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Editorial :

Informed consent or Service Contract

Mahesh Baldwa

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Keywords :

National Medical Commission, Code of Conduct, Guidelines, Registered Medical Practitioner, Generic Medicine

Introduction :

Before studying Regulations relating to Professional Conduct of Registered Medical Practitioners, let one understand what the eleven guidelines and five levels of penalties are which come inbuilt in it.

Purpose of real / informed consent

The main purpose of the informed consent process is to protect the patient to uphold autonomy of patient party. Primary purpose of consent is risk disclosures to patient. Consent form by itself is legally incomplete to protect doctor against allegations hurled by patient to seek compensation. Consent protects against patient voluntarily accepting risks of treatment, surgery, *volenti non fit injuria*.

Purpose of switching to "Contract for medical services" is to augment Informed Consent

"Contract for rendering/ hiring of medical services" includes consent of patient party along with a number of terms and conditions which are usually not part of consent.

Legal contract

A contract is a legally binding agreement between two or more parties as per terms of contract, typically involving the medical services. Section-74 of Indian Contract Act (ICA)1872, governs liquidated damages. Parties at the time of contracting may stipulate an amount in the agreement itself, which shall become payable on the breach of contract, by the doctor in favour of the patient.

Valid contract for hiring/ providing of medical services

Valid contracts to be legally enforceable if agreement contains all of the following legal criteria:

- An offer (in the form of proposed surgery / treatment)
- Acceptance by patient party by signing valid consent.
- Clearly defined terms and conditions (about complications, disabilities, guarantee, warnings, disclaimers)
- Consideration (defined in terms of money and payment schedules)
- Intention to create legal relations (doctor-patient relationship)
- Capacity of the parties (competent to contract)
- Legality of purpose (standard surgery/ treatment)
- Description of liquidated damages in case of breach of contract.

Is real / informed consent, a quasi-contract as per s. 68-72 of ICA-1872?

No, it is not a quasi-contract. Real / informed consent paves way for implied contract based on the conduct between doctor and patient.

What is consent in the eye of law?

Section 13 of Indian Contract Act 1872 says "it is when two or more persons agree upon the same thing and in the same sense."

Consent means that patient party voluntarily and willfully agrees to doctors' proposition. The patient party who consents must possess sufficient mental capacity. Consent also requires the absence of coercion, pressure, force, fraud, misrepresentation and trickery. Consent under

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section 13 under ICA is an essential constituent of a contract [defined under section 2 (h) of ICA] as an agreement enforceable by law. Consent is one of the defenses available for doctor against allegations of tort (civil wrong) of negligence.

Does Consent protect doctors ?

Yes, to some extent. Consent protects doctor by principle of *volenti non fit injuria* against allegation of tort of battery and assault. It is an incomplete defence against allegation of negligence. Consent only allows describing risks about procedure, complications and like.

Is Consent form a legal binding?

Consent form is not a legally binding contract. Consent is one of the legal components of valid contract. A contract is an agreement which creates legally enforceable obligations between parties by obtaining valid consent. Hence even informed consent is incomplete let aside real consent; therefore it is time to switch to "contract for hiring / rendering of medical services" to augment legal value of informed consent / real consent.

Is Breach of Contract a Tort?

Even though contract law and tort law are similar, breach of contract is not a tort. In tort law, there is no contract between the parties involved. There is simply a duty of care that is imposed by the law upon the parties to take due diligence.

What is a tort and how does it differ from a breach of contract?

Damages in torts are compensated by civil court as un-liquidated. Damages in breach of contracts are decided by civil court as per terms and conditions of contract defined as liquidated damages.

Can an act be both a tort and a breach of contract?

Yes, contract law and tort law can intersect in certain cases. If a breach of contract harms the other party, for example, the wronged party (patient) could file a claim against defaulting party (doctor) in pursuit of financial compensation. Breach of contract intercepts with law of tort is obvious if unqualified doctor treats or when an instrument is left inside body, wrong gas for anesthesia is used, wrong side is operated upon leads damage to patient.

Can you exclude negligence from a contract?

It is not possible to exclude or restrict liability for death or personal injury resulting from negligence. An exclusion clause, warning or disclaimer should not be used to expressly exclude negligence.

Compensation granted under Tort v/s Contract – which is bitter?

Consent v/s contract for medical services from point of view of restricting compensation in consumer and civil jurisdiction. Consumer and Civil court usually decide one of the following aspects

a. Deficiency in medical service
b. Was there unfair trade practice ?
c. Was there medical negligence ?

Hence one should defend forcefully against alleged medical negligence and try and convert all allegations of negligence to deficiency of service for getting under liquidated damages under law of contract, since damages are defined and liquidated within the confines of contracted terms hence as per terms and conditions of contract civil court has to decide. Primary aim should be to convert all allegation of negligence to deficiency of service domain so as to align court granting liquidated compensation as per contract terms and conditions. Medical negligence under law of torts paves way of civil court to grant compensation at court's own discretion as un-liquidated with no holds barred on court to grant compensation.

Choice is yours- which bitter pill to swallow – liquidated damages under contract law or un-liquidated damages under law of tort.

Overview :

Criminal Liability for Medical Malpractice in Ethiopia

Melkamu Meaza

Received for publication : 26th Oct. 2023 Peer review : 31st Oct. 2023 Accepted for publication : 12th November 2023

Key Words: Medical malpractice, Criminal negligence, Standard of Care, Healthcare errors

Abstract :

Background: Ethiopian law criminalizes breach of professional duty that results in the death or bodily injury to a patient if the act is not performed in accordance with accepted practice and amounts to grave professional fault.

Objective: The objective was to identify misconducts that lead to criminal charges, as well as the legal criteria for determining whether such acts deviate from accepted practice and sufficiently constitute grave professional fault to be considered a crime.

Methods: The judgment of a criminal medical malpractice case No. 212639 (2016) was utilized in the manuscript.

Each defendant was found to have committed professional misconducts. Defendants were charged with violating Criminal Code Article 575(2b) by failing to provide assistance that endangers the life or health of a patient while under a professional duty. Only eyewitness accounts were used as evidence. The first defendant, a pediatrician was acquitted due to lack of supporting evidence. In contrast, the second defendant, a nurse, was found guilty by the court. Documentary evidence or expert opinion was not used to determine whether the act violated accepted professional practice or constituted a grave fault.

Conclusion: Although there are explicit statutory provisions for criminalizing professional misconduct, neither accepted medical practice nor grave fault are clearly defined in the law, which explains why Ethiopian courts have difficulties in determining who is liable for criminal negligence.

Introduction :

"Medicine is the most distinguished of all the arts, but due to the ignorance of all those who practice it, as well as those who casually judge such practitioners, it is now by far the least esteemed of all the arts. The chief reason for this error seems to be this; medicine is the only art that our states have made subject to no penalty save that of dishonor, and dishonor does not wound those who are compacted of it [1]."

Medicine is regarded as one of the noblest and most revered professions in society. Medical professionals are held with high regard by the community, since they are members of a learned profession who serve as valued advisors helping to maintain their health, restore the wellbeing of the sick, and avoid premature and unnecessary deaths. Nonetheless, practicing medicine is a high-risk activity that can affect both patients and those who practice it; as well as have negative human consequences and legal ramifications [2].

In the United States, the 1999 Institute of Medicine report identified healthcare errors as a leading cause of death and injury, with 44,000 to 98,000 deaths per year, surpassing the number of fatalities from traffic accidents [3]. Studies that were conducted later on revealed that, with an average 251, 454 deaths annually, medical errors rank third among all causes of death in the US[4,5]. According to WHO figures, adverse outcomes from substandard care are among the top ten global causes of mortality and disability, with up to four out of every ten patients experiencing harm in primary and outpatient care worldwide. Moreover, one out of every ten patients receiving hospital care in high-income countries is thought to suffer harm,

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whereas hospitals in Low and Middle income Countries (LMICs) experience 134 million adverse events annually as a result of subpar care, which results in 2.6 million fatalities[6]. There is no documentation or data in Ethiopia that illustrates the prevalence, incidence, and effects of medical errors.

Evidence suggests that Ethiopian practitioners may be subject to administrative, civil and criminal penalties for the errors made and harm caused to patients. According to a 2019 study, the Health Professionals Ethics Committee [HPEC] received 27 complaints of bodily injury, and 72 claims of wrongful deaths between 2011 and 2017 [7]. No studies are showing how common medical malpractice lawsuits are in civil and criminal courts.

To hold medical practitioners liable for criminal malpractice, the court must assess not only the degree of deviation from accepted practice, but also the type and degree of fault, as well as how fault is committed, all of which are subject to several limitations. As a result of the intricacies and ambiguities in the processes for evaluating due diligence under the law, courts may be required to go above and beyond what is specified by statute.

The variety of legal criteria that courts establish and apply to circumstances of criminal medical malpractice serve as evidence that scholarly study is both important and timely to enable consistent interpretation and implementation of the law. Given this, this article will look into the law and explore how Ethiopian courts interpret it to make medical malpractice a crime. In doing so, this article presents and analyses a written verdict of Federal First Instance Court [FFIC] file No. 212639 (2016) from a medical and legal perspective. Circumstances that enable individuals more likely to commit crimes, the trial process and judgments are looked into, with special emphasis on professional duty in medical settings and deviations thereof. This extends to additional concerns that might come up when a court has to establish unlawful conduct to hold the offender criminally liable for infringing upon the law.

This study examines the uniqueness and complexity of a case to comprehend particular events and their larger significance. Single case study may indeed be appropriate in some situations, such as when the case is extreme or unusual, representative or typical, revelatory and longitudinal, and can stand alone, according to Yin's practical designs for conducting case studies [8]. Since this particular case was the only one with a written verdict from the criminal benches of FFICs that was available, it may thus be regarded as an extreme or unusual case of liability for medical misconduct in Ethiopia. Furthermore, the written judgment employed in this research can be considered trustworthy because it contains accurate names, references and event information, making it stable and able to be reviewed repeatedly.

This case study is an exploratory, qualitative investigation that makes use of a single case-embedded design that includes multiple analytical units (main, smallest, intermediary)[8]. The researcher's analytical strategy involved categorizing the data according to the ideas of interest, creating a concept map, pattern generation, matching and application of logical models to provide results and a basic understanding of the case[8].

The medical perspective's analytical framework is divided into three categories: antecedents, medical services and individual behaviors of the defendants [9]. Additionally, to recognize the distinctive categories of causation in medical malpractice, the seven legal principles of engaging in safe and legal clinical practice were adopted[10].

The legal perspective, on the other hand,

divides its analytical framework into two categories: the criminal charge that has been filed and the court hearing procedures up until the final decision. Although the defendants in the selected case were prosecuted not for criminal negligence, but for violating the law by 'failure to render aid or assistance to a patient in danger', it is believed that the findings of this research would provide insight into the criminal acts and behaviors of medical professionals and the circumstances that surround them as well as explain the legal characteristics that led to the criminal malpractice lawsuits.

The research also utilized normative legal research methods to gather and analyze primary and secondary sources from Ethiopia such as proclamations, regulations, Federal Supreme Court Cassation Bench (FSCCB) judgments, directives, journals, manuals, guidelines and standards to address the legal concerns at hand.

The Law

Although there is no data on the number of medical practitioners being charged or convicted of malpractice crimes in Ethiopia, it is thought to be a rare occurrence. There hasn't been a case of criminal medical malpractice published by the FSCCB yet.

Although there isn't a specific law that governs criminal medical malpractice in Ethiopia, criminal liability is covered under various sections of the criminal code as well as other proclamations, regulations.Medical professionals who negligently cause a patient's death (Criminal Code, art 543-2) or any physical harm (Criminal Code, art 559-2) are criminally held accountable for their actions. If they are found to be at fault, they may be charged and held liable if all legal, material and moral elements of a crime are present (Criminal Code, art 23-2). The provisions of the criminal code that specify whether an act qualifies as a crime, as well as the punishments and measures that apply to criminals, are referred to as the legal element. Acts of commission or omission that led to a breach of a legal or professional duty constitute the material element or *Actus reus* (Criminal Code, art 23-1). A person's intention or negligence to commit a crime is known as the moral element, or mens rea, often known as 'guilty mind' (Criminal Code, art 57-1). The elements needed to establish a case of criminal negligence are explained below, starting with the moral ingredients of crime.

A. Guilty Mind

The Ethiopian Criminal Code of 2004 recognizes two mental elements as components of criminal guilt: intention and negligence (Criminal Code, art 57, 58, 59).

(I) Intention

Criminal intention relates to the offender's subjective state of mind, which can take two forms: direct or indirect. Direct intention exists when a person conducts a criminal act with full knowledge and aim to achieve a specific result (Criminal Code, art 58-1a). On the other hand, indirect intention exists when a person is aware his actions may have criminally punishable consequences, but nonetheless proceeds with the action, regardless of whether such repercussions may occur (Criminal Code, art 58-1b). By examining how the criminal conduct was carried out, the presence of intention is established, rather than by proving the subjective state of the offender at the time the crime was committed[11].

(ii) Negligence

Criminal negligence may be advertent or inadvertent. Advertent negligence is a conscious act that occurs when a person is aware that engaging in illegal activity will have adverse effects that are punishable, but chooses not to take into account; in the hope that it won't happen, or with the idea that enough precautions have been taken to avoid it (Criminal Code, art 59-1a). On the other hand, inadvertent negligence is an unconscious act that occurs when a person acts with a criminal lack of foresight, without thought,

or without exercising the necessary caution; while he should or ought to have been aware that his actions may have repercussions, that are subject to criminal punishment (Criminal Code, art 59-1b). In the instance of inadvertent negligence, the person should have known the illegal consequences of his actions, or could have known it if he had made an effort [12].

The criteria for demonstrating negligence is the person's awareness, knowledge or comprehension of the relationship between the conduct and the result; the level of which the offender has is measured by taking into consideration the offender's experience, level of education and other factors [12].

B. Elements of Criminal Negligence

Medical professionals are not criminally liable for the acts done in the exercise of their professional duties as long as it is done according to the accepted practice of the profession and does not commit any grave professional fault (Criminal Code, art 69). To hold a medical professional criminally liable for negligence, one must generally prove the following 4 elements: duty of care, a breach of duty, causal relationship between breach of duty and bodily injury or death of the patient and grave professional fault.

(i) Duty of care

The first condition is that the healthcare provider has either contractual or legal obligation to the patient. This obligation arises anytime a relationship is established between the patient and the healthcare provider. A medical professional is said to owe a responsibility of reasonable professional care to a patient when providing services and this duty is generally assumed whenever a practitioner delivers patient care. When there is no established relation between the providers and the patients, a duty does not exist; but when such connection is made, a duty of reasonable care arises (Civil Code, art. 2639–2640).

(ii) Breach of duty

The second element is a breach of professional duty or accepted professional practice, which is demonstrated by invoking the concept of standard of care. The term 'standard of care' has no clear legal or clinical definition, but it often refers to the laws, rules and standards that apply to professionals in the medical field; as well as the care that a reasonable professional in the same circumstances would have given the patient, as determined by expert assessment (Criminal Code, art 554).

When it comes to health professionals, if the care fails to provide the intended benefit, or results in bodily harm or death, this alone does not hold them accountable; unless they failed to exercise proper skill, and follow accepted practice in carrying out their duty of care. This raises the issue as to the degree of departure from 'accepted practice' that is used to determine a breach of duty, which the law is unable to expressly address: To what abstract standard of care would a practitioner be held in order to avoid liability? How much weight is given to evidence-based and current scientific knowledge in determining deviations from the standard of care? Moreover, whether the court should be the final arbitrator of the standard of care or it should seek advice from a particular body of the medical profession are not directly addressed in the law.

Some violations of the duty of care are so egregious that no expert testimony is required. In other instances, the court will decide whether there has been a breach of duty based on the documentary or witness evidence offered; however, if there is any uncertainty about the case's facts, consequences, gravity, expert analysis or testimony will be employed to assist in resolving the matter (Criminal Code, art 554). It is always up to the court to determine what constitutes reasonable care in a given situation and whether to give weight to any particular body's opinion or expert testimony relevant to the case at hand[13].

Following the conclusion of the prosecution's case, the court would consider the evidence that was provided and if it sufficiently and convincingly establishes the guilt, reaches a verdict (Criminal Procedure Code, art 141).

(iii) Causation

A cause-and-effect relationship between the claimed wrongdoing and the harm or death must be established to prove this third condition. Only adequate or proximate acts that are typically capable of creating the result in question are considered to have caused it and there is no presumption of causation if the alleged act is not ordinarily capable of causing bodily harm or death (Criminal Code, art 24-1).

A comprehensive care and team approach to patient treatment is at the heart of today's healthcare sector and because more than one health worker is frequently involved in providing patient care, determining causation becomes increasingly difficult. If the outcome is the result of the act for which the accused person is charged, a causal relationship is established. This relationship ceases to exist when an extraneous preceding, concurrent or intervening act itself produces the result (Criminal Code, art 24-2). On the other hand, if the cumulative effect of the acts produces the outcome, the law presumes existence of causation arising from each act, even if each cause cannot individually produce the result (Criminal Code, art 24-3).

(iv) Grave professional fault

A practitioner who negligently breaches a professional standard of conduct or duty and causes injury or death to another person is said to be at fault. Criminal culpability arises when the act is deemed unlawful and constitutes a grave professional fault (Criminal Code, art 69). In this regard, the Ethiopian criminal code is deficient in characterizing 'grave fault' and the test for determining the degree of fault; as a result, the matter appears to be left to the court's discretion.

The Practice

The study of court cases on criminal medical negligence is essential for gaining a thorough understanding of the current practice in the legal field of study. In light of this, an effort has been made to identify cases handled by Addis Ababa's five Federal First Instance Courts [FFIC]. Due to the lack of defined categories in the database, searching and recognizing cases seemed to be challenging. Nonetheless, one case with File No. 212639 heard by the FFIC Lideta criminal bench, which was then appealed to the Federal High Court [FHC] was eventually obtained.

The case is extensively discussed in the part that follows, starting with a short description of the events that led to the criminal prosecution, continuing on to the charge, court hearing, and judgment followed by the findings, discussions and lastly a conclusion.

Federal Public Prosecutor v. Dr (A Pediatrician) & Sr (A Nurse) : The Case

A. Summary of Events

o Day one: Monday, July 22, 2013
Place: Abebech Gobena Maternity Hospital
Time:1 PM

A Cesarean section was performed to deliver the twins. The first defendant, a pediatrician, asserted that she attended the delivery and offered the twins the necessary care, a claim that was corroborated by the doctor who conducted the delivery of the babies. Additionally, the first defendant claimed that she saw the twins after the mother was sent to the ward and confirmed that they were both in good health.

Time: 4 PM

The first attendant (third witness for the prosecution) said that when she noticed one of the twins wasn't doing well, she went to the second defendant, the night shift nurse and told her about the twins' condition. Approximately 20 minutes later, the mother realized that the other twin was also not doing well and sent the attendant to alert

the second defendant of the situation but she claimed that the second defendant failed to show up.

- **Day two: Tuesday, July 23, 2013**

Place: Abebech Gobena Maternity Hospital

The second defendant is said to have visited the twins in the morning but the first defendant never appeared in the morning or throughout the day.

- **Day three: Wednesday, July 24, 2013**

Place: Abebech Gobena Maternity Hospital

Time: Before 6 AM, early in the morning

The mother claimed that she informed the second defendant when one of the twins became seriously ill and distressed.

Time: 8 AM

It was claimed that the first defendant visited the twins, noticed the warning signals of a critical illness and opted to refer them right away to a facility with an ICU and specialized neonatal care.

The ambulance was said to have arrived at Yekatit 12 Referral Hospital but they were informed that there was no bed available.

The ambulance was said to have arrived at Zewditu Memorial Hospital where the twins were accepted and admitted for treatment and care.

- **Day four: Thursday, July 25, 2013**

Place: Zewditu Memorial Hospital

It was stated that the twins had received a treatment for 'sepsis' since their hospitalization. However, despite treatment, their condition deteriorated.

- **Day five: Friday, July 26, 2013**

After being admitted for over 48 hours, the twins were pronounced dead.

B. The charge Filed

The case was initially brought before the FFIC Arada criminal bench but the public prosecutor withdrew the charge with the court's approval. Following that, the public prosecutor then filed a criminal charge at the FFIC Lideta criminal bench, where the case was heard and a verdict was reached.

(i) Against the first defendant

The first defendant, a pediatrician, was charged with violating professional obligations by failing to go to aid or provide assistance to the preterm twins, who were in immediate and grave danger in contravention of Article 575(2b) of the Criminal Code of Ethiopia.

The elements of the charge were stated as follows: (i) On day one, knowing the twins were premature, she failed to admit them to the incubator room for treatment (ii) On day two, she breached her duty of care by failing to visit the twins and (iii) On day three, she failed to make a timely decision to allow the twins to obtain better treatment, instead referred them late without ensuring that there was enough oxygen in the portable tank.

(ii) Against the second defendant

The second defendant, the night shift nurse, was charged with violating professional obligations by failing to go to aid or provide assistance to the preterm twins who were in immediate and grave danger in contravention of Article 575(2b) of the Criminal Code of Ethiopia.

The elements of the charge were stated as follows: (i) On day one, knowing that one of the twins was very sick and vomiting from both the mouth and nose, she commanded attendants to provide care for him in the same way she had previously instructed them; and (ii) On the same day, she warned attendants not to call her again and disturb her sleep, which caused the twin's condition to deteriorate.

C. The Hearing

Following the reading and explanation of the criminal charge to the defendants during the initial hearing, the court asked each accused if they had any objections to the charge; however, neither defendant raised any preliminary objections. The accused were then asked to enter a plea of guilty or not guilty. Without disputing the allegations, both entered a plea of not guilty to the criminal offense.

D. Evidence and Judgment

(i) Opening of the case and calling of witnesses for the prosecution

The public prosecutor began his case by briefly summarizing the accusations that he intends to establish, stating that the first witness will testify to the breach of duty by both defendants; the second witness will testify specifically to demonstrate the third element of the offense against the first defendant; the third and fourth witnesses will testify to the violation of duty of care by both defendants, particularly against the second defendant and the fifth witness will testify whether a duty of care exists between the first defendant and the twins and the sixth and seventh witnesses to testify about the twins' health status upon arrival and admittance to Zewditu Memorial Hospital.

(ii) Witness examination for prosecution

- Following is a summary of the first witness' testimony, the mother of the twins:

The first defendant visited the twins soon after they were born and affirmed that they were both in good health. However, later that night, when one of the twins became ill, the second defendant arrived, removed the baby's cloth, threw it away and then directed us to give him a body bath and left. A few minutes later, I learned that the other twin was similarly ill and the third witness, whom I sent to call the second defendant, informed me that the defendant had slammed the door in front of her face, warning her not to disturb her sleep anymore. On day two, the first defendant was absent and no nurse visited the twins. At the end of day two, one of the twins was in distress and making noises; the second defendant was present but she was not paying attention to us. She admitted during cross-examination that she is unsure whether the first defendant was on duty on day two or it was her duty to check the oxygen cylinder to see if it was full.

- Following is a summary of the second witness' testimony, the father of the twins:

The twins were in good health on the first day, so I departed the hospital late that evening. After I arrived home, I was informed that the twins were sick and that the second defendant was not providing the necessary assistance to the twins. The first defendant, whom I met on day three morning, decided to refer the twins to another hospital. During the transfer, the 'nurse' who accompanied the twins in the ambulance informed me that the oxygen had run out and the cylinder was empty. Additionally, I verified it by checking it myself. The sixth witness informed me when we arrived at Zewditu Memorial Hospital that the twins were very ill and that the referral was made too late.

- Following is a summary of the third witness' testimony, the first attendant of the twins:

On day one, the twins were in good health, but late at night, I went to notify the second defendant that one of the twins was severely ill, but she slammed the door and warned me not to wake her up again.

- Following is a summary of the fourth witness' testimony, the second attendant of the twins:

The second defendant failed to attend on day one late at night after she was alerted that the twins were ill. She was harsh toward me on the morning of the second day when one of the twins was in my hands.

- Following is a summary of the fifth witness' testimony, the doctor (obstetrician):

After birth, the twins were in good condition. The First defendant was keeping an eye on the twins in the operating room. It is customary for us to monitor babies ourselves if a pediatrician is not available to do so. The twins were kept at the hospital because the mother required postoperative care.

- Following is a summary of the sixth witness' testimony, the pediatrician at Zewditu Memorial Hospital:

The twins arrived at our hospital on day three in the morning and were both 'on oxygen'. They had sepsis, which can occur 'any time and place'. We treated them accordingly but they were in poor condition and despite the therapy, the twins deteriorated the next day and died after 48 hours. I saw the referral paper but except for the first defendant's name, nothing was written on it to indicate the treatment given or care provided.

(iii) Expert testimony

The prosecutor did not summon any expert to testify.

(iv) Documentary evidence

A death certificate declaring that 'uncontrolled sepsis' was the cause of death was the only piece of documentary evidence that the prosecutor produced. Both defendants argued that the evidence did not prove that the twins' deaths were caused by a breach of professional duty. The medical files from both hospitals weren't brought in as evidence.

(v) Judgment rendered by the court

After reviewing the case, the court came to the conclusion that the prosecutor failed to call the witness, a nurse who is alleged to have accompanied the twins during referral and confirmed the absence of oxygen in the cylinder; and also failed to produce evidence to show whether the first defendant was on duty on day two, to prove a breach of duty. Moreover, the court dismissed the testimony of the second witness, on the ground of contradiction with the testimony of both the first and fifth witnesses. In light of the sixth witness testimony confirming the twins were breathing upon arrival and sepsis as the cause of death; the court granted a judgment of acquittal, stating that the prosecutor had failed to sufficiently and convincingly provide evidence to prove the charge brought against the first defendant.

(vi) Opening of the case and calling of witnesses for the defense

The court opened a case of defense case against the second defendant, citing the first and third witnesses' statements about her refusal to appear and aid the twins. After reading a statement of defense, the second defendant called four witnesses to testify.

- Following is a summary of the first witness' testimony, the doctor (obstetrician):

I am aware that the twins were stable till 5:00 p.m. on their first day. I was alerted that one of the twins was ill on the morning of day three, we took the twin to the delivery room, gave oxygen and warmth and then handed over to the pediatrician (the first defendant).

- Following is a summary of the second witness' testimony, Day shift nurse 1:

When we visited the twins on the morning of day two, the mother of the twins made no complaint. The twins remained stable for the remainder of the day, which I handed over to the night shift nurse in the evening (second defendant). The night shift nurse (second defendant), along with others, were scurrying and racing about when I returned on day three morning because both twins were ill.

- Following is a summary of the third witness' testimony, Day shift nurse 2:

On day one, I handed over the twins to the night shift nurse (second defendant); I'm not sure what happened after that. We don't have a incubator room therefore, the twins were never admitted to such a room. On day two, I did not see the pediatrician (first defendant) visit the twins.

- Following is a summary of the fourth witness' testimony, a colleague (It is unclear whether she works as clinical staff or not):

The night shift nurse (second defendant) told the Obstetrician that the twins were sick on the morning of day four and he then put them on oxygen. I am the one who accompanied the twins to Zewditu Memorial Hospital soon after the pediatrician arrived and ordered that they be referred.

(vii) Judgment rendered by the court

After reviewing the case the court

concluded that because the defense witnesses weren't there on the day and during times the claimed offense was committed, they could not refute the allegation of breach of duty made by the prosecution witnesses. For this reason, their testimony was dismissed and a guilty verdict was rendered for violating article 575 (2b) of the criminal code, by failing to go to aid or provide assistance to the preterm twins who were in immediate and grave danger.

(viii) Appeal

The prosecutor appealed against the lower court's acquittal decision claming that the witness testimony did not receive a thorough examination, which would have sufficiently established the first defendant's guilt that led to the twins' deaths. Furthermore, the prosecutor underlined the fifth and sixth witness testimony by stating that it is the responsibility of the Pediatrician to follow the twins after delivery and the twins were suffering from sepsis, which can be diagnosed early and if treatments were initiated immediately, they could have survived.

The appellate court file could not be found for review thus; I was unable to make any further comments. On the contrary, there was no documentation to back up any appeals made by the second defendant.

3. Results

A. The Facts

This case's factual analysis reveals five key elements. The first defendant was charged with failing to :

(i) Admit premature twins to the incubator room for treatment.

(ii) Provide regular follow-up and care for the twins despite a duty of care existed.

(iii) Refer the twins promptly despite their deteriorating health conditions.

(iv) Fail to check for an oxygen tank before granting a referral.

(v) Failing to provide assistance and care for the twins who were in danger, was the allegation brought against the second defendant.

These facts allegedly led to a delay in treatment, which resulted in sepsis and death. However, there was no proof showing that the defendant's conduct or inaction caused the twins' deaths.

B. Findings of Defendants' Conduct Analysis

The defendant's ability to give care was influenced by several factors. The seven legal principles[10] which are recognized as a universal approach to safe care, mainly in nursing practice, were used to define eight distinct types of defendants' behavior. Each of these behaviors is related to one of the three primary themes: the antecedent, medical care, and the defendants' behavior,[9] and the following discussion will go into additional detail on this.

(i) Antecedents

The factors that led to medical malpractice litigation were both outside the clinical practice and present in the environment of care that hampered the performance of professional duties. The defendant's professional duty to give care was impacted by several relationship and communication problems. Poor communication between staff and twins families or attendants; the obstetric and pediatric unit's staff, as well as the day and night shift staff of the obstetric ward, were recognized as general antecedents. The failure of the second defendant night shift nurse to communicate effectively with the twins' families and failure to promptly warn the first defendant pediatrician or other senior doctors of the twins' deterioration are two behaviors that were found to be the main antecedents in the current case.

(ii) Medical service

Three behaviors hindered the provision of quality medical care in the current case: failing to provide basic newborn treatment and care appropriate for preterm babies promptly, failing to examine the twins frequently and adequately and failing to monitor the twins and discover early

signs and symptoms of worsening illnesses.

(iii) Individual behaviors of the defendants

In the current case, three defendants' activities contributed to the breach of duty in the twins' care: failing to follow the premature twins to appropriately provide safe and timely care and treatment, failure to conduct routine activities responsibly, and failure to adhere to the standard of care and follow hospital procedures, such as patient referral.

C. Findings of Legal Analysis

(i) Documentary evidence

Even though sepsis was mentioned as the cause of death for the twins, the report on the death certificate did not explicitly imply that the defendant's actions were the primary culprit. On the other hand, the report written on the referral paper didn't demonstrate the treatment provided; and that, as the prosecution later emphasized in the notice of appeal, the twin's death was attributed to the failure to offer immediate aid, as well as the delay in referral for better treatment. Both parties to the litigation offered no other documentary evidence to the court.

(ii) The Court's judgment

The four key points of fact served as the foundation for the court's decision to acquit the first defendant. The prosecutor failed to produce any evidence that was sufficiently and convincingly enough to prove a duty of care existed on day two; a duty of care had been breached by not admitting the twins to the incubator room, her failure to initiate prompt treatment or referral and her failure to check for an oxygen tank before granting a referral; thus, unable to persuade the court that Article 575(2b) of the Criminal Code had been violated.

On the other hand, the fifth key fact served as the foundation for the court's conviction of the second defendant; implying that the prosecutor's evidence was substantial and convincing to prove a breach of professional duty by failing to offer immediate aid, in violation of Criminal Code Article 575(2b).

Discussion :

A. The Medical Perspective

As stated in the preceding section, health practitioners must observe and apply the seven 'must do' legal principles in their everyday medical practices and for all patients to improve patient outcomes and avoid legal liability. By following these principles, all medical practitioners can proactively reduce the risk of medical malpractice, as well as ensure quality of the service they provide.

To explore and determine whether these principles are being violated in the context of this case study, four guiding questions are put out to aid in discussion from a medical standpoint which can be used as an illustration by administrators and managers of healthcare facilities to help medical practitioners improve their core competencies and overall understanding of the competencies anticipated and demanded of them.

(i) Has the second defendant prioritized her interest over the patients?

A healthcare professional should have the clinical knowledge and ethical conduct required to provide treatment to patients and receive feedback from clients, as well as perform critical supervision and monitoring to improve the practice of professional medical care. Following a routine as well as prescribed procedures enables the discovery of a critical condition requiring a specific response. Even though the twin's hospital files, in this case, were not revised, it is possible to infer from the witness testimony that the second defendant did not attempt to put the interests of the patients before her own.

By modifying the obligation owed to the patient by the circumstances, the second defendant, who is under an ethical obligation to observe the twins on her own, could have immediately and appropriately replied to the call for assistance.[14].

(ii) Was the twin's deterioration a foreseeable

event?

The WHO defines preterm birth as babies born alive before the 37th week of pregnancy is completed. Every year, an estimated 15 million babies are born prematurely around the world, accounting for more than one in every ten, with roughly 1 million dying as a result of preterm birth complications. A lifetime disability, including learning difficulties, vision and hearing impairments, and other disabilities are common among survivors.[15].

According to a study conducted in five hospitals in Ethiopia, the three main primary reasons for death for preterm infants hospitalized in neonatal ICUs were respiratory distress syndrome; sepsis, pneumonia, and meningitis (together known as neonatal infections); and asphyxia. Of these infants, 29% passed away by the age of 28 days after birth.[16].

Another study indicated that, the pooled prevalence of neonatal sepsis among admitted neonates was high, that babies weighing less than 2.5 kg were 1.42 times more likely to acquire neonatal sepsis than newborns weighing 2.5 kg or more; and that this finding from Ethiopia was comparable with studies from Afghanistan, Sweden, and Spain. The study also suggested aseptic measures be followed when performing procedures, especially on preterm and low birth weight babies, since low birth weight babies are more likely to be premature, have immature immune systems, are unable to feed, quickly lose body heat, have low glucose levels and are more likely to develop hypoglycemia, all of which may increase the risk of neonatal infections[17].

In the case at hand, the twins' preterm birth and the need for special care were known to the pediatrician and the obstetrician who oversaw the delivery. They were also aware that their setting did not provide care for preterm. Nevertheless, they chose to keep the twins rather than transfer them right away to a place where treatment and care for premature newborns is available. Taking the above scientific evidence and the facts from the case into consideration, it may have been predictable that the twins' condition would get worse without due precautions and timely interventions.

(iii) How was time crucial in this case study?

Overall, before they were referred, about 30 hours had passed since the twins' health started to deteriorate. The twins initially displayed symptoms and indicators of a health issue in the evening of the day they were born, as reported by the mother and attendants. If the night shift nurse had been acting ethically and understood the risks involved with the twins' condition; she would have responded to the call for help, assessed the twins and given them the care they needed, as well as immediately alerted the pediatrician or the respective seniors who were on duty and handled the morning handover properly.

On day two, the pediatrician did not visit the twins nor did she delegate her responsibilities to her colleagues; either directly or indirectly by informing a responsible person in the setting. The fact that daytime nurses did not notice the twins' precarious state also played a significant role in the delay, which allowed the twins' condition to further deteriorate to levels that were detrimental to their well-being.

The frantic activity of the night shift nurse and others on day three morning, the immediate notification to the obstetrician who moved the twins to delivery room and the pediatrician's quick referral soon after without adhering to institutional procedures, all show that they were learning about the twins' life-threatening condition for the first time that morning and that it was quite late.

(iv) What actions ought the defendants to have made to prevent the twins' deterioration?

The WHO listed steps to be taken to enhance preventive and promotive care, care of complications, family involvement and support,

acknowledging the effects of preterm delivery as a global health concern, and the need to undertake intervention measures in a timely fashion[18]. The following are the preventive measures :

(i) Thermal care for all preterm babies to produce a thermoneutral environment.
(ii) Administering surfactant and maintaining constant positive airway pressure to manage respiratory distress syndrome.
(iii) Oxygen therapy directed by blood oxygen saturation values.
(iv) Empirical antibiotic treatment and additional supportive care as indicated [19].

In the case at hand, at the professional's level, the premature twin's risk of complication and death should have been anticipated before or at birth and then standard precautions and interventions put into practice as soon as possible, without delay. On the other hand, at the institutional level, a strong clinical risk management plan and implementation, as well as supervision to ensure adherence to standard protocols might have been used, to aid clinical personnel in swiftly deploying preventive and promotive care, care for complications, family engagement and support; and taking action at the earliest possible time.

B. The Legal Perspective

(i) The prosecution

The prosecutor invoked Article 575(2b) of the Criminal Code which specifies the breach of a duty to offer aid to a person in imminent and grave danger of his life, body or health. Furthermore, the indictment submitted to the court makes no indication of whether the prosecution believes that this offense led to the twins' deaths. Although violation of this article is an offense that can result in criminal culpability in the absence of proof of injury, the death of the infants could have been regarded as an aggravating factor of the offense.

To prevail in criminal proceeding, a prosecutor must provide evidence to the court that sufficiently and convinicingly establishes that the accused committed a crime. However, the prosecutor, who bears the burden of proof and persuasion, opted to call witnesses but there is no indication that documentary evidence, such as patient files, referral documents, autopsy reports, and so on, as well as expert opinion, were considered.

(ii) The trial

Additional witnesses

The prosecutor's omission to summon the seventh witness, the 'nurse' who allegedly escorted the twins during the referral, and affirmed the absence of oxygen in the cylinder, was one of the reasons the court cited for the decision of acquittal. If this was the case, in my opinion, the evidence of this witness is indispensable in the interest of justice; thus the court could have exercised it's authority to compel her to testify (Criminal Procedure Code, art 143-1).

The other reason for the court's decision for acquittal was the testimony of the sixth witness, the pediatrician, who testified that the twins were breathing upon arrival at ZMH. Based on this testimony, the court concluded that the twins were 'not in lack of oxygen on their trip of referral', because they were just breathing on arrival, and went on to say 'leaving alone sick newborns, even adults cannot survive with the scarcity of oxygen for several minutes'. If this was the case, in my opinion, the court could have exercised it's authority, in the interest of justice, to summon an expert to give an opinion on this matter before coming to a conclusion.

Causation

Lack of proof of causation may have led the prosecutor to choose article 575 (2b) of the criminal code (failure to render aid to a victim) over article 543 of the criminal code (homicide by negligence). Given that sepsis was identified as a clinical factor in the twins' demise and that neither the prosecution nor the defendants objected to the admissibility of

the death certificate or the testimony of the witness, the following inquiries regarding causation might be made:

(I) Could the defendant's actions, in the ordinary course of things, result in the twins' deaths?

(ii) Can sepsis and the wrongdoing of the defendants be regarded as necessary conditions acting together to cause the twins' deaths?

(iii) Is sepsis dependent or independent if it is deemed to be an intervening cause?

(iv) Is it likely that sepsis disrupted the chain of causation, therefore exonerating the defendants from criminal liability?

Standard of care

The fifth prosecution witness stated that it is 'customary' for newly born babies to be monitored and cared for by obstetric staff if a pediatrician is not available. The national minimum standard for MCH Specialty Centers, on the other hand, requires to have one pediatrician available during working hours and on-call duty specialists accessible afterwards. This raises the issue of legal foundation the courts are utilizing to establish a standard of care and the degree of deviation thereof.

Conclusion

This case outlined eight distinct categories of professional misconduct, examined each from a medical standpoint and demonstrated that behaviors such as neglecting patients and practicing with incompetence could result in unintended consequences, one of which is criminal prosecution.

On the other hand, the defendants were charged with violating Article 575(2b) of the Criminal Code, thus the court looked at the evidence to determine whether this particular article had been infringed. Although this was a typical case of criminal negligence, the court did not go on to assess the type and degree of fault committed, the standard of care or breach thereof, the causality and consequences of the defendant's unlawful acts, revealing the gap exists in criminalizing negligent acts arising from the medical profession.

Furthermore, the study revealed that any medical staff member can face criminal charges for failing to perform their obligations; hence, legal liability is a possibility for nurse practitioners, just as it is for doctors and other medical staff. Therefore, all medical professionals should be able to detect problems and learn from their mistakes; hence, conforming to the accepted standard of care, provide appropriate clinical assessment, intervention and evaluation, including communicating with other staff, patients and families as promptly as possible are essential practices. This means that when medical practitioners act in situations where risks can occur, they must be capable of anticipating and avoiding such risks in order to protect patients from complications, injury and death, as well as to avoid legal implications.

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Review Article :

Punishment for cheating but no punishment for causing harm or death.

Dr. Yash Paul

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Keywords: Branded drugs, Generic drugs, Cost of drugs, Harmful drugs.

In America, Theranos's Chairperson and CEO was awarded 11 years imprisonment and President was awarded 13 years imprisonment because they had cheated shareholders of the company and people by making false claims. In India, deaths due to diethylene glycol (DEG) in cough syrups have been reported since 1972, but neither any owner of a pharmaceutical house nor the licensing authority personnel have been punished.

Recently National Medical Commission (NMC) issued instructions to the doctors to prescribe generic drugs only. But on August 23, 2023 it put on hold the earlier instructions as per The Gazette of India dated August 24, 2023. NMC has shown concern regarding the high cost of branded drugs, but has shown no concern regarding the harmful medicines being marketed.

Recently, the Indian Pharmaceutical Industry has been in the news for all wrong reasons. In October 2022, 66 Gambian kids were reported to have died following consumption of cough syrups made in India. In December 2022, 15 children from Uzbekistan were reported to have died by consuming cough syrups made in India. These deaths occurred because of high quantity of DEG in cough syrups. It should be noted that DEG is an industrial solvent, not meant for human consumption. The incidences of death because of DEG were not new.

In India, the first incidence of DEG death took place in Madras (Chennai) in 1972, killing 15 children after they had consumed a cough syrup called Pipmole-C that had been adulterated with DEG. The second event took place in Bombay (Mumbai), in 1986 at JJ Hospital killing 14 patients after they consumed glycerin that had been adulterated with DEG. The third mass DEG poisoning took place in Bihar in 1988 killing 11 patients. The fourth event took place in Gurgoan in 1998 when 33 children between the age of two months to six years died after consuming cough syrup adulterated with DEG. The fifth event took place in Ram Nagar in Jammu region between December 2019 and January 2020, wherein at least 17 children experienced adverse effects and 11 died from kidney failure.

DEG poisoning is a well-known and well-documented problem with Pharmaceutical Industry since 1937, when the first mass DEG poisoning event took place in the United States. The first batch of Elixir Sulfanilamide entered the American market in October 1937, and in a matter of days doctors reported deaths of six patients who had consumed Massengill's drug (SE, Massengill of Bristol, Tennessee was the manufacturer). Despite a frantic recall effort, a total of 105 paitents, including 34 children had died in United States, after consuming Massengill's Cough syrup. The Chief Chemist at Massengill's killed himself while awaiting a trial before court of law, for his role in the incidence. The deaths of these patients provoked an overhaul of Federal Food, Drug and Cosmetics Act in 1938 with an increased focus on safety. The United States has never experienced another mass DEG poisoning event after 1937.

From time-to-time, media has been highlighting issue regarding nexus between pharmaceutical industry and doctors. What is the issue? Pharmaceutical houses sponsor medical conference and Continuing Medical Education seminars where doctors update their knowledge

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regarding new medicines. This expenditure on doctors is passed on to the consumers.

Recently, NMC has issued instructions that doctors should prescribe generic drugs only because generic drugs cost less as compared to branded drugs. NMC also prohibited pharmaceutical industry to sponsor medical conference and seminars for doctors etc.

To prescribe costly brands of medicines is immoral. Prescribing costly medicines to provide benefit to particular pharmaceutical house cannot be justified, so NMC had taken such steps. But because of strong protests by medical fraternity NMC has put on hold the recommendations. There are some issues which are more serious but NMC has ignored these putting peoples' lives at risk. Author will mention three examples.

1. Chlorpheniramine Maleate is not recommended for children below one year of age and Phenylephrine HCl is not recommended for children below two years of age. Many anti-cold drops are available in the market. Wallace Pharmaceutical Ltd. makes and markets. Flucold AF Drops containing these two ingredients for infants and packing mentions the dosage for childrens below two years also as follows: 1-6 months 0.1 ml; 7-12 months 0.1-0.2 ml; 1-3 year 0.2- 0.4 ml and 3-6 years 0.3 -1 ml; 3-4 times in 24 hours.
2. Drug formulations bound to harm.
   Multidrug (containing more than one antibiotic) is recommended for treatment of tuberculosis, malaria and serious infections in neonates. Trimethoprim with Sulphamethoxazole in 1:5 ratio is an approved combination. Presently many antibiotic combinations are available. There are twofold problems with these combinations: (i) Do these combinations provide any real benefit? Answer is no; and (ii) quantity of drugs in these combination formulations is such that in case dose is calculated according to one molecule (medicine), dosage for other molecule may not be correct. Example of Cefixime and Ofloxacin combination for children is presented. Quantity of both molecules is 100 or 50 mg per 5 ml of syrups. Recommended dose of Cefexime is 4 mg per kg twice a day and 7.5 mg per kg twice a day for Ofloxacin. In case required dose is calculated according to Ofloxacin then the administered dose of Cefexime would be almost double of the recommended dose and may cause toxicity; on the other hand if required dose is calculated according to Cefexime then Ofloxacin will be administered under dose and may result in antibiotic resistance.
3. Anti-cold Tablets having different formulations - There are 28 different formulations, having different ingredients and different quantities of the ingredients. 28 is not the number of products, but it is the number of formulations. Are all these formulations effective, safe and science based because all have been made after obtaining licenses?

In 2013 the author had stated: "What is the role and necessity of Drug Controller General of India and State Drug Controllers? A patient takes a drug prescribed by a doctor because patient has full faith in the treating doctor knowing that a doctor would abide by the cardinal principle of medical profession 'cause no harm.' A doctor prescribes a drug believing that any drug which has been licensed must be safe and approved. Is it a misplaced trust"? [1].

Medical Council of India (MCI) - a statutary body for establishing uniform and high standards of medical education in India was established in 1933. National Medical Commission (NMC) was constituted by an act of Parliament known as the National Medical Commission Act 2019 and came into force on September 25, 2020, replacing MCI to oversee medical education.

Intent of NMC to issue instructions to

prescribe generic drugs is to lessen the burden of expenses on medicines. Safety of people from medicines cannot be over looked. As being stated repeatedly, existence of nexus between pharmaceutical industry and doctors, cannot be brushed aside.

Q.1 Why such irrational and harmful drugs are being made? Answer is because these are selling.

Q.2 Why such drugs are selling? Answer is because doctors are prescribing.

Some bitter Truths:

1. Sometimes human beings become inhuman towards fellow human beings to make more money.
2. There is urgent need to put interest of people over and above the commercial interests of pharmaceutical industry.
3. Why MCI or NMC did not take up the issues regarding harmful medicines being made and marketed, and focused on prescribing of generic drugs only?

There is urgent need for intervention by NMC on humanitarian grounds.

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Letter to the Editor :
Many women are punished for giving birth to a girl for no fault on their part.

Dr. Yash Paul

Received for publication : 4th Dec. 2023 Peer review : 07th Dec. 2023 Accepted for publication : 11th Dec. 2023

Many women are punished for giving birth to a girl for no fault on their part.

Hindi newspaper 'Rajasthan Patrika' Jaipur edition dated 27th October 2023 reported under title 'Because of female fetus, in-laws killed the woman'. The incidence is reported from Bihar Sharif from Bihar State. The Woman had been married for seven years and had given birth to two daughters. On suspicion that she is again pregnant with female fetus she was beaten to death and was hung to project it as a case of suicide. Such incidences have been reported in the past from all over the country.

Genes determine the structure and other functions of body. These genes are transmitted to the baby in the form of chromosomes from both the parents. There are 46 chromosomes in human body occurring in 23 pairs, one from the mother and one from the father. Sex of the fetus is primarily determined at the very moment when the ovum is fertilized by the type of sex chromosome supplied by the spermatozoa from the father.

The 23rd pairs of chromosomes divide in two, in the ovum in the female and in the sperm in the male. ln females the 23rd pair has 'XX' chromosomes and in males this pair has 'XY' chromosomes. When the 23rd pair in female divides in two every ovum will have 'X' chromosome. When the 23rd pair divides in the male, half of the sperms will have 'X' chromosome and the other half will have a 'Y' chromosome. ln case a sperm having 'X' chromosome unites with ovum, it will result in 'XX' chromosomes in embryo and in case a sperm having 'Y' chromosome unites with ovum it will result in 'XY' chromosomes. Embryo with 'XX' chromosomes becomes female and embryo with 'XY' chromosomes becomes male.

Though this scientific information is known since year 1905 still many women are shamed, harassed or penalized for no fault on their part. Ministry of Women and Child Development, National and State Commissions for Women and NGOs should take up this issue to create awareness among the people, to protect women from wrong allegations and injustice on humanitarian grounds.

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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. Sudhir Mishra, email : drmishras@gmail.com

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Medicolegal News

Compiled by : Dr. Santosh Pande

Wrongful Use Of TB-Drugs, Not Referring To Pulmonolgist: Senior Medicine Specialist Slapped Rs 25 Lakh Compensation

New Delhi: The National Consumer Disputes Redressal Commission (NCDRC) recently held a South Kolkata-based senior medicine specialist guilty of medical negligence for wrongful use of anti-TB drugs on a patient resulting in acute liver failure.

Dr. Dutta from Kolkata has been directed by the Apex Consumer Court to pay Rs 25 lakh as compensation along with an interest at 6% from the date of filing of the case in 2017.

The top consumer court took this decision after taking note of the fact that the doctor started anti-tubercular as therapeutic trial, in spite of the test reports being negative for tuberculosis.

The matter goes back to 2015 when the complainant's husband, who had been suffering from fever, cough and vomiting, consulted the medicine specialist Dr. Dutta. Consequently, the doctor prescribed for several tests and after examining the test reports, he prescribed medicines of tuberculosis.

Allegedly, after taking the medicines for one week continuously, the patient's body colour became yellow and urine became deep dark and his condition deteriorated considerably. When the patient informed the same to the doctor, Dr. Dutta allegedly informed that it was a normal effect of the medicines and further advised the patient to continue the same.

As advised, the patient continued the medicines and his condition allegedly worsened day by day. Thereafter, the patient was admitted to KPC Medical College and Hospital, Kolkata and the treating doctor at KPC Medical College examined the test reports and the prescription of the medicines given by Dr. Dutta.

The treating doctor at the medical college, after going through the test reports, informed that the patient was not suffering from tuberculosis and as a result of the prolonged use of the medicines of tuberculosis, his liver was badly affected.

Consequently, Liver Function Test of the patient was conducted in 2015 and medicines were prescribed. Even though the patient remained admitted at KPC, his condition allegedly did not improve. Thereafter, the doctors advised to shift the patient to higher centre NRS Medical College. As per the complaint, the doctors at the Peerless Hospital and Research Centre also opined that due to prolonged use of medicines of tuberculosis. The patient died while undergoing treatment at Peerless. The Death Certificate mentioned the cause of death as "Sepsis with multi organ failure in a case of anti-tubercular drug induced. Acute fulminant liver failure". Thereafter, alleging negligence and irresponsible treatment provided by Dr. Dutta, the wife of the deceased patient filed the consumer complaint and demanded Rs 17019005 as compensation.

On the other hand, Dr. Dutta informed the Commission that on clinical examination, he was of the opinion that the patient was suffering from lower respiratory tract infection of the right side of the chest. He also informed about the medicines that he prescribed to the patient and about the fact that a Montoux test was advised by him and the report was negative. Since, the patient's condition did not improve tests like USG whole abdomen, Serum Amylase and Liver Function Test were prescribed.

Dr. Dutta submitted that LFT report was almost normal, USG showed SOL and fatty liver. Thereafter, CT Scan of the whole abdomen was

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prescribed, which showed haemangioma of liver with right sided pleural effusion. Mycobacterium Tuberculosis PCR Mycosure Test. HRCT chest showed right pleural effusion with fibrotic densities of right lung with bronchiectasis in upper lobe with mediastinal lymph nodes. The report also suggested suspected tubercular ethology. Then he prescribed Anti-tubercular as therapeutic trial and started three drug regime with least hepatotoxic drug.

In this regard, the treating doctor also informed the Commission about premises on which he started the Anti-tubercular medicines. Apart from pointing out that India is still a country with TB endemic, he also referred to many sputum negative Mantoux negative tuberculosis, where only clinical suspicion and intuition yielded the desired recovery. Apart from this, the doctor before prescribing the drugs, allegedly, also took nite of the fact that the patient's LFT was almost normal.

The doctor further informed that it was quite unusual to develop hepatotoxicity due to Rifampin and INH within seven days. He argued that there may be some other factors requiring consideration. The doctor further denied any negligence conducted by him and claimed that he treated the patient honestly with his experience of over 30 years and ability as per best medical practice standards and ethics.

After taking note of the submissions and arguments made by both the parties, the Apex Consumer Court also perused the medical record including the drugs that were prescribed by the treating doctor. The Commission also took note of the LFT report dated 22.08.2015 showing that everything was normal and the report dated 24.09.2015 showing that the liver was damaged.

Referring to one of the drug Rifampicin, which was prescribed by the doctor, the NCDRC bench observed, "Medical literatures show that Rifampicin has common side effects of gastrointestinal, anorexia, nausea, vomiting, abdominal pain, hepatitis, reduced effectiveness of oral contraceptive pill and rare side effects of renal failure, shock or thrombocytopenia, skin rash, 'flu syndrome', colitis, pseudo adrenal crisis osteomalacia, haemolytic anaemia. lsoniazid has common side effects of Peripheral neuropathy, hepatitis, if age is above 40 years, sleepiness/ lethargy and rare side effects of convulsions, pellagra, joint pains, agranulocytosis, lipoid reaction, skin rash, acute psychosis."

In this respect, the Commission opined that the patient's liver got damaged because of the continuous consumption of Rifampicin Isoniazid and noted, "From the above evidence, it is proved that the patient, whose liver was normal on 22.08.2015, was found totally damaged in Liver Function Test Report dated 24,09,2015, due to continuous consumption of Rifampicin lsoniazid from 26.08.2015."

Further, the Commission noted that the doctor started the anti-tubercular as therapeutic trial in spite of the fact that the reports were negative for tuberculosis. "In spite of test reports being negative for tuberculosis, Dr *** Dutta started antitubercular as therapeutic trial on his clinical suspicion. Based on clinical suspicion, the doctor has right to use expansive diagnostic test and procedure, which are necessary to reach appropriate diagnosis of the suspected disease. But the opposite party, instead of coming to a conclusion about the disease, started anti-tubercular as therapeutic trial ignoring test reports of negative tuberculosis," noted the Commission.

The NCDRC bench opined that the doctor should have referred the patient to pulmonologist instead of prescribing the anti-tubercular. Holding that the doctor committed gross medical negligence, the Commission noted, "If the medicines prescribed by him were not giving required result, he would have referred the patient

to pulmonologist, instead of prescribing anti-tuberculosis drugs as therapeutic trial on clinical suspicion, which only permit expansive diagnostic test. When the patient reported to him on 05.09.2015 with yellowish discoloration of the whole body and complained high coloured urine, then again he committed negligence in visualising side of effects of anti-tubercular drugs and asked the patient to continue with same medicines, instead of stopping these medicines. From above evidence, it is proved that Dr **** Dutta had committed gross negligence in treating the patient, which resulted in his death."

At this outset, the Apex Consumer Court also referred to the Supreme Court order in the case of Jacob Mathew, where the top court bench had held that negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do.

Therefore, the NCDRC bench directed the concerned doctor to pay Rs 25 lakh as compensation along with interest @6% per annum from December, 2017. Further, the Apex Consumer Court also granted directed Dr. Dutta to pay Rs 50,000 as costs.

"In view of the aforesaid discussion, the complaint is partly allowed with cost of Rs.50000/-. Dr Kabir Dutta (opposite party-2) is directed to pay Rs.2500000/- with interest @6% per annum from December, 2017 till the date of payment, within a period of three months from the date of this judgment," read the order.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/wrongful-use-of-tb-drugs-not-referring-to-pulmonolgist-senior-medicine-specialist-slapped-rs-25-lakh-compensation-119135 Accessed on 25/10/2023*

No Medical Negligence Or Mistake In Diagnosis: SC Dismisses Plea Against Indraprastha Apollo Hospital, Neurosurgeon

New Delhi: In a relief to Indraprastha Apollo Hospital and a Neurosurgeon, the Supreme Court has upheld the decision of the National Consumer Disputes Redressal Commission, and dismissed a medical negligence case against the facility and the doctor. The court noted that principles of Res Ipsa Locutor get attracted where circumstances strongly suggest partaking in negligent behaviour by the person against whom an accusation of negligence is made.

A Division Bench of Justices A.S. Bopanna and Prashant Kumar Mishra said that there was no mistake in diagnosis or a negligent diagnosis by the neurosurgeon, adding that in the absence of the patient having any history of diabetes, hypertension, or cardiac problem, it is difficult to foresee a possible cardiac problem only because the patient had suffered pain in the neck region.

The Case: The case involving allegations of medical negligence was filed under Section 2(c)(iii) of the Consumer Protection Act, 1986 against Indraprastha Apollo Hospital and others following the death of the complainant's husband. The deceased had undergone a major neurosurgery performed by the doctor (a Senior Consultant, Department of Neurosurgery) at the hospital but subsequently passed away while receiving follow-up care.

Rajan suffered from Chiari Malformations (Type II) with Hydrocephalous and had consulted the neurosurgeon in the year 1998, who advised surgery. The procedure was performed, and the patient was then shifted to a private room. However, he began experiencing severe neck pain and other symptoms, which allegedly led to his death. The complainant's primary grievance was that no doctor from the neurosurgery team who had conducted the operation attended the patient after

he was moved to the private room. The complainant argued that, after such a major surgery, the patient should have been placed in the Intensive Care Unit (ICU).

NCDRC's Conclusion: The instant appeal was filed against the order of the Commission issued in 2010 that rejected the complainant's allegation. The Commission had dismissed the complaint, stating that the appellant failed to establish a connection between the patient's cardiac arrest and the surgery or post-operative care. This decision was supported by an affidavit from Prof. Gulshan Kumar Ahuja, a Professor of Neurosurgery at AIIMS and a senior consultant at the hospital, who stated that the complications suffered by the patient were unrelated to the surgery. He further stated that pain in the neck accompanied by symptoms of profuse sweating and nausea cannot be a symptom of cardiac respiratory arrest.

Furthermore, the medical records confirm the deceased had no prior history of diabetes, hypertension, or heart issues, and the neck pain was linked to the cervical surgery without evidence of pain in other body regions. The Commission, considering the facts, found no conclusive proof of medical negligence, and the care leading up to the cardiac arrest was not deemed inadequate, precluding liability for the hospital or the doctor. The legal principle of "Res Ipsa Loquitur" isn't relevant in this case's particulars, the Commission had added.

The Contentions: The appellant, represented by Shri Nikhil Nayyar, raised several points alleging medical negligence by the hospital and the neurosurgeon. It was contended that the hospital's practice of transferring patients to private rooms after surgery was not followed in patient's case. They further raised concerns about the lack of care after the patient complained of pain in his neck and other symptoms as a normal post-operative symptom. Furthermore, the failure to address Ventricular Tachycardia (VT) appropriately was highlighted, along with concerns about the accuracy of the findings in the disputed order. The appellant asserted that the case demonstrated negligence due to a lack of care, underlining the absence of senior doctors or specialists during a critical period and the failure to investigate the source of the pain.

On the other hand, the hospital's counsel countered these arguments, emphasizing that the hospital was well-equipped with advanced medical facilities and that the patient received care from the doctor, an internationally renowned expert who formerly headed the Neurosurgery department. The Neurosurgeon was assisted by Dr Brahm Prakash, a senior Neurosurgeon. It was emphasized that the patient recovered excellently after neurosurgery with no post-operative complications, which is why he was transferred to the recovery and later private room.

The counsel highlighted the patient's pre and post-operative medical records to argue that neither the hospital nor the treating doctors were negligent. They also pointed out that his symptoms did not suggest cardiac arrest and that it would have been impossible for the doctors to predict this outcome. They further reference the Commission's findings and a precedent, Bombay Hospital & Medical Research Centre v. Asha Jaiswal and Others, to support the dismissal of the present appeal.

Meanwhile, Meenakshi Arora, the senior counsel for the neurosurgeon, aligned her arguments with those made on behalf of the hospital and reiterated the Commission's findings and the precedent set by Bombay Hospital v. Asha Jaiswal. Furthermore, the neurosurgeon explained that it was standard practice to examine patients in the recovery room first, and only those showing complications or with pre-operative medical

problems were transferred to the Neurology Intensive Care Unit. The patient had regained consciousness when moved from the Operation Theatre to the Recovery Room, and this was in line with the procedure as most neurosurgical patients were similarly treated. Dr. Brahm Prakash and Dr. Tyagi examined the patient around 5 p.m., and the patient only complained of mild neck pain, considered normal after cervical surgery. The neurosurgeon emphasized that they had received no calls or messages about the patient's condition from the time they left the hospital around 5:30 p.m. until the call from the appellant at about 11:15 p.m. Senior counsel firmly denied the appellant's claims, asserting that the impugned order has no defects warranting intervention from the court and should be dismissed.

Court's Analysis and Findings: The Supreme Court analyzed the evidence presented and relevant legal principles. It considered the critical issue at hand as whether the respondents were negligent in providing proper post-operative medical care to the patient, and whether the Commission erred in dismissing the appellant's complaint.

Initially, the Court underscored that the crux of this case revolved around the absence of appropriate post-operative medical care, rather than focusing on any negligence by the doctor during the Neurosurgery. The Court took note of the allegation that the patient should have been transferred to the ICU instead of a private room. After a thorough review of the pertinent evidence, it was observed that standard practice dictated that patients with no signs of complications in the recovery room and lacking pre or post-operative issues were typically sent to their rooms.

It said; "The patient would have been shifted to the ICU immediately, if serious complications would have arisen after the surgery, therefore, in the absence of complications in the surgery or soon thereafter, the patient was not required to be shifted to ICU and there is no negligence on this count by either of the respondents."

In addressing the specific facts of this case, the Court concluded that the appellant had failed to present any evidence establishing a link between the patient's heart attack and the surgical procedure or negligent post-operative care. It observed; "There is no evidence put forth by the complainant to establish that heart attack suffered by the patient had any connection with the operation in question or that it was on account of negligent post operative care."

The Court also acknowledged that the patient had no history of diabetes, hypertension, or cardiac problems. Thus, it was challenging for the medical staff, including the duty doctor and the hospital, to anticipate a cardiac arrest, especially since the patient had not complained of pain in any other body part except the neck region. It noted; "It is significant to notice that the patient did not have any history of diabetes or hypertension or any cardiac problem. Therefore, it was difficult for treating doctors including the duty doctor or the hospital to assume that the patient may suffer cardiac arrest and moreover, the patient had also not complained of pain in any other part of the body except neck region."

Regarding the circumstances under which a medical practitioner may be held liable for negligence, the Court referenced the case of Jacob Mathew v. State of Punjab and another, (2005) 6 SCC 1, which outlined two key criteria: either the professional lacked the necessary skills they claimed to possess, or they failed to exercise the skills they did have competently.

The Court also drew upon Bombay Hospital & Medical Research Centre v. Asha Jaiswal and Others, 2021 SCC online SC 1149, which discussed earlier judgments, including

Martin F. D'Souza v. Mohd. Ishfaq, (2009) 3 SCC 1. In the latter case, it was emphasized that mere treatment failure or an unsuccessful surgery does not automatically imply medical negligence using the doctrine of res ipsa loquitur.

It said; "In so far as the applicability of principles of Res Ipsa Locutor, in the fact and circumstances of the case, it is to bear in mind that the principles get attracted where circumstances strongly suggest partaking in negligent behaviour by the person against whom an accusation of negligence is made. For applying the principles of Res Ipsa Locutor, it is necessary that a 'Res' is present to establish the allegation of negligence. Strong incriminating circumstantial or documentary evidence is required for application of the doctrine."

Subsequently, the Court concluded that there was neither an erroneous diagnosis nor a negligent one by the Neurosurgeon. Given the patient's lack of any history of diabetes, hypertension, or cardiac problems, it was unreasonable to foresee a cardiac issue solely based on the patient's neck pain. Therefore, the Court held that the appellant had not substantiated claims of negligence on the part of the hospital and the doctor in their post-operative care. The appeal was subsequently dismissed.

It held; "The case in hand stands on a better footing, in as much as there was no mistake in diagnosis or a negligent diagnosis by Respondent no. 2(Neurosurgeon). In the absence of the patient having any history of diabetes, hypertension, or cardiac problem, it is difficult to foresee a possible cardiac problem only because the patient had suffered pain in the neck region."

"For the foregoing, this Court is of the considered view that the appellant has failed to establish negligence on the part of Respondents (hospital and the neurosurgeon) in taking post-operative care and the findings in this regard recorded by the Commission does not suffer from any illegality or perversity. The appeal sans substance and is, accordingly, dismissed."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/no-medical-negligence-or-mistake-in-diagnosis-sc-dismisses-plea-against-indraprastha-apollo-hospital-neurosurgeon-119235 Accessed on 25/10/2023*

Bladder Injury Caused By Suprapubic Catheterization Done By Junior Resident: Hospital, Surgeon Slapped Compensation

New Delhi: The National Consumer Disputes Redressal Commission (NCDRC) has upheld the decision of District Forum holding a Ludhiana Hospital vicariously liable for the acts of negligence on the part of a junior doctor (3rd year Resident, General Surgery) and a Professor, (Dept of General Surgery) in treating a Non-Hodgkin's Lymphoma (NHL) patient, who eventually died due to interruption in Chemotherapy session and later explorative laparotomy.

Concluding medical negligence, the Forum had directed the Hospital and the two doctors to pay a compensation of Rs 3 lakh to the deceased patient's wife.

Presiding Member of the Commission, Dr Inderjit Sing was hearing two Revision Petitions (RPs) filed by Shallu, wife of the deceased, against Dayanand Medical College & Hospital and others. The petitions were lodged against the State Consumer Disputes Redressal Commission, Punjab's order dated March 3, 2016, pertaining to appeals filed against the District Consumer Disputes Redressal Forum's decision.

The petitioner, brought forth her grievances against Dayanand Medical College & Hospital (OP-1), a junior doctor, third year resident, General Surgery (OP-2), a Professor, Dept of General Surgery (OP-3), and United India Insurance Co. Ltd (OP-4), seeking redressal under the Consumer Protection Act 1986. The case

revolves around the demise of Shallu's husband, Jatinder Kumar, due to alleged medical negligence during the course of treatment for Non-Hodgkin's Lymphoma (NHL).

The patient, Jatinder Kumar was admitted to Dayanand Medical College & Hospital for treatment of end-stage Non-Hodgkin's Lymphoma from May 30 to June 20, 2011. The hospital assured that chemotherapy could cure the ailment, and the treatment commenced. However, complications arose during the third chemotherapy session when attempts to change the catheter failed, necessitating a referral to the surgery unit. At the surgery unit, a junior doctor and a third-year medical student, were unable to change the catheter. It was explained to the complainant that there was a urinary infection, and the catheter needed to be directly connected to the urine bladder through minor surgery by a senior surgeon. The patient was then referred to the emergency ward, where OP-2(the junior doctor/resident, GS), was on duty.

In the emergency ward, the attending doctor opted to perform the procedure herself despite being a junior doctor. The petitioner alleged that the procedure was performed by an inexperienced medical student (a third-year PG medical student/a junior doctor), resulting in severe complications as following the surgery, the patient experienced extreme discomfort and was unable to pass urine.

Despite seeking further medical assistance, the patient's condition continued to worsen, culminating in the discovery of a significant hole in his urinary bladder. Subsequent surgeries and medical interventions were unsuccessful, and the patient passed away on October 4, 2011.

The petitioner alleged that despite these complications, the hospital did not transfer the patient to a urology specialist. Furthermore, chemotherapy, a critical aspect of cancer treatment, was interrupted due to the alleged negligence, ultimately contributing to the patient's demise. The petitioner filed a complaint with the District Consumer Disputes Redressal Forum, Ludhiana, alleging medical negligence.

The District Commission, in its order dated December 12, 2014, ruled in favour of the complainant (the petitioner), demanding compensation for alleged medical negligence. It held the medical practitioners responsible for the deficient service, a finding upheld by the Board of Doctors.

The three-member Board of Doctors (BODs), consisting of medical experts including a Senior Medical Officer (SMO), a Specialist, and a Radiologist, conducted a thorough investigation. Their unanimous opinion highlighted critical details regarding the medical treatment received by the patient. The Board emphasized that a standard surgical procedure, Suprapubic Catheterization (SPC), was performed on the patient despite being a high-risk patient with immune compromise and neuropathic bladder injury.

"After carefully going through all the relevant medical record, statements of the dealing doctors, Board of Doctors is unanimously of the opinion that patient Jatinder Kumar was diagnosed as stage IV NHL under treatment require supra public drainage for passage of Urine which was done at DMC, Ludhiana by the doctor (third Year Resident, General Surgery). Ordinarily SPC is a minor surgical procedure done in emergency, but in this case the patient was immune-compromised and was having neuropathic bladder injury at the rate of ultra-operative and post-operative complications is known to be higher and ideally in such high risk cases SPC should have been performed by senior surgeon or under his supervision with Anesthetic backup. As a complication of the above mentioned procedure, the patient had to undergo explorative Laprotomy

and around 1-2 litres of pus was drained out during the procedure following which patient remained in ICU on ventilator support for a considerable period of time, following which the definite treatment of Non-Hodgkin Lymphoma (Chemotherapy) was interrupted. So, in the opinion of the members of the board in this case, SPC and Later explorative laparotomy increased the morbidly and contributed to the mortality," the relevant portion of the BOD report read.

The procedure, which is typically minor, led to complications, requiring an explorative laparotomy due to a substantial pus build up. Regrettably, this surgery disrupted the patient's chemotherapy schedule, further complicating his condition and ultimately contributing to his unfortunate demise.

Eventually, the District Commission directed the hospital and the doctors to pay Rs 3,00,000 to the complainant with a 9% annual interest on account of compensation. Additionally, a sum of Rs. 7,000/- as litigation expenses was to be paid by them. Moreover, the insurance company was mandated to reimburse the claim paid by the other parties involved.

Dissatisfied with this ruling, the petitioner filed an appeal with the State Commission challenging the Order of the District 2016, allowed the appeal of the OP's (the hospital and the doctors), effectively setting aside the District Forum's order, and dismissed the appeal of the complainant/petitioner, seeking an enhancement of compensation.

The State Commission disagreed with the conclusion of the District Commission, questioning Commission. However, the State Commission, through its order dated March 3, the competency of the treating doctor and challenging the connection between the surgical procedures and the patient's deteriorating health.

The State Commission underscored the importance of thoroughly evaluating all aspects of the case before attributing negligence. They emphasized the need to consider the patient's conduct and adherence to the prescribed treatment plan. The Commission disregarded the expert opinion of the BODs, deeming it inconclusive.

Aggrieved, the petitioner moved the apex consumer court contesting the State Commission's order on various grounds. The counsel for the petitioner submitted that the State Commission overlooked vital evidence, including a Board of Doctors' report, supporting allegations of medical negligence by the doctors. The report spotlighted the doctor's alleged independent surgery on a vulnerable patient, causing severe complications. The petitioner cited statements from the doctors to support these claims.

Moreover, the petitioner noted instances where the doctor performed a complex surgery independently, resulting in significant harm to the patient's urinary bladder. It was further emphasized that the State Commission's alleged failure to consider the interruption in chemotherapy due to the doctors' actions, intensifying the patient's suffering and potentially contributing to their eventual demise.

Additionally, the petitioner argued that the State Commission showed bias by focusing on the patient's failure to report after the surgery, disregarding the critical condition, lack of response from hospital authorities, and subsequent ventilator dependence due to the alleged negligence.

In the Revision Petition (RP), the counsel for both the parties presented their arguments. The petitioner's counsel argued that negligence led to interruptions in chemotherapy, impacting the patient's condition and eventually causing his death. On the other hand, the respondents' counsel emphasized the patient's medical conditions and the hospital's adherence to standard protocols,

highlighting no initial allegations of negligence. Further, the insurance company contended that the petition lacked maintainability due to the absence of a direct contractual relationship. All the parties referenced legal cases to support their respective positions, emphasizing the need for substantial evidence to prove medical negligence.

NCDRC conducted a thorough examination of the State Commission's orders, District Forum records, medical board reports, case laws, and rival contentions of the parties. It found that the Medical Board of Doctors (BODs) unanimously opined that the patient's condition necessitated supra pubic drainage for urine passage, a procedure that was performed by a third-year resident doctor under general surgery. Due to complications arising from the procedure, an exploratory laparotomy was required, significantly impacting the patient's condition and interrupting the planned chemotherapy.

The Commission concluded that the BODs' expert opinion should hold significant weight. They emphasized that the BODs were appointed by the District Forum and NEW were comprised of senior doctors and specialists from a government hospital. The court deemed their unbiased and clear opinion as a critical piece of evidence demonstrating negligence on the part of the medical practitioners.

It observed; "We have carefully gone through the above stated observations of State Commission for not relying upon the report of BODs, but do not find it justifiable. It was a well constituted Board of Doctors, consisting of experts and senior doctors of Government Hospital, who have given this unbiased clear expert opinion on the negligence on the part of respondent doctors. No doubt it is left to the courts/commission whether to accept or not any such opinion of such expert BODs, in the instant case, the BODs having been appointed as per orders of District Forum, consisting of expert/senior Doctors, given an unbiased clear opinion, we find no reason for not accepting such expert opinion as an important piece of evidence showing negligence on the part of OPs. Hence, we are of the considered view that State Commission went wrong in discarding the expert opinion of BODs and setting aside the findings of District Forum about medical negligence on the part of OP doctors. We have carefully gone through the orders of District Forum and note that District Forum had considered at length all the facts of the case and rival contentions of the parties as well as medical literature relied upon by the parties and have given a well-reasoned order. It is not correct that District Forum has given its findings simply based on expert opinion/report of BODs. It has duly considered other evidence also before it while concluding medical negligence on the part of OP doctors (OP-2 to OP-3) and OP-1 hospital was held vicariously liable for the acts of negligence on the part of OP-2 & OP-3. District Forum has also taken note of various case laws relied upon by the parties."

Referring to the judgement by Hon'ble Supreme Court in Jacob Mathew (Supra) case, the Commission further highlighted the difference between negligence in civil law and criminal law, emphasizing that the standard of negligence required for civil liability need not be as high as that required for criminal liability. In medical negligence cases, the key components to establish liability include proving a breach of duty, deviation from the standard of care, and resulting damages.

Subsequently, the court upheld the original findings of the District Forum, stressing the significance of expert medical opinion and emphasizing the need for a thorough assessment of all evidence in cases of medical negligence.

It said; "In view of the foregoing, we are of the considered opinion that State Commission went wrong in setting aside the order of the District

Forum and allowing FA/155/2015 filed by OP-1 to OP-3. Hence, we allow RP/1924/2016, set aside the order of State Commission in FA/155/2015 and restore the order of District Forum dated 12.12.2014 in CC/24/2015, with modification with regard to liability of OP-4 Insurance Company as stated in para 15 above. As regards FA/349/2015 filed by complainant for enhancement of compensation, we are of the considered view that District Forum after considering the entire facts and circumstances of the case, have awarded a reasonable amount of compensation. As the FA/349/2015 filed by the complainant was dismissed on the grounds of FA/155/2015 having been dismissed, the State Commission did not consider the case of Complainant for enhancement of the compensation. We have carefully gone through the RP/1925/2016 filed by complainant for enhancement of compensation. Reasons/grounds for enhancing the compensation from the one awarded by District Forum are not found convincing/acceptable. Hence, RP/1925/2016 is dismissed and order of District Forum with respect to quantum of compensation is upheld. All payments as awarded by District Forum, to be made by OP-1 to OP-3, who are held liable jointly and severally, within 2 months of date of the order, along with simple Interest @9% p.a. as per order of District Forum till the date of actual payment. OP-1 shall be free to file its claim to OP-4 Insurance Company within one month of disbursement of amounts as per the order to the complainant/ petitioner herein. Thereafter OP-4 Insurance Company shall process such claim on merits within a maximum of two months and disburse the eligible amount to OP-1."

The court also clarified the procedure for claiming compensation from the involved insurance company, ensuring that proper protocols are followed for a fair resolution.

It held; "As regards liability of OP-4 Insurance Company, District Forum has directed OP-4 to reimburse the claim so paid by OP-1 to the complainant. In this regard, we have considered the contentions of OP-4, that the Hospital holds a professional indemnity (Medical Establishments) Policy with OP-4 and according to the terms and conditions of this policy, OP-4 is obliged to indemnify the insured hospital. However, this liability is contingent upon specific stipulations, and it materializes only if the hospital is deemed liable for any single accident within the defined policy duration. The counsel asserts that it is the hospital's claim that OP-4 would scrutinize for indemnification. Hence, if OP-1 hold a valid policy and is held liable for negligence by competent Court/Commission, it is for OP-1 to formally lodge a claim with OP-4 Insurance Company by observing the due process and submitting requisite documents, whereupon it is incumbent upon OP-4 Insurance Company to consider such claim on merits in accordance with the terms and conditions of policy held by OP-1 and if found eligible, disburse the same. Hence, District Forum went wrong in directing OP-4 Insurance Company straightaway to reimburse the claim so paid by OP-1. To the extent, the order of District Forum needs modification."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/bladder-injury-caused-by-suprapubic-catheterization-done-by-junior-resident-hospital-surgeon-slapped-compensation- Accessed on 26/10/2023*

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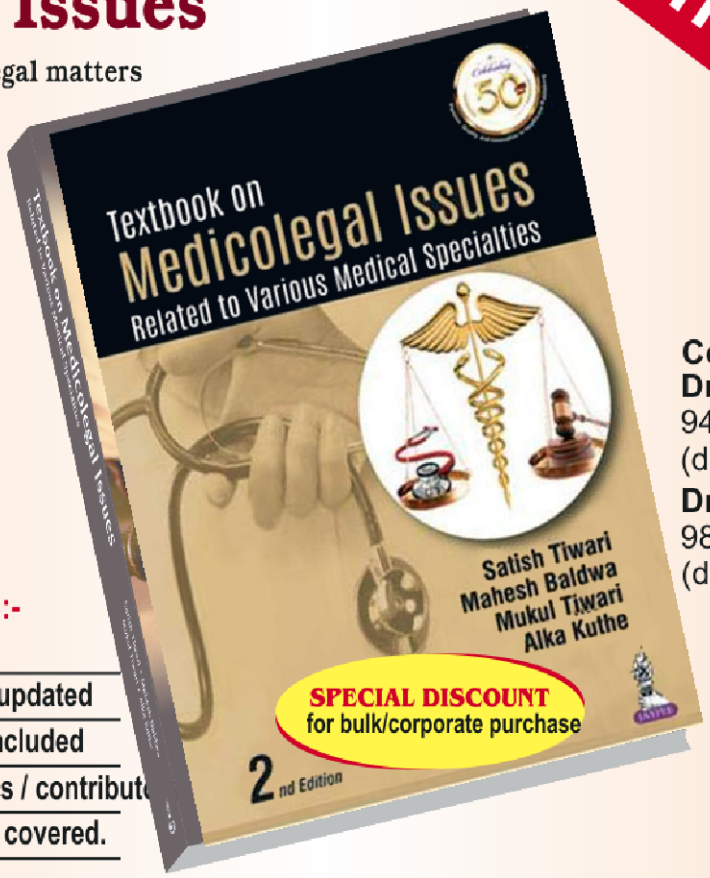

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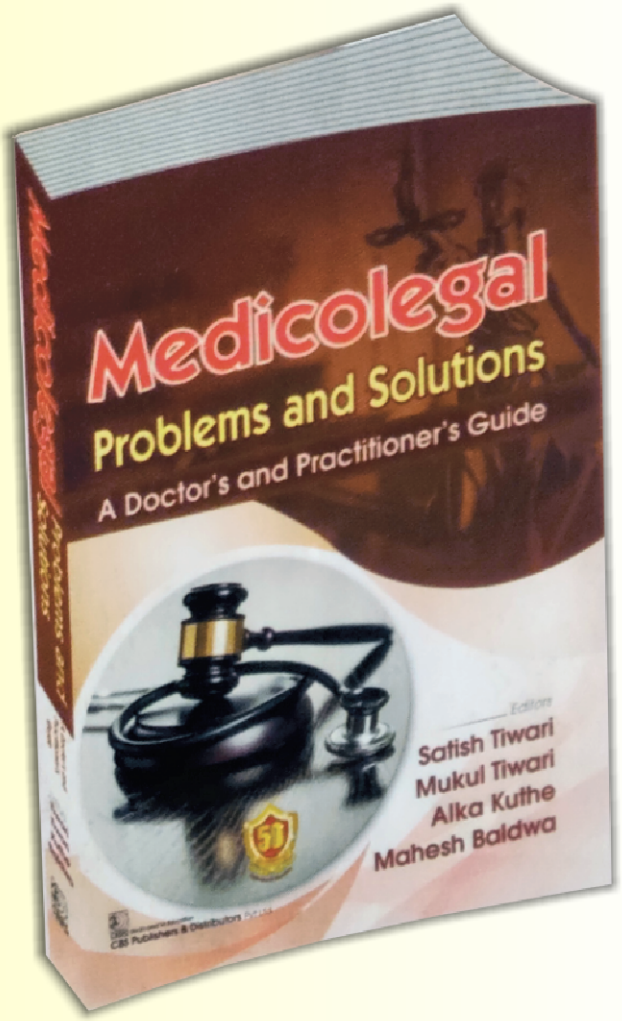

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