligence while performing open reduction and internal fixation (ORIF) on a patient, the National Consumer Disputes Redressal Commission (NCDRC) gave clean chit to the hospital.

Although the patient had alleged that he had to suffer disability because of non-union of bones, the top consumer court opined that "non-union or mal-union of fracture is a known complication, which could arise by improper

follow-up, weight bearing or infection. The disability was not due to the negligence of treating doctor or hospital."

The matter goes back to 2010 when the Complainant suffered fracture of right Radius and Ulna bones after meeting with an accident. Thereafter he was taken to Malwa Ortho Hospital and was operated for Open Reduction and Internal Fixation (ORIF). A few days after the operation, the Complainant developed swelling and pain. When he approached the treating hospital, he was given some medicines but the condition did not improve. Later, after conducting X-ray of the right hand, it was revealed that the bones of the patient were not properly fixed, screws and plates were loose and separated, moving freely. Thereafter, a second operation was conducted for removal of plates and the plaster of paris was fixed.

Therefore, the Complainant alleged that while applying plaster, there was no union of fractured ulna bone and the Complainant's hand bent towards one side. As a result, the patient became handicapped and unable to do his work properly. Following this, the Complainant visited few hospitals in Rampura Phool, Amritsar and Sri Muktar Sahib. However, all those hospitals advised for another surgery.

Finally, after visiting Civil Hospital, Muktsar, the patient was declared to be 35% handicapped and a certificate had been issued in this regard on October 5, 2011. Since the patient was a teacher, he had to remain on medical leave during the time of treatment. Although the patient requested the hospital to pay the amount spent by him, the request had been refused and following this, the Complainant filed a complaint before the District Forum, Sri Muktsar Sahib.

While considering the matter, the District Forum relied upon the evidence of Dr. H.S. Sohal, Professor and Head of Department of Orthopaedics, Government Medical College, Amritsar. As per the evidence Government Rules pointed out that benefit of disability cannot be given if it falls below 40%. Since the disability of the complainant was 30%, the District Forum dismissed the complaint.

However, the Punjab State Commission allowed the appeal and directed the hospital and nursing home to pay Rs 1.5 lakh along with interest. Being aggrieved with this order, the hospital approached the NCDRC bench. The apex consumer court noted that the Complainant after suffering commutated fracture of both forearms and dislocation of wrist joint was taken to Bansal Nursing Home, where Dr. Jain performed ORIF surgery with DCP with bone grafting and G Graft. Thereafter the Complainant visited the hospital after 4 months when the X-rays revealed dislocation of plates. Consequently, Dr. Jain removed the plates and POP was applied and the patient was discharged.

The Consumer Court further noted that the Complainant was advised surgery if bones did not unite but the Complainant ignored the advise. The bench also perused the statements on record given by the Officers and Doctors at Civil Hospital, Muktsar.

It was observed by the court that the Junior Assistant CMI, the In-charge of Disability Certificate issuing division stated that no record was available about the issuance of disability certificate by the Civil Hospital and no entry in the physically handicapped dispatch register. There was no serial number on the certificate.

Referring to the hospital records, the Commission noted that no application made by the Complainant for issuance of disability certificate and no document regarding any tests carried upon him. Another statement of Rtd. CMO revealed that the disability certificate less than 40% disability shall not be issued. "The certificate got signed from him in routine and it does not bear any number and

even the certificate issuance register had no entry of issuance of such certificate between 14.09.2011 to 05.10.2011," noted the commission.

Apart from this, the Commission also referred to the third statement of Dr. H.S. Sohal, Professor and Head of the Department of Orthopaedics, Govt. Medical College, Amritsar, who was also Head of the Department for State of Punjab to issue disability certificate. Dr. Sohal had opined that no certificate can be issued without any number.

"Certificates can be issued even if the disability is less than 40% but the benefits of disability and for compensation as per Govt. rules if disability of 40% or above. In the certificate, dislocation of Ulno Carpal joint was mentioned, but such joint never exists in body. He further opined that there was no negligence of the Operating Surgeon, the patient did not follow the instructions given by the operating doctor, such disaster can happen," noted the Commission.

Therefore, after perusing the Disability Certificate, which does not bear any serial number and appears to be a forged document and was issued without any authority, the Commission noted, "Thus, there is a possibility of the Certificate being procured in connivance with the officials of the hospital."

Referring to the RTI information, the Commission noted that the Complainant was Govt. School Teacher and he was on duty as a teacher taking regular classes and seminars. He also performed census work during the year 2010 and 2011." Therefore, exonerating the hospital from charges of negligence, the Commission mentioned in the order,

"On the basis of foregoing discussion, it is evident that the treating doctor was a qualified Orthopaedician and performed ORIF as an accepted standard of practice. The non-union or mal-union of fracture is a known complication, which could arise by improper follow-up, weight bearing or infection. The disability was not due to the negligence of treating doctor or hospital."

The Commission, therefore, set aside the order of the State Consumer court and mentioned in the order,

"The State Commission erred by holding the OPs liable for the disability suffered by the Complainant. The Order of State Commission is set aside and the Revision Petition is allowed. Consequently the Complaint filed before the District Forum is dismissed."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/disability-due-to-non-union-of-bones-after-orif-ncdrc-absolves-punjab-hospital-of-medical-negligence-110750 Accessed on 05/05/2023*

Advising Chemo Without Tissue Diagnosis Amounts To Medical Negligence: Commission Directs Tata Memorial Hospital, Doctor To Pay Rs 5L Compensation

Mumbai: Noting that without tissue diagnosis advising chemo was the act of omission, the National Consumer Disputes Redressal Commission (NCDRC) has held Parel's Tata Memorial Hospital and a doctor guilty of medical negligence, and directed them to pay a compensation of Rs 5 lakh to a female patient.

The patient went through two cycles of chemotherapy after an oncologist diagnosed her as suffering from stage 4 stomach cancer without even verifying the biopsy report. The biopsy report procured subsequently did not detect malignancy.

Presiding Member of the Commission, Dr S M Kantikar did not rule on the aspect as claimed by the patient that she was wrongly diagnosed and clarified it as a case of contributory negligence, since the patient, Sabitari Agarwal, herself was negligent, who did not bother to collect the biopsy report.

The patient said that she had first come to the hospital from Chattisgarh on March 21, 2007

after complaining of abdominal pain and undergoing various tests. The ulcerated growths were sent for biopsy. She alleged that without waiting for the reports when she was asked to undergo chemotherapy, she went to Udaipur. She could afford only two chemotherapy cycles and also underwent a blood transfusion between the two sessions. She said that her condition worsened and she returned to Tata Memorial on June 11, 2007 where the report was finally taken. The woman said that losing confidence, she went back to Udaipur and was treated for other ailments. She said she suffered from TB, but took two chemo cycles unnecessarily.

Being aggrieved due to alleged medical negligence and deficiency in services, the patient filed a Consumer Complaint before the State Commission against the doctor and the hospital claiming Rs. 72,58,000/-.

However, she moved the national consumer commission in 2012 after Maharashtra State Consumer Disputes Redressal Commission rejected her plea. The state consumer commission had denied allegations that she was wrongly diagnosed as suffering from cancer. It had said that the oncologist had evaluated clinical reports properly and correctly and even after discharge, a hospital in Udaipur still suspected that she was a case of carcinoma of stomach.

Before the apex consumer body, the grouse of the Complainant was that she brought the biopsy of stomach growth from Udaipur, it was given at hospital for HPE study but the doctor prescribed chemotherapy without waiting for the biopsy (HPE) report. Thus, she took two cycles of chemotherapy at her home town. She developed severe complications. Surprisingly, the HPE was reported as "moderate to severe chronic active gastritis with atrophy and foveolar hyperplasia. H. Pylori organisms are noted." It was negative for malignancy.

Meanwhile, the hospital and the doctor denied the allegations. The doctor submitted that best possible professional care and skill was taken to start the patient on appropriate management in existing circumstances, when the overall picture supported gastric carcinoma. He also submitted that even the Udaipur hospital report suspected cancer. He further submitted that, "It was the fault of the patient who didn't wait to collect the HPE report and she didn't stay in the hospital but insisted to go to her home town, adding that she took only one cycle of chemotherapy."

Examining the case, NCDRC focused on the pivotal issue of 'was it a reasonable standard of practice to advice Chemotherapy without tissue diagnosis (HPE).' It observed; "In the instant case, admittedly the biopsy specimen was given to the hospital on 21.03.2007, but the doctor on the basis of clinical and radiological assessment diagnosed it as a malignancy and without waiting for the HPE report advised EOX regime for the patient. The hospital at the time of discharge gave the patient a recommendatory letter for chemotherapy under the guidance of an Oncologist. It was also advised that the CBC/Liver Function Test/RFT had to be done before administering each cycle. Moreover, the contention of hospital and the doctor that the relatives of the Patient were also negligent in not enquiring about the result of HPE report, they should have enquired about it within one week about the status of the report. In my view, such contention is not tenable in the instant case."

The Commission further referred to the case of Devarakonda Suryasesha Mani and Others versus Care Hospital, Institute of Medical Sciences and Others[1], in the Hon'ble Supreme Court that dismissed the appeal filed by the Complainant and held; unless the appellants are able to establish before this Court any specific course of conduct suggesting a lack of due medical attention and care, it would not be possible for the Court to second-

guess the medical judgment of the doctors on the line of medical treatment which was administered to the spouse of the first appellant. In the absence of any such material disclosing medical negligence, we find no justification to form a view at variance with the view which was taken by the NCDRC. In the instant case, the Commission observed; "Without tissue diagnosis advising chemo was the act of omission. It amounts to lack of due care from the doctor, thus medical negligence."

It further added that; "I find this case is of contributory negligence, because the patient herself was negligent, who did not bother to collect the biopsy report from TMC and secondly, before starting first cycle of Chemo, the concern hospital did not verify the biopsy report."

The Commission, eventually directed the hospital and the doctor to pay Rs 5 lakh jointly and severely to the Complainant within six weeks from May 23, 2023, failing which, the amount shall carry interest of 9% p.a. till its realization. It held; "Considering the peculiar facts and circumstances of the instant case, as the incident occurred in 2007, we are now in 2023, the Complainant deserves just and proper compensation. To meet the ends of justice, in my view, Rs. 5 lakh appears to be just and adequate compensation."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/advising-chemo-without-tissue-diagnosis-amounts-to-medical-negligence-commission-directs-tata-memorial-hospital-doctor-to-pay-rs-5l-compensation-112157 Accessed on 03/06/2023*

Child's Death During Hernia Surgery: HC Refuses To Quash IPC 304 Against Caretaker Of Hospital

Allahabad: Responding to a petition filed by a doctor who was challenging FIR against him under IPC 304, the Allahabad HC has refused to give him relief.

The concerned petitioner, who claimed to be the caretaker of a private hospital in Varanasi and got booked under IPC 304 for diagnosing Hernia in a patient and advising surgery which was performed without proper consent by the treating doctors at the hospital.

Denying to quash the criminal proceedings against the caretaker, the HC bench of Justices Anjani Kumar Mishra and Ms. Nand Prabha Shukla observed, "The contention of the learned counsel for the petitioner that he is a care taker, is merely his defence, which is not to be considered in a writ petition which seeks quashing of the FIR."

However, the bench denied commenting on the merits of the case and noted, "The investigation is at the inceptive/nascent stage. Material has to be collected whether the offence is culpable or is a case of gross negligence. It is too early to conclude whether the petitioner could avail and seek the protection in the light of the guidelines/parameters as laid down by the Hon'ble Supreme Court in Jacob Mathew Vs. State of Punjab and Another..."

These observations have come from the High Court bench while considering a plea seeking quashing of the First Information Report (FIR) registered under Section 304 IPC.

The petitioner, who is the Caretaker of Varanasi-based Medicity Neuro and Critical Care Hospital, allegedly diagnosed the informant's son suffering from Hernia and advised surgery. Accordingly, the informant deposited the money for treatment. However, the doctors allegedly operated on the child without seeking written consent from the parents/natural guardian and the child died during the treatment.

The counsel for the petitioner contended that the petitioner did not operate on the informant's son and he is merely the Caretaker of the hospital. Claiming that the petitioner has been falsely implicated for ulterior purposes, the petitioner's counsel relied upon the judgment and

order passed in the case of Dr. P. Kumar VS. State of U.P. And Another, where the top court bench had stated that the medical practitioner should not be prosecuted in every such case where due to critical condition a patient expires.

Further, the petitioner's counsel argued that the Supreme Court has laid down the guidelines with regard to the cases of medical negligence and has issued direction that in such cases the matter should first be referred to a competent doctor or committee of doctors specialist in the relevant field and when such a doctor or committee reports that there is prima facie case of medical negligence, only then notice should be issued to the doctor or hospital concerned.

It was also pointed out that the top court bench has also warned the police officers against arresting or harassing the doctors unless the facts clearly come within the parameters laid down in Jacob Mathew's case.

On the other hand, the Counsel for the State asserted that the petitioner diagnosed and advised surgery to the informant's son suffering from Hernia. The gross negligence on the part of the petitioner is that the surgery/operation took place without seeking consent of the natural guardian/father/first informant of the deceased, who was available at the time of the incident.

Referring to the consent letter, the State Counsel contended that the said consent has been procured from the uncle and grandmother of the patient despite the natural guardian being present at the place of the incident. Taking note of the FIR, the bench denied relief to the petitioner and observed, "From the bare reading of the First Information Report, it is apparent that the son of the first informant died during the treatment/surgery undergone for Hernia. The impugned First Information Report has been registered under Section 304 IPC and the petitioner being a care taker was supposed to be responsible for providing medical care. The contention of the learned counsel for the petitioner that he is a care taker, is merely his defence, which is not to be considered in a writ petition which seeks quashing of the FIR."

"The investigation is at the inceptive/nascent stage. Material has to be collected whether the offence is culpable or is a case of gross negligence. It is too early to conclude whether the petitioner could avail and seek the protection in the light of the guidelines/parameters as laid down by the Hon'ble Supreme Court in Jacob Mathew Vs. State of Punjab and Another reported in 2005(5) Supreme 297, in regard to medical negligence. The criminal prosecution cannot be thwarted as from a bare reading of the FIR, the allegations disclose commission of a cognizable offence," it further noted.

Ref.: *https://medicaldialogues.in/news/health/childs-death-during-hernia-surgery-hc-refuses-to-quash-ipc-304-against-caretaker-of-hospital-112362 Accessed on 03/06/2023*

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128	Dr. D P Gosavi	Amravati	Pediatrician
129	Dr. Narendra Gandhi	Rajnandgaon	Pediatrician
130	Dr. Chetak K B	Mysore	Pediatrician
131	Dr. Shashikiran Patil	Mysore	Pediatrician
132	Dr. Jagruti Shah	Amravati	Ob & Gyn
133	Dr. Jyoti Varma	Wardha	Dentistry
134	Dr. Shubhangi Narwade	Pune	Ob & Gyn
135	Dr. C P Ravikumar	Banglore	Ped Neurologist
136	Dr. Sudipto Bhattacharya	Kolkata	Pediatrician
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140	Dr. Kalpesh Jain	Dungarpur(Raj)	Pediatrician
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143	Dr. Anjali Deshmukh	Amravati	Ob & Gyn
144	Dr. Bharat Asati	Indore	Pediatrician
145	Dr. Nitin Gawande	Amravati	Radiologist
146	Dr. Pushpa Junghare	Amravati	Ob & Gyn
147	Dr. Rajesh Boob	Amravati	Pediatrician
148	Dr. Shirish Modi	Nagpur	Pediatrician
149	Dr. Apurva Kale	Amravati	Pediatrician
150	Dr. Prashant Gahukar	Amravati	Pathologist
151	Dr. Asit Guin	Jabalpur	Physician
152	Dr. Sanjeev Borade	Amravati	Ob & Gyn
153	Dr. Usha Gajbhiye	Amravati	Pediatric Surgeon
154	Dr. Kush Jhunjhunwala	Nagpur	Pediatrician
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168	Dr. Rashmi Bagade	Washim	Physician
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170	Dr. Madhuri Barabde	Amravati	Surgeon
171	Dr. Varsha Bijwe	Amravati	Surgeon
172	Dr. Deepak Kukreja	Indore	Pediatrician
173	Dr. Pallavi Pimpale	Mumbai	Pediatrician
174	Dr. Susruta Das	Bhubneshwar	Pediatrician
175	Dr. Sudheer K A	Banglore	Pediatrician
176	Dr. Bhushan Murkey	Amravati	Ob & Gyn
177	Dr. Jagruti Murkey	Amravati	Ob & Gyn
178	Dr. Sneha Rathi	Amravati	Ob & Gyn
179	Dr. Vijay Thote	Amravati	Opthalmologist
180	Dr. Subhash Rathi	Amravati	Physician
181	Dr. Satish Agrawal	Amravati	Pediatrician
182	Dr. Ravi Motwani	Gadchiroli	Pediatrician
183	Dr. Shrikant Shingane	Amravati	Dentistry
184	Dr. Ashwin Deshmukh	Amravati	Ob & Gyn
185	Dr. Anupama Deshmukh	Amravati	Ob & Gyn
186	Dr. Aanand Kakani	Amravati	Neurosurgeon
187	Dr. Anuradha Kakani	Amravati	Ob & Gyn
188	Dr. Sikandar Adwani	Amravati	Neurophysician
189	Dr. Seema Gupta	Amravati	Pathologist
190	Dr. Pawan Agrawal	Amravati	Cardiologist
191	Dr. Madhuri Agrawal	Amravati	Pediatrician
192	Dr. Subhash Borakhade	Akot	Pediatrician
193	Dr. Unmesh Luktuke	Jamshedpur	Pediatrician
194	Dr. Arunima Luktuke	Jamshedpur	Opthalmologist
195	Dr. Prashanth S N	Davanagere	Pediatrician
196	Dr. Abhishek P.V.	Hyderabad	Pediatrician
197	Dr. Kallem Venkat Reddy	Hyderabad	Pediatrician
198	Dr. Harsha Yandapally	Hyderabad	Pediatrician
199	Dr. Jyoti Agrawal	Amravati	Pediatrician
200	Dr. Sonal Kale	Amravati	Ob & Gyn
201	Dr. Gopal Belokar	Amravati	ENT
202	Dr. Vijay Rathi	Amravati	Pediatrician
203	Dr. M. Himabindu	Hyderabad	Dermatologist
204	Dr. Manish Jain	Gurgaon	Nepherologist
205	Dr. Shalu Gupta	Gurgaon	Ob & Gyn
206	Dr. Saurabh Ambadekar	Amravati	Pulmonologist
207	Dr. Anju Bhasin	New Delhi	Pediatrician
208	Dr. Prabhat Singh Baghel	Satana	Pediatrician
209	Dr. Aditi Singh	Satana	Ob & Gyn
210	Dr. Satendra Singh	Satana	Pediatrician
211	Dr. Preeti Volvoikar	Gurgaon	Dentistry
212	Dr. Ajay Daphale	Amravati	Physician
213	Dr. Surita Daphale	Amravati	Pathologist
214	Dr. Sachin Kale	Amravati	Physician
215	Dr. Pradnya Kale	Amravati	Pathologist
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228	Dr. Rakesh Chouhan	Indore	Pediatrician
229	Dr. Naresh Garg	Gurgaon	Pediatrician
230	Dr. Ujjwal Dhawale	Amravati	Physician

S.N	Name	Place	Speciality
231	Dr. Gajanand Pounikar	Nagpur	Pediatrician
232	Dr. Utkarsh Bansal	Lucknow	Pediatrician
233	Dr. Raj Tilak	Kanpur	Pediatrician
234	Dr. Vipul Agarkar	Amravati	Dentistry
235	Dr. Nikhil Soni	Amravati	Endodentist
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244	Dr. Vishal Mahant	Nagpur	Pediatrician
245	Dr. Chetan Dixit	Nagpur	Pediatrician
246	Dr. Prakash Arya	Gwalior	Pediatrician
247	Dr. Sunita Arya	Gwalior	Ob & Gyn
248	Dr. Sagar Patil	Nagpur	Gastroenterologist
249	Dr. Sushma Khanapurkar	Bhusawal	Gen Practitioner
250	Dr. Sameer Khanapurkar	Bhusawal	Pediatrician
251	Dr. Samir Bhide	Nashik	Pediatrician
252	Dr. Ganesh Badge	Pune	Pediatrician
253	Dr. Saurabh Varshney	Nagpur	Cardiologist
254	Dr. Neeraj Sharma	Gurgaon	Pediatrician
255	Dr. Rajendra Vitalkar	Warud	Gen Practitioner
256	Dr. Kalpana Vitalkar	Warud	Ob & Gyn
257	Dr. Shweta Bhide	Nashik	Opthalmologist
258	Dr. Pramod Wankhede	Raigad	Pediatrician
259	Dr. Shrikant Dahake	Raigad	Gen Practitioner
260	Dr. Nikhil Badnerkar	Amravati	Nepherologist
261	Dr. Nilesh Gattani	Mehkar	Orthopedic Surgeon
262	Dr. Aishwarya Gattani	Mehkar	Pathologist
263	Dr. Manasi Kavimandan	Amravati	Physician
264	Dr. Yashodhan Bodhankar	Amravati	Surgeon
265	Dr. Akash Yende	Dhamangoan	Physician
266	Dr. Bhushan Katta	Amravati	Pediatrician
267	Dr. Mahesh Sambhare	Mumbai	Pediatrician
268	Dr. Surbhi Gupta	Gurgaon	Ob & Gyn
269	Dr. Devdeep Mukherjee	Asansol (W.B)	Pediatrician
270	Dr. Santosh Usgaonkar	Goa	Pediatrician
271	Dr. Ameet Kaisare	Goa	Opthalmologist
272	Dr. Sushma Kirtani	Goa	Pediatrician
273	Dr. Madhav Wagle	Goa	Pediatrician
274	Dr. Preeti Kaisare	Goa	Pediatrician
275	Dr. Varsha Amonkar	Goa	Pediatrician
276	Dr. Varsha Kamat	Goa	Pediatrician
277	Dr. Harshad Kamat	Goa	Pediatrician
278	Dr. Siddhi Nevrekar	Goa	Pediatrician
279	Dr. Dhanesh Volvoiker	Goa	Pediatrician
280	Dr. Pramod Shete	Paratwada	Pediatrician
281	Dr. Bharat Shete	Paratwada	Surgeon
282	Dr. Rekha Shete	Paratwada	Ob & Gyn
283	Dr.Pankaj Bagade	Amravati	Physician
284	Dr. Rajesh Shah	Mumbai	Pediatrician
285	Dr. Navdeep Chavan	Gwalior	Plastic Surgeon
286	Dr. Nehal Shah	Mumbai	Peditrician
287	Dr. Poonam Sambhaji	Goa	Pediatrician
288	Dr. Vijay Mane	Pune	Radiologist
289	Dr. Shailja Mane	Pune	Pediatrician
290	Dr. Bhakti Salelkar	Goa	Pediatrician
291	Dr. Kausthubh Deshmukh	Amravati	Pediatrician
292	Dr. Pratibha Kale	Amravati	Pediatrician
293	Dr. Milind Jagtap	Amravati	Pathologist
294	Dr. Varsha Jagtap	Amravati	Pathologist
295	Dr. Rajendra Dhore	Amravati	Physician
296	Dr. Veena Dhore	Amravati	Dentistry
297	Dr. Ruturaj Deshmukh	Amravati	Pediatric Neurologist
298	Dr. Satish Godse	Solapur	Physician
299	Dr. Sumant Lokhande	Mumbai	Pediatrician
300	Dr. Ninad Chaudhari	Amravati	Pediatrician
301	Dr. Vijaya Chaudhari	Amravati	Ob & Gyn
302	Dr. Arundhati Kale	Amravati	Pediatrician
303	Dr. Sachin Patil	Nagpur	Pediatrician
304	Dr. Nisha Patil	Nagpur	Ob & Gyn
305	Dr. Harsh Bhayana	Hissar	Pediatrician
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307	Dr. Pinky Paliencar	Goa	Pediatrician
308	Dr. Ashok Saxena	Jhansi	Pediatrician
309	Dr. Subhendu Dey	Purulia	Pediatrician
310	Dr. Sangeeta Bhamburkar	Akola	Dermatologist
311	Dr. Aniruddh Bhamburkar	Akola	Physician
312	Dr. Nilesh Dayama	Akola	Pediatrician
313	Dr. Paridhi Dayama	Akola	Pediatrician
314	Dr. Nilesh Toshniwal	Washim	Orthopedic
315	Dr. Swati Toshniwal	Washim	Dentistry

Hospital Members

1	Meva Chaudhary Memorial Hospital	Jhansi	Nursing Home
2	Usgaonker's Children Hospital	Goa	NICU
3	Chirayu Children Hospital	Nashik	Children Hospital
4	Yash Hospital	Satana	Children Hospital
5	Multi city Hospital	Amravati	Multyspecialty
6	Phulwari Mahila & Bal Chikitsalay	Gwalior	Mother & Child care
7	Sarthak Hospital	Satna	Multispecialty
8	Boob Nursing Home	Amravati	
9	SJS child Care Centre	Amritsar	
10	Paramitha children hospital	Hyderabad	Children Hospital
11	Paramitha Women and Kids	Secunderabad	Women & Kids
12	Radiant Hospital	Amravati	Multispecialty
13	Nabajatak Child Development centre	Kolkata	Children Hospital
14	Lotus Health Care	Indore	New Born Care
15	Kale Nursing home	Amravati	Nursing Home
16	Hedagewar Hospital, Mudholkar Peth	Amravati	Multispecialty
17	Hedagewar Hospital,Dastur Nagar Road	Amravati	Multispecialty

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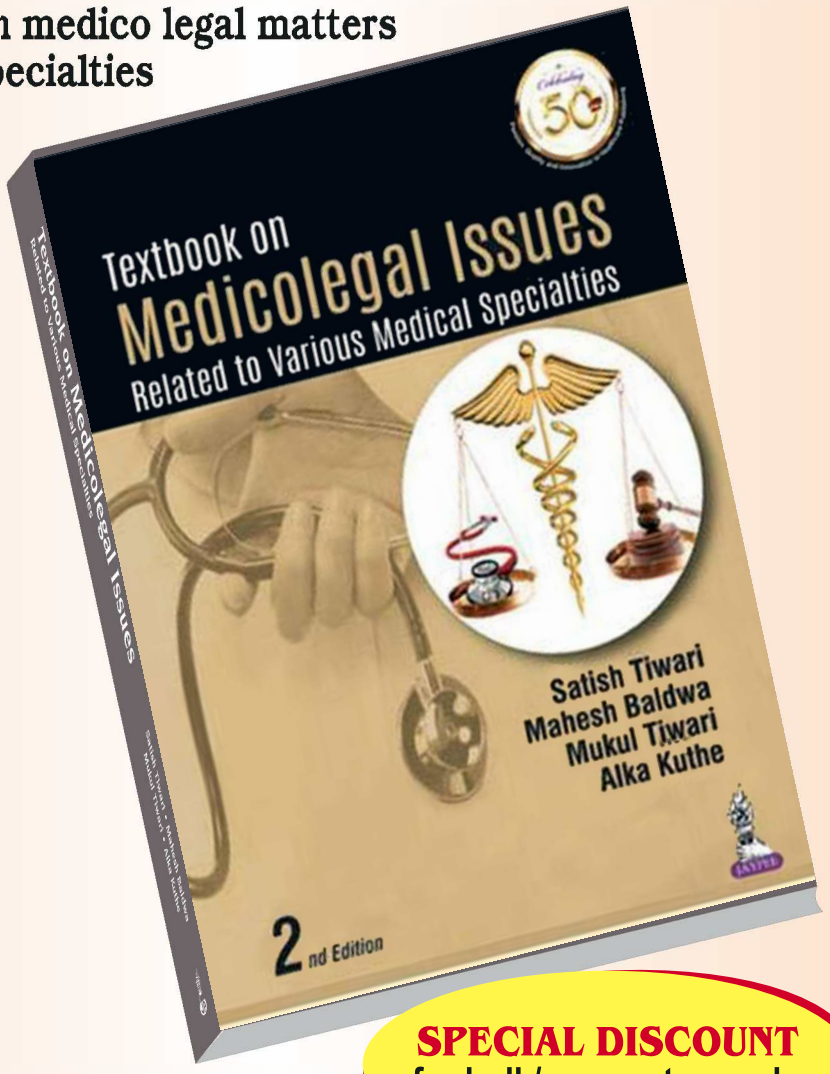

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9422857204
(drsatishtiwari@gmail.com)
Dr. Mukul Tiwari
9827383008
(drmtiwari161@gmail.com)

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SAIMS Campus, Indore-Ujjain State Highway, Near MR-10 Crossing,Sanwer Road,
Indore, Madhya Pradesh- 453555, Ph- 0731-4788905

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