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Editorial :

Future of nursing homes without a facility of ventilator!!!

Dr. Utsav Parekh

Received for publication : 10th April 2022 Peer review : 16th April 2022 Accepted for publication : 30th April 2022

Keywords :

Healthcare system. Minimum standards, Private Hospital, Medical Services.

Nursing homes in India are an integral part of our healthcare system. The minimum standards for Allopathic Hospitals under Clinical Establishment Act, 2010 are developed on the basis of level of care provided, as defined below[1]:

Hospital Level 1 (A): General Medical services with indoor admission facility provided by recognized allopathic medical graduate(s) and may also include general dentistry services provided by recognized BDS graduates. Example: PHC, Government and Private Hospitals and Nursing Homes run by MBBS Doctors etc.

Hospital Level 1(B): This level of hospital shall include all the general medical services provided at level 1(A) above and specialist medical services provided by Doctors from one or more basic specialities namely General Medicine, General Surgery, Pediatrics, Obstetrics & Gynecology and Dentistry, providing indoor and OPD services.

Level 1(A) and Level 1(B) Hospitals shall also include support systems required for services like Pharmacy, Pathology Laboratory, X-Ray etc. Example: General Hospital, Single/Multiple Medical Specialties provided at Community Health Centre, Sub Divisional Hospital, and Private Hospital of similar scope, Nursing Home, Civil / District Hospital in few places etc.

In a recent JFM Court judgement at Bidar, Karnataka Jan 6, 2022, well-known medical practitioners of a nursing home were sentenced to two years of imprisonment and fined for having operated a woman for hysterectomy which unfortunately led to the death of a woman at the nursing home without having facility of ventilator [2].

In another case, M. Rajavadivelu vs Janamma Hospital & Ors. on 4 March, 2013 the appellant had contended that his late wife was otherwise keeping good health, had been admitted to the hospital for undergoing Hysterectomy, which was done under general anaesthesia. The appellant was thereafter informed that the surgery was successful and the patient would recover within one hour. However, at the appellant was told by the surgeons that the patient had developed complications and would need to be shifted to the nearby hospital for ventilator support. The NCDRC applied the principle to test medical negligence is whether a doctor exercised a reasonable degree of care and caution in treating a patient [Supreme Court Case Indian Medical Association v. V.P. Shantha (1995) 6 SCC 651] and stated that medical negligence and deficiency in service is established because the Respondents conducted a major surgery under general anaesthesia without taking due care and caution to ensure that critical life-saving equipments like the ventilator were available in case of post-operative complications, which can occur following any major surgery. The NCDRC awarded compensation in the case [3].

While interestingly, in a case of Smt. Anita vs Dr. (Smt.) Vandana Sethi on 12 September, 2014, as per the filed complaint, the Complainant's husband stated that the his wife was operated for Cesarean Section in haste, resulting in failure of operation, by which the new-born child died in half an hour after birth. During operation the doctor arranged an ambulance and referred his wife to other hospital. The complainant alleged that the

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operation was conducted at a place where there was no life-saving equipment. Learned counsel for the Complainant has placed reliance on (2013) 1 CPR (NC) 463; M. Rajavadivelu vs. Janamma Hospital & others. SCDRC stated that the present case is not a case of major surgery and the complainant was shifted immediately to the higher centre by the doctor. Therefore, this ruling does not apply in the instant case. The complaint was dismissed by the SCDRC opining that the Complainant has utterly failed to prove her case on the basis of facts filed on the record, as no expert evidence to show negligence of the Opposite Party is on the record. Contrary to it, the Opposite Party is a qualified doctor, who along with other two qualified doctors performed the Cesarean operation of the Complainant, but unfortunately due to serious complications as mentioned above her new born child died and she developed complications for which she was referred to a higher centre and Opposite Party sent her after arranging ambulance which shows the bonafide of opposite party [4].

In case of Dr. Valli Velayutham Anbu vs Sri Gokulam Hospital on 24 September, 2013, SCDRC Chennai stated that the patient was allowed to be admitted in the higher care centre for the reason that there was ventilator care facility. Therefore, the contention of the Complainant that there was no proper facility in the first attending hospital is unacceptable and untenable [5].

In case of K. Dasharatham vs Dr. Hema Raghu Chitneni on 30 December, 2013 SCDRC Hyderabad dismissed the charges of negligence on a doctor who shifted the patient operated for hysterectomy to the other hospital with a ventilator facility [6].

The Supreme Court itself in the case of Bijoy Sinha vs Biswanath Das in 2017 has held that doing hysterectomy in a nursing home without the facility of an ICU was negligence [7].

In Smt. Leela Devi vs. Dr. Shatrughan Ram & Anr. NCDRC has expressed its view that skill of medical practitioners differs from doctor to doctor, the very nature of the profession is such that there may be more than one course of treatment, which may be advisable for treating a patient and negligence cannot be attributed to a doctor so long as he is performing his duty to the best of his ability and with due care and caution [8].

In Dr. Ashok Rajgopal & Others vs. Ms. Deepti Ranjan, the Hon'ble State Commission has expressed its view that a professional should be held liable for medical negligence if one of the two findings is found, i.e., either not possessing of the requisite skills which professed to have possessed, not exercised, with reasonable competence [9].

In Madan Lal & Others vs. Dr. R.K. Chaudhary & Others, the Hon'ble State Commission has expressed its view that if basic principle relating to medical negligence which is known as BOLAM Rule are not observed then heavy onus lies upon the complainants to prove medical negligence which can be discharged by cogent evidence. Mere averment in the complaint which is denied by other side, is no evidence by which Complainant's case can be proved [10].

Over the period of time, our country has a traditional healthcare system which is gradually transforming into a corporate hospital system along with the private healthcare nursing homes. They are distributed on a various scale delivering utmost medical care according to their surrounding social needs and the capacity building system. Economical system of a geographical area also plays a great role into the development of these multi-layer healthcare system. However, whatever the level of healthcare system would be, the delivery of its in-patient care would be reasonable to the cost, affordable to the community and up to the mark in delivery of care and skills.

Until now, the requirement of a ventilator is considered routinely as a part of Intensive Care Unit (ICU) in context of Indian Healthcare System. It was hardly considered while setting up a nursing

home in the country. However, the judgements cited above are showing the different needs and requirements changing from time to time. Medical fraternity would be having different concerns on these judgements which depict mixed responses regarding the consideration of no presence of ventilator as a negligence.

Ideally, the nursing homes are satisfying the basic healthcare needs in specific areas. Stringent laws such as compulsory presence of a ventilator or ICU would be beneficial to the patient at large but at the same time the setup of such facilities would be dependent on multiple resources, training, cost and other factors which may question the existence of a nursing home.

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Review Article :

Evidence By Doctors: Legal Implications Through Case Analysis

Dr. Pratyusha Das

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Keywords:

Doctor, Evidence, Court, Document, Examination

Introduction

Doctors play an integral part in Criminal Justice Administration. According to Section 45 of the Indian Evidence Act, 1872 doctors are none other than experts on whose opinion the courts depend to convey judgements. Medical evidence includes documentary as well as oral evidence presented in the court by doctors. As experts' doctors are examined-in-chief and cross examined in the courts. Documentary evidence of doctors include injury report, post mortem report etc. The testimony of doctors is also vital to corroborate other evidences. As doctors can deliver evidence in the criminal justice administration in the form of documentation and testimony, similarly they can also create evidence as a mode of self-defence which is mostly civil in nature and is applicable when doctors are sued for negligence. Here somebody else is delivering the evidence against the doctors. Therefore, doctors are means for delivering and creating evidence.

The evidence given by doctors generally is corroborative in nature, however, sometimes the medical witness may become a witness of fact and provide opinion on certain aspects of the case. Medical evidence is not merely a check upon the testimony of eyewitnesses rather it is also regarded as independent testimony as it may establish new facts which were not introduced in other oral evidence. For example, the mark of tattooing of a bullet injury found by an expert doctor could lead to an opinion of whether the range was small or big which information is not possible to derive from ordinary eye witnesses. In the same context the kind of weapon used may be identified from nature of injuries, size and depth of the wound. Evidence given by doctor is considered as opinion evidence but frequently it becomes direct evidence of facts found on person of the victim. (Smt. Majindra Bala Mehra v Sunil Chandra Roy, AIR 1960 SC 706) [1].

Documentary Evidence By Doctor

Whenever there is an unnatural death case reported to police, the dead body is sent to a doctor for conducting post mortem or autopsy. After the inquest is held under section 174 CrPC the police officer forwards the body with a view to its being examined to the nearest Civil Surgeon or other qualified medical man appointed in this behalf by the State Government.

Again, under section 176(1A), if any Judicial Magistrate or Metropolitan Magistrate or Executive Magistrate or police officer holding an inquiry or investigation, gets information of a death of a person, the body will be forwarded for examination to the nearest Civil Surgeon or other qualified medical practitioner appointed in this behalf by the State Government within twenty-four hours of the death of the person.

After receiving request letter for conduction of post-mortem examination along with complete inquest paper including brief history, statements, hospital documents, investigating officer's report etc., the doctor proceeds with the process. It involves identification of the deceased, external examination and internal examination. The internal examination consists of inspecting the internal organs of the body. After conducting the examination, the doctor is required to prepare a report known as the "post mortem report"[2]. A Post Mortem Report Form is available, where the findings of the post mortem examinations are made. The post-mortem report contains cause of death and other particulars like a) The name of the medical examiner b) the name of the deceased c) the case number d) date and time e) the address of the place where it is done[3].

Understanding Legal Implications of Injury

In some cases a victim is brought with severe injuries which might cause his death. There might be different types of injuries leading to death which may be antemortem or postmortem in nature

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or even fresh or old. Injuries may occur due to burn or an offence committed on the victim. In such cases when the victim is brought to the emergency of the Hospital, the attending doctor must first prepare an injury report. The injury report helps in fixing the quantum of punishment and also to ascertain the cause of death, if it leads to death. It is well settled that doctor can never be absolutely certain on point of time or duration of injuries (Ram Swaroop v State of U.P., AIR 2000 SC 715)[4]. In an injury report injury are to be mentioned one after the other with their position, approximate measurement and type of the injuries i.e., abrasion, bruise, laceration injuries etc. Injury may be in the form of simple injury or grievous injury. A simple or slight injury is one which is neither extensive nor serious and which heals rapidly without leaving any permanent deformity or disfiguration.

As per section 319 of IPC Simple hurt causes bodily pain, disease or infirmity to any person. Section 320 of IPC deals with various kinds of grievous hurt. There are eight types of grievous hurt. Emasculation, Permanent privation of the sight of either eye, Permanent privation of the hearing of either ear, Privation of any muscle or joint, Destruction or permanent impairing of the powers of any joint, Permanent disfiguration of head or face, Fracture or dislocation of bone or tooth, any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain or unable to follow his ordinary pursuits. According to section 53A of the Code of Criminal Procedure, marks of injury, if any, on the person of the accused should be mentioned by the Registered Medical Practitioner, who examines the person accused of rape.

Understanding Legal Implications of Post Mortem

Post mortum is conducted in all unnatural death cases or where cause of death is not known. It is the duty of the MO (Medical Officer) to conduct post-mortem examination when nothing is known about causes of death[5]. In any death occurring in prison, police custody, jail custody or prison, asylum or borstal school, post-mortem is to be done under Video Photography as per Directive of Human Rights Commission. Post mortem is also conducted in exhumation cases[6]. The Medical Officer usually the Civil Surgeon will be responsible for transmission of articles to Chemical Examiner, on the basis of the requisition made by the Magistrate or the Police in this matter[7]. Whenever it is required to send something to the Chemical Examiner, it should be forwarded to him without least possible delay. The articles sent to chemical examiner should be accompanied by statement containing all possible information that may serve to guide the Chemical Examiner in his investigation.

The different parts of body like liver, stomach etc should be sent in separate containers and any substance which is subject to decomposition shall be forwarded by immersing it in methylated spirits or wine used in the proportion of one third of the matter of the articles. Each container should be properly sealed, numbered and weighed, which are to be recorded[8].

New protocols for post-mortem have been set up recently which allows the procedure to be conducted after sunset. The new procedure promotes organ donation. The hospitals will be newly equipped for the same. To preserve evidences for future legal complicacies and to rebut any suspicion, video recording facilities for post mortem are provided for all post mortems conducted at night[9]

Understanding Legal Implications of Examinations

There are two types of examinations which a doctor might undergo, examination-in-chief and cross-examination. A doctor is called in the procedure of Examination in chief on behalf of the prosecution to exhibit the reports which were submitted to police. In the Examination in chief- the doctor may be asked questions by the prosecution to assert/affirm the facts of the case before the court. The defence may cross-examine the doctor on the testimony given in the examination in chief to rebut the facts placed by the doctor. New questions apart from issues taken in the examination in chief may also be a part of cross-examination. The purpose of cross-examination is also to test the veracity of the statements put in the chief before the court.

The documentary evidence provided by doctors are inadmissible in courts unless the doctors are examined. In case the doctor is dead or cannot be found in such situation the documents will be relevant by the provisions of section 32 of

the Indian Evidence Act, 1872. [Hadi Kirsani v. State (1965) AIR 1966 Orissa 21]

Case Studies

Two case studies have been discussed hereunder to understand the injury report and post mortem report. Nirbhaya case is one of the leading cases in this regard where death was stated to have caused by sepsis with multi-organ failure following multiple injuries. The injury report of Nirbhaya case is cited herein. [Mukesh v. State (NCT of Delhi) (2017) 6 SCC 1]

Case Study 1 [Mukesh v. State (NCT of Delhi) (2017) 6 SCC 1]

Facts: On 16-12-2012, the deceased Nirbhaya along with her friend PW1 had visited PVR to watch a movie. After the show was over, they reached the bus stand where they boarded a white colour bus as a boy in the bus was calling for commuters. The bus started to move without any more commuters and the lights were switched off. Four men were already inside the drivers cabin and two men were outside the driver's cabin. Then PW1 was abused with a result of inviting and altercation. Then PW1 was assaulted and injuries were caused to his head, both the legs and the other parts of body which consequently led to his fall on the floor of the bus when he heard the painful cries of the lady who was being treated as an object and a prey for the pervert act of gang rape, unnatural sex. Insertion of iron rod in the private parts of the victim, pulling out the internal organs.

Observations by the Court of Case Study 1

Placing reliance on the post mortem report the learned advocate for the appellant/accused submitted that the report reveals that the uterus was not damaged, which refutes the prosecution story that the rod was inserted in the victim's private parts and intestines were pulled out. However, the Supreme Court rejected the aforesaid contention pointing that the doctor was not cross-examined by the defence on the said ground. The Hon'ble Court also dealt with the contention in detail. The Court clarified although the uterus, tubes and the cervix were not damaged, that does not mean that the intestines could not have been damaged. The Court referred to the dying declaration of the prosecutrix that she was raped through the vagina and also the anus and stated it is not essential that the rod has been inserted only through the vagina. It has been observed by the Court that the anus is directly connected to the intestines via the rectum and, thus, deep penetration by use of a rod or other long object could have caused injuries to the bowels/intestines. To support its views the Court referred to the excerpts from Gray's Anatomy: Descriptive and Applied, 34th Edn. [Orient Longman Publication] at pp. 1572 and 1579.

Case Study 2 [State of West Bengal v Pradip Das (2021) and others Sessions Case No.2/2011]

Facts: The facts of this case is that the victim, a girl of 16 years had love affairs with the prime accused, A1, who in the pretext of marrying the victim had set up physical relationship with her. One night the victim was called for marriage where she was accompanied by the accused and two other men. They outraged her modesty and even tried to rape her in presence of AI, who did not raise any protest.

The next day i.e., on 29.09.2009 the victim to save her face from the society tried to commit suicide by setting fire upon her person by sprinkling kerosene oil and ultimately on 11.10.2009 she succumbed to her burn injury in District Hospital Hoogly. After completion of investigation A1 was booked under sections 493, 376(f), 354, 417, 109 and 306 of IPC and A2 and A3 were booked under sections 354, 417, and 306 of IPC.

Oral Evidence

Examination-in-Chief

Dr. Hazra (PW-15) examined the patient when she was admitted in the hospital. In his examination in chief Dr. Hazra stated that on 29.09.2009, the victim was admitted in the hospital through emergency and he examined the patient on 29.09.2009. The particulars in the Bed Head Ticket (B.H.T.) of the patient is noted by his own handwriting and the said B.H.T. is marked as Exhibit-8.

The doctor (PW-15) has further stated that on 01.10.2009 at 10.45 a.m. he personally recorded the statement of the patient in presence of S.I. and on duty sister in the ward. The said statement bears his handwriting as well as signature and that is proved to be Exhibit-9. The patient expired on 11.10.2009 at 2.25 P.M.

Cross-examination

In course of cross-examination on behalf of accused A1 (Pradip Das), Dr. Hazra made it clear that the patient suffered 80%-85% burn. There was

loss of fluid from the body surface due to burning of skin. Such situation is called hypo-volumic shock. On account of that patient was administered inter-venous fluid. This witness has also made it clear that before recording the statement of the patient on 01.10.2009 he did not note the blood pressure, pulse rate, consciousness and condition of patient. He also did not note when last sedative was administered to this patient. The doctor also did not record the dying declaration in verbatim in question answer form. Doctor said the patient made the statement in Bengali but he reduced the same in English. The doctor also voluntarily testified on oath before court that in his own handwriting he noted that the patient was conscious, responded to all commands, urine passed and advised continuity.

Observations by the Court of Case Study 2

Apparently, it appeared that the statement of doctor is contradictory as once he stated he did not record the condition of the patient prior to the recording of Dying Declaration. But subsequently he on the same breadth has claimed that in his own handwriting noted that the patient was conscious, responded to all commands, urine passed and advised continuity. On careful scrutiny of the document marked Exhibit-8, the court found that the doctor has proved portion of B.H.T. under the caption diagnostic procedure which makes it explicit to the court that the doctor on the same day, i.e. on 01.10.2009 has noted in the diagnostic procedure that on 01.10.2009 the patient was found as before. Patient was conscious fully responds to all commands, urine passed. From this document it is also apparent that on 30.09.2009 the patient passed urine and replied. Thus, from this note of the doctor, the condition of patient as on 01.10.2009 and day before recording of statement was ascertained by the court. The court observed that the doctor is an impartial witness and the court did not find any reason which may motivate the doctor to depose falsely against the accused persons. [State of West Bengal v Pradip Das (2021) and others Sessions Case No.2/2011]

Dying Declaration- Law Relating to Dying Declaration

Recording of Dying Declaration is one more essential role of the doctor which is used as evidence in judicial proceedings. If the Dying Declaration is made in fit mental condition and is untainted with malice, it is regarded as a substantive piece of evidence. It is the duty of the court to ensure that it is not tutored, prompted or imagined. Therefore, the rule that Dying Declaration cannot form the sole basis of conviction is not an absolute rule. It may be in both the forms oral or writing or may be communicated by signs in positive and definite manner. In majority situations, it is made orally before death which is recorded in writing by a doctor, or a police officer or a Magistrate. For the purpose of making the declaration authentic it is prudent to call a magistrate although the statements are not to be recorded on oath. There is no specific format to record Dying Declaration but essentially whoever records the Dying Declaration must ascertain that the deceased was in a fit state of mind. When a Magistrate testifies that the declarant was in a fit state of mind, when the statement was made even without the doctor examining him the court may act upon such declaration by confirming the truthfulness and voluntariness of the statement. The voluntariness or truthfulness of the statement may also be proved with other evidence but it is a rule of prudence to get a certification by the doctor. [*Laxman v State of Maharashtra* (2002) SCC (Cri) 1491]

"The Supreme Court has exhaustively laid down the following guidelines with respect to the admissibility of Dying Declaration:

i. Dying declaration can be the sole basis of conviction if it inspires the full confidence of the court.
ii. The court should be satisfied that the deceased was in a fit state of mind at the time of making the statement and that it was not the result of tutoring, prompting or imagination.
iii. Where the Court is satisfied that the declaration is true and voluntary, it can base its conviction without any further corroboration.
iv. It cannot be laid down as an absolute rule of law that the dying declaration cannot form the sole basis of conviction unless it is corroborated. The rule requiring corroboration is merely a rule of prudence.
v. Where the dying declaration is suspicious, it should not be acted upon without corroborative evidence.

vi. A dying declaration which suffers from infirmity such as the deceased was unconscious and could never make any statement cannot form the basis of conviction.
vii. Merely because a dying declaration does not contain all the details as to the occurrence, it is not to be rejected.
viii. Even if it is a brief statement, it is not to be discarded.
ix. When the eyewitness affirms that the deceased was not in a fit or conscious state to make the dying declaration, medical opinion cannot prevail.
x. If after careful scrutiny, the court is satisfied that it is true and free from any effort to induce the deceased to make a false statement and if it is coherent and consistent, there shall be no legal impediment to make it the basis of conviction, even if there is no corroboration." [Atbir v Govt. (NCT of Delhi) (2010) 9 SCC 1, Pg 113]

Case 1 Analysis on Dying Declaration

In the Nirbhaya case three dying declarations were recorded. The second and third Dying declarations were objected to by the Learned counsel of the appellants on the ground of it being tutored and not voluntary and that only the first dying declaration recorded by the doctor immediately after the incident when the prosecutrix was taken to the hospital should be considered as relevant. The Learned advocate pointed out that in the first declaration the prosecutrix did not mention the names of the accused persons neither mentioned the fact of iron rod being inserted or the unnatural offence whereas she did so in the other declarations. Moreover, he pointed out that when the prosecutrix was on oxygen support she could not have given such a lengthy second dying declaration of four pages. The Learned Counsel requested the court to take account of the fact that since the prosecutrix was admitted in hospital she was continuously under the influence of morphine and she was not conscious. The second dying declaration was recorded by the SDM after a delay of four days which was taken up to rebut its relevancy instead of it being recorded by a Magistrate. Although the third dying declaration was made to the Metropolitan Magistrate through gestures and it was recorded in writing, its credibility was alleged that false medical certificate was created and it was not video-graphed.

The second line of argument presented by the Learned Counsel was that the dates of both the second and third dying declarations have been manipulated. He pointed out the overwriting on the second declaration and pointed out that it was recorded on the previous day on which the date was put. Even he pointed out the overwriting of the date on the third dying declaration. It was submitted that three times the date has been modified to fit in the fake chain of circumstances of the prosecution version.

Mr. Luthra Learned Senior Counsel on behalf of the State resisted the submissions on behalf of the appellants and judiciously claimed that the three dying declarations are well-corroborated and consistent with medical evidence, the prosecution witness (PW1), the friend of prosecutrix and other scientific evidence. Mr. Luthra pointed out that the first dying declaration was a brief description of the entire episode of the heinous act and it is very natural that in a state of shock nothing more could be expected of the victim. She was declared fit to make her statement only after receiving medical attention. PW 52, the doctor, had conducted the examination of the prosecutrix and found her to be oriented, fit, conscious and meaningfully communicative for making statements and endorsed to that effect. Thereafter, SDM recorded her second dying declaration where the victim narrated the detailed incident and named the accused persons. Even the SDM deposed before the court that the prosecutrix was in a fit mental condition to give the statement. Even the third declaration recorded by the Metropolitan Magistrate through gestures and writings was also consistent with the previous two declarations which adds to its credibility and establishes reliability conclusively.

Observations by the Court on Case 1

In the first dying declaration recorded by the doctor as soon as the prosecutrix was brought to the hospital, she described the incident of gangrape and the injuries caused to her in brief, however, she could not describe the detailed incident of insertion of iron rod as it appeared from the record that Nirbhaya had lost sufficient quantity of blood due to which she was drowsy. Although she has stated

the incidence in brief, she responded to verbal commands so the court found that it is natural, reliable and is equally consistent with the other two declarations recorded.

The second dying declaration was recorded by the SDM where the exact details of the incidence with the injuries were recorded. Before recording the statements, the Learned SDM convinced herself that the prosecutrix was fit to state as the stability of the prosecutrix before recording the second dying declaration was recorded by the doctor (PW-52) who on an application endorsed and found her conscious, oriented and meaningfully communicative. Thereafter the second dying declaration was recorded. The dying declaration was signed by the prosecutrix and contained the details of the gang rape, unnatural sex, the injuries caused on her person by the iron rod and insertion of hands by the accused, description of bus and lastly the throwing of the victims from the bus in severe condition. The SDM forwarded the record of the statement with a forwarding letter to the ACP, duly signed by herself. The dying declaration which was signed by the prosecutrix was also countersigned by the Learned SDM who further issued a certificate that the prosecutrix has signed all pages in her presence after which she affixed her signature on it. There was no overwriting of date as noticed by the court on the exhibited document. However, in the forwarding letter sent to ACP the date was overwritten but on cross-examination she stated that the date was overwritten by her which ruled out the possibility of fabrication at the request of the prosecution. Learned SDM also explained the overwriting as "human error" which was correctly interpreted by the trial court and acknowledged by the High Court as a complete explanation.

The third dying declaration was recorded by the Metropolitan Magistrate who signed the document thereafter. The court appreciated the fact of signing the document irrespective of the date being overwritten but there was no cross-examination on the aspect of date being overwritten. In this case, unlike the second dying declaration the forwarding note to the investigating officer in continuation to the statement of the prosecutrix was very clear with the signature and the date without any overwriting being visible. The court was of the view that the Learned Counsel for the appellant raised the issue of overwriting of date in the third dying declaration to substantiate his apprehension of manipulation by the prosecution. The court held that the issues pointed out from the side of the appellant was insignificant compared to the prosecution case on a terra firma. The court observed that it is beyond human prudence to discard such a detailed and well signed statement of the prosecutrix for the err of one single prosecution witness. It was further observed by the court that the testimony of the doctor (PW-52) who was the incharge of the ICU and under whose supervision the entire treatment and the recording of prosecutrix's statements were made cannot be discarded on ground of negligible errors.

Another argument placed from the appellant's side was that the prosecutrix failed to disclose the names of the accused persons in the statements given to the doctor in the MLC but in the dying declaration she mentioned the names of the accused which means the statements are tutored and are not relevant to form the basis of conviction.

The Apex court was of the view that the argument forwarded was unjustified in the context of the deadly traumatized and sub-conscious situation of the prosecutrix when she was transported to the hospital. In the MLC her condition was described as drowsy, only responding to verbal commands, not completely alert due to shock and excessive blood loss. After three times operation was conducted on her the prosecutrix was stated to be in a fit state to make statements. The Dying declarations made by her could be corroborated by the testimony of her friend (PW-1) and by the medical evidence. [*Mukesh v. State (NCT of Delhi)* (2017) 6 SCC 1, Para 164-173]

Case 2 Analysis on Dying Declaration

In another case of Hooghly, Learned Advocate representing the defence condemned the Dying Declaration arguing that dying declaration does not bear the certificate of doctor. He further contended that dying declaration is a valuable piece of evidence if it is found to be credible but in this particular case so called dying declaration marked as Exhibit-9 cannot be coloured as dying declaration, as it does not bear the certificate of doctor showing mental alertness and consciousness of the patient. Pulse or blood pressure were not

noted by the doctor. He further pointed out that the patient was provided with sedative drug which causes drowsiness. In these circumstances, it is very risky to rely upon the statement of the patient. He also contended that admittedly police was present at the time of recording statement. Statement of patient is not proved to be voluntary. Accordingly, this statement of the patient cannot be said to be dying declaration and should not be relied upon. In support of his contention, he referred the decision of Hon'ble Supreme Court of India in two reported cases.

The merit of the contention was decided by the court taking up to the reported case referred by defence, where the Hon'ble Apex Court did not rely upon the Dying Declaration considering the manner in which it was recorded. In that referred case conviction was based solely on the dying declaration recorded by one A.S.I. who knew that Special Executive Magistrates were available, but in the present case the situation is altogether different. In this case the statement of the patient was recorded by doctor in presence of staff nurse and police officer. Accordingly, the court was of the humble view that the decision of the Hon'ble Supreme Court of India in the reported case, has got no application in this case in hand.

Observations by the Court

It has been observed by the court that a dying declaration is generally to be recorded by an executive magistrate with certificate of a medical doctor about the mental state of the declarator. But it does not mean that under all circumstances it is to be recorded by a Magistrate and Magistrate only and to be certified by a doctor and lacking of it would make the dying declaration unreliable. What is necessary is that the person who recorded it, must be satisfied that the deceased was in a fit state of mind to make the statement, and has clear capacity to observe and identify the assailant and that he was making the statement without any influence or rancor. At the same time it is settled principle of law that court cannot be too technical and in substance it feels, convinced about the trustworthiness of the statement which may inspire confidence such a declaration can be acted upon, without any corroboration. The court relying on Laxman v State (2002) 6 S. C.C. 710, viewed that, merely because the dying declaration does not bear the certificate of a doctor, it should not be thrown at the threshold. In such a situation the court should try to find out about the truthfulness of the statement appearing in the declaration and whether it is free from any doubt. [State of West Bengal v Pradip Das (2021), Bhombal Biswas @ Biswajit, Sukhen Debnath, Pg 6 of 21]

Conclusion & Suggestions

The evaluation of the role of doctors under the Indian Evidence Act is quite pertinent in the administration of criminal justice. It is prudent to be meticulous while the doctors are preparing injury report or post-mortem report or when they record dying declarations. A doctor conducting post mortem is expected to record cause of death and preserve viscera for chemical analysis. In a particular case the Hon'ble Supreme Court observed that the doctor failed to discharge his professional commitment and helped the accused, so the Director General of Health Services was directed to initiate disciplinary action against the doctor. [Sahabuddin v State of Assam (2012) (80) ACC 1002 (SC)]

Medical officers should aptly record the type of injury to avoid legal complications. In case of discrepancy in the number of injuries recorded in the medical examination report and the PMR, such inconsistency was held to be immaterial where both the doctors aligned with cause of death and the nature of injuries. [Prahalad Patel v State of M.P (2011) CrLJ 1474 (SC)]

While recording dying dclarations it is prudent on the part of the doctor to record the mental alertness and consciousness of the patient, to avoid recording statements only before police, overwriting to be avoided, to record the declaration after the fitness certificate is issued. Both or either the executive magistrate or judicial magistrate may be called by doctor, if situation permits to record the dying declaration.

Medical experts should remember, that the examination in courts is conducted based on the documentations. So, it is appropriate to maintain the medical records as per rules and regulations. Unless the doctor is examined both the injury report and the post-mortem report would remain inadmissible [10].

Mostly doctors become prey in Consumer disputes for their negligence nonetheless criminal

liabilities may also be fixed on doctors for gross negligence or rash and negligent act. The Supreme Court on April 29, 2022 upheld a decision of Bombay High Court that doctors and healthcare services are not excluded from the purview of Consumer Protection Act, 2019 [11]. Just after this on May 8, 2022, Consumer Court held Max Super Speciality Hospital and its surgeons guilty for leaving cotton during brain surgery. Hyderabad Consumer Dispute Redressal Forum has ordered Diagnostic Centre to pay Rupees 2 Lakh for wrong creatinine level reports. It is to be noted that a doctor may be prosecuted under criminal law when it could be proved that standard of negligence by a doctor is "gross negligence" or "recklessness" which may be distinguished from lack of necessary care or precaution or required skill. [Dr. Suresh Gupta v Govt. of NCT of Delhi and Another (2004) (6) SCC 422]

Failure to take consent might be the other reason for fixing liability on a doctor. Therefore, to avoid complications of Medical Negligence, the doctor should act with due care and caution. Medical records should be maintained as per the Code of Medical Ethics Regulations, 2000. The doctors should maintain proper records of patients. Doctor should avoid performing illegal abortion, should not arbitrarily refuse treatment of patient. Any confidential matter concerning the patient during the medical attendance should not be revealed. The doctor should acquaint the patient party about the condition of the patient without exaggerating or minimizing. The patient should not be neglected at any circumstance nor a doctor should withdraw from a case without appropriate notice.

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Perspective :

Doctors Can Refuse To Treat A Patient : What Is New?

Dr. Yash Paul

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Keyword: Medical ethics, Violence against doctors.

Abstract: Since time immemorial physicians have been rendering their services for the good of humanity. Miscreants have also been in existence since long. For last few years violence against doctors has been on the rise. It is for the government to control this malady.

In the month of May 2022, the National Medical Committee (NMC) had come out with many new suggestions and recommendations regarding Allopathic Registered Medical Practitioners (RMPs). However , two recommendations need deliberation.

1. RMPs (except doctors in government service or emergencies) can refuse to continue to treat a patient in case family members or friends of the patient are abusive, unruly and violent.
2. Doctors can refuse to treat patient if pre-indicated fees not paid.

1. Unruly abusive and violent act towards doctors.

It is the duty of a doctor to render services without any bias. Geneva Convention on Prisoners of War signed on July 27,1929 and further modified in 1949 state that doctors are expected to render their services to "Prisoners of War", who belong to enemy defense service. These enemy soldiers were fighting on behalf of their country, thus performing their duty. As prisoners even these enemy soldiers are to be provided proper medical care. It is pertinent to state high ethical and moral standards were maintained in ancient India. During the war between Ram and Ravan, Lakshman had become unconscious when hit by an arrow shot by Ravan's son Meghnath. Ram was on vanvas (in exile) and was not accompanied by any Raj Vaid (Royal Physician). Ram requested vaid Sushen, the Raj Vaid (Royal Physician) of Ravan to attend Lakshman. Vaid Sushen examined Lakshman and prescribed Sanjeevni booti which was fetched by Hanuman and Lakshman recoverd. This shows that Vaid Sushen performed his duty even for enemy of his king.

Doctors render their services to the criminals and convicts in jail and hospitals. No doctor will refuse to treat an injured or sick criminal. But, attacking doctors and their establishments for whatsoever reasons by any one falls in different category.

Dr. R.D. Lele in a book titled 'The Medical Profession & the Law [1] cited Charak Samhita which stated: "The physician should regard all his patients as if they were his own children and vigilantly guard them from all harm considering this to be his highest religion." Under sub-head 'rights and responsibilities' Dr. Lele cited situations where a doctor can refuse to treat a patient if doctor finds that the patient and his/her relatives are not co-operative.

Justice V.S. Deshpande in Foreword to the above mentioned book stated: "The deterioration of standards in the medical profession is but a reflection of the deterioration of standards in other profession and in the all-pervading public life of our country"

The author joined government service in August 1963 and was posted at Bharatpur, a small town in Rajasthan. We had limited medical facilities regarding investigations, medicines etc. Many patients could not be saved but relatives of the deceased persons always thanked the doctor for all efforts done before taking away the dead body. Thus, what Justice V.S. Dehpande had written in 1992 holds true even now, after three decades.

In November 2014, issue of Pediascene, a medical bulletin from Bijnor (UP) published by Dr. Vipin M. Vashishtha in an article titled 'Are the strikes by the doctors justifiable?' the author had stated: "There are news galore regarding doctors going on strikes from different parts of the country…….. because of manhandling of the doctors and staff by relatives of the patients, and/or damage

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to the properly of the hospital or clinic. Doctors should not go on strike, because this would put other innocent people at risk, whereas no direct harm will occur to culprits. Doctors should inform the police of that area, Indian Medical Association and State Medical Council that in future aggrieved doctors as well other doctors of that area will not attend to culprits in any condition till case is settled by the courts." [2].

2. Fees not paid.

Charak Samhita states: "Whoever having been treated by a physician does not recompense him whether or not there be a previous understanding for remuneration, that man is beyond redemption" [1] Under sub-head 'Doctors' rights and responsibilities' Dr. Lele stated: Doctor can refuse to treat a patient if his/her fees is not paid'.

Government medical facilities and some charitable institutions provide services free or at reduced rates. A doctor out of compassion may give discount or waive off the charges but these cannot be demanded or forced. Charak Samhita written about 2500 years ago, 300-200 BC defines a good physician as well provides protection against rogues in the society.

Thus, both issues regarding refusal to treat a particular patient are in existence. The National Medical Committee should persuade the government to impose harsh punishments for people resorting to violence against doctors and hospitals and develop mechanisms for their proper implementations.

3. Use of Red Cross emblem is permitted to members of Army Medical Corps (AMC) and Red Cross Society only. For doctors there is a different emblem. The author would like to state an issue which was raised by him in year 2004[3]. The author had stated: "With changing time, because of great increase in traffic accidents, now on the spot emergency medical help is often required. The Indian Medical Association should make some recommendation for those doctors who desire to render emergency services anytime, anywhere, when need arises. These doctors should keep an 'Emergency Box' in their vehicles. The necessary appliances, tools or equipment for the 'Box' should be specific, which can be advised by a committee consisting of different specialties eg. Orthopedic Surgeons, Cardiologists Neurologists etc., and some short training be imparted to these doctors."

Sign of Red Cross or 'PLUS' is identified even by illiterates to be associated with a doctor, who may fail to identify the new symbol allotted to the doctor. So special 'Red Cross' symbol should be designed.

In case of an accident or emergency it should be obligatory for the doctors using the special 'Red Cross' symbol to attend and transport the patient to appropriate place. Appropriate charges for such services should also be laid down as guidelines so that rendering such services are neither refused nor done for any financial gain. For poor people doctors should render free services or 'token' charges be paid by IMA [3].

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Perspective : Short communication

Confessions By A Doctor

Dr Yash Paul

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Keywords : Confessions, Punishments

Confession is a signed statement by someone in which he/she admits that particular crime has been committed by him/her. Like every wrong doer I have excuses for the wrong acts done more than half a century ago. I mention here three instances with whole truth.

I joined Rajasthan government services in August 1963 after qualifying as a pediatrician. At that point of time there were three Medical Colleges in Rajasthan: S.M.S Medical College, Jaipur; S.P. Medical College, Bikaner and R.N.T Medical college, Udaipur. Alwar, Bharatpur, Jodhpur, Kota and Sikar were the only cities and towns in Rajasthan where pediatricians were posted. I was posted at Bharatpur.

Bharatpur was a small town with one government hospital and one railway dispensary with one doctor. Most of the railway staff used to bring their children to the government hospital for treatment. Kota was my home town. Whenever any of my family members from Kota used to come to Bharatpur my wife and I used to go to the railway station to receive or see them off. Railway staff at the railway station insisted that I should not buy platform tickets for my wife and myself as a gesture of goodwill towards me because I used to treat their children.

Once when my wife and I had gone to the railway station to see off my mother who was going back to Kota, we did not find any familiar staff member at the station so I purchased two platform tickets along with a train ticket to Kota for my mother. After departure of the train when we walked to the exit gate, one of the known staff member noticed the platform tickets in my hand. He got very furious, I apologized and assured him that such mistake will not occur in future. He said 'a mistake is a mistake and punishment is a must'. When I asked him regarding the punishment he ordered us to come with him to his office and take tea with him.

Second incidence occurred in the year 1968. I had to go to Jaipur to appear for an interview for selection of Lecturers in pediatrics. I boarded a Rajasthan Roadways bus, when I wanted to buy a ticket the conductor refused to give me a ticket and said he would issue ticket in case there is any checking on the way. There was no checking so I travelled free from Bharatpur to Jaipur.

Third incidence occurred in year 1969. I had been selected as Lecturer and posted to the newly established Medical College at Jodhpur. At a time when the Radiologist at Bharatpur hospital was on leave, I had to prepare reports for some of the X-ray plates done during his absence. I got a call from Bharatpur to appear in the court regarding an X-ray report. At Bharatpur. I had been tenant of an uncle of Late Prof. Purushottam Chaturvedi who was Lecturer in Commerce and later Vice Chanceller of M.D.S. University Ajmer and Chanceller of Central University of Haryana. During my visit to Bharatpur to attend the court I stayed with him. He came with me to drop me at the railway station to catch the train for Jodhpur. At the station the then Station Master also joined us. The moment the train arrived I realized that I had left my thermos at Prof. Chaturvedi's house and said it loudly. The station master said “Chaturvedi Saheb will fetch my thermos”. I pointed out that train's haltage is for seven minutes only. The station master said “seven minutes will start when thermos arrives.” Thus, the train was delayed by more than fifty minutes.

My excuse is that I played passive role only in these three wrongful acts while other people played active role in these acts out of goodwill to Medical profession. It is for the readers to give their verdict on the quantity of guilt on my part.

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Perspective:

Sample collection & trace evidence preservation of medico-legal importance in clinical practice

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Keywords:

Trace evidence, Blood stains, Seminal stains, Sample collection, Medico-legal cases.

Abstract:

In medico-legal cases, a clinician has the responsibility of collecting and preserving trace evidence. If they are not collected in time there is always the possibility of loss or sometimes there may be a chance of tampering too. Every clinician must be familiar with different types of trace evidence, conditions where the question of their collection may arise, and how to collect and preserve them. The trace evidence are useful in the identification of an accused, the weapon used, nature of the crime, place of the incident and to determine the modus operandi of the crime. Early detection and collection in cases of biological trace evidence are of utmost importance because many of them may disappear later.

Introduction:

Trace evidence is a very small, minute or microscopic exchanged particles resulting from the interaction of objects or people during the commission of a crime [1,2]. Commonly encountered trace evidence are hair, fibers, skin, blood stains, salivary stains, seminal stains, paints, etc. As they are very small they can be easily transferred from person to person or place to person and play a very important role in the criminal investigation [3,4]. The basic principle of this particle transfer is known as Locard's exchange principle. Sir Edmond Locard observed that it is impossible to commit a crime without taking or leaving trace evidence [5].

It is very difficult to detect the presence of trace evidence by the culprit or by other people. So, there is always a chance of finding these trace evidence as they remained undisturbed or undestroyed for a reasonable period of time. If they are recovered in time, then much important information as - a possible source of their origin, the sequence of events, the link between accused and the culprit, their modus operandi, etc. may be established. So, they are also known as "Silent Witness".

During professional practice, a clinician may come across such situations where there is a need to collect and preserve such trace evidence. Such a situation may be a case of examination of a rape victim or accused; other sexual offenses and criminal cases. In such cases, a clinician has dual responsibilities, firstly as a doctor to extend treatment to the patient, and secondly to help the judiciary system by collecting and preserving the trace evidence.

Sources & Types Of Trace Evidence [3,4]:

Trace evidence is formed when a piece of material breaks or detaches from one surface and transfers to another surface during physical contact. Trace evidence may be broadly divided into two categories viz.

1. Organic trace evidence like blood, semen, saliva, skin, hair, etc., and
2. Inorganic trace evidence like paints, glasses, fibers, dust, etc. The nature and composition of this trace evidence may vary from one case to another. However, some important cases where a clinician may come across trace evidence are given below.

A. Rape & Sexual Offense Cases:- Blood stains, seminal stains, saliva stains, smegma, vaginal secretion stains, menstrual blood stains, pubic hair, foreign hairs, traces of oil or lubricants, broken buttons, fecal matters, urethral discharges, nail scrapes, etc.

B. Physical Assault Cases: Blood stains, saliva stains, nail scrapes, hairs, fibers, broken pieces of weapon, any other foreign bodies, gun powder residue, etc.

C. Road Traffic, Railway & Other Accident Cases: Grease stains, dust, grasses, tire marks, dust or sand particles, grasses, tool marks, etc.

D. Criminal Abortion Cases: Products of

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conception, blood stains soap, or any other chemicals, any foreign body, etc.

Important Collection Techniques [3,4]:

Trace evidence may be collected during the clinical examination by using different methods like picking, lifting, scraping, clipping, combing, etc. according to the case and situation. Trace evidence like hairs, fibers, etc. can be easily picked up by using clean forceps. Very small fibers, dust or sand particles, pollens, etc. may be lifted by using an adhesive cello tape. Thicker dry blood stains, seminal stains, paints, etc. may be preserved by the scraping method. Skin tags present in the fingernails may be removed by clipping with clean clippers or scissors. The combing method is useful for retrieval of foreign hairs from the head and pubic region. Some special techniques for trace evidence collection are described below.

A. Blood Sample: For liquid blood, we may soak it on a white filter paper, white gauge, or a white sterile cotton cloth piece. Air dry it at room temperature & keep it in a paper bag or box after sealing. We should not dry it directly in sunlight or heat as it may damage the sample. Before packing it, we must dry it properly otherwise the sample will be damaged due to fungus or bacterial growth. A polythene bag, glass container, or any other air-tight container should not be used as it doesn't absorb moisture.

If a blood stain is seen on clothes, then we must note the type, colour, texture, and size of the cloth first. Next, note the number, size, shape, and position of all stains. Then remove the cloth, air dry it at room temperature and keep it with minimum possible folds. Keep it in a paper box after sealing.

If blood stains are seen on the body surface, and if they are wet, then we can use a dry cotton swab to soak in. If the stains are dry, then rub them with a cotton swab soaked with normal saline.

B. Semen Sample: A clean syringe or disposable pipette is used for collecting the liquid semen sample. Then it can be transferred onto a clean swab or cotton cloth by absorption technique. If a semen-like substance is found on the cloths like panties, bras, etc., the whole cloth is collected. We must make sure that all must be air-dried before packing & sealing.

C. Saliva Sample: The classical method is the use of a wet cotton swab or a wet filter paper to retrieve the saliva from the suspected body area (The single swab technique). In case of the double swab technique, we need two sterile cotton swabs and about 3 ml of distilled water. Soak the 1st swab in sterile distilled water & roll it over the suspected area by applying slight pressure and by following a circular motion. Within 10 seconds roll the 2nd dry swab across the now moist area with moderate pressure to absorb the wetness from the skin into the second swab. Allow both the swabs to dry, pack and seal them together. This technique is especially useful if a DNA test is needed later on.

Another method for saliva collection is the Spitting Method. Saliva is allowed to accumulate in the mouth then he spits it into a test tube. The advantage is that it can be used when the flow rate is very low and where evaporation of saliva has to be minimized and the disadvantage is that it might have some stimulatory effects. To avoid this stimulatory effect, we may use another technique known as Draining Method. In this method, the person is made to sit quietly with head bent down & mouth open to allow saliva to drip passively from the lower lip into sterile tubes. Saliva thus collected by draining is without any stimulation and is more reliable. In cases of an uncooperative person, we may use the Suction Method. Here, saliva is allowed to accumulate on the floor of the mouth and aspirated continuously using micropipettes, syringes, saliva ejector, or an aspirator.

Preservation Techniques [3,4]:

Many of the biological trace evidence may be preserved by simple air drying at room temperature. They don't require the addition of special preservatives. If the physician thinks that the sample may be useful for DNA analysis later on then the best method of preservation is by freezing it. If the samples are to be transported within 48 hours then they may be preserved in an ice box. Inorganic trace evidence can be preserved as it is.

Packaging & Labelling [3,4]:

The size and type of packaging to be used depending on the size and the type of the collected trace evidence. In most instances, a paper bindle/glassine bindle/or a coin envelope will be used. The trace evidence should be placed in the smallest container that the trace evidence will

comfortably fit in. The trace evidence should never be preserved in direct contact with cotton. If the trace evidence is subject to breakage, as is the case with glass or even large paint samples, then it can be packaged in a bindle and placed into a box to prevent further breakage. Every package or envelope must be sealed and labeling must be done properly. The label must have the name of the sample, sample number, police case or MLC number, name of the victim or accused, name & signature of the doctor, date & place etc. Thus collected samples must be kept under lock and key till the final dispatch to the police investigating officer after obtaining a receipt of acknowledgment.

Discussion:

Generally, it is the duty of forensic science laboratory personnel/technicians to collect and preserve trace evidence. However, a clinician may be the first contact person in a medico-legal patient examination and in such situations, he needs to know about the collection & preservation of samples of medico-legal importance. Problems may arise as there is generally a lack of special kits and equipment for the collection of such trace evidence by general practitioners. Moreover, there is a lack of awareness amongst the general practitioners as this deviates from their routine work.

Trace evidence of blood may also be useful for toxicology analysis [5]. Biological trace evidence such as blood and semen often yields vital evidence in contemporary criminal investigations [6,7]. In cases where physical findings are not informative, examination of trace evidence always provides corroborative evidence to link to the accused [8]. So, in all medico-legal cases, the doctors must collect & preserve available trace evidence. Failure to collect or destroy after collection of such evidence is punishable offence as per Sec.201, IPC.

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Medicolegal News

Compiled by : Dr. Santosh Pande

NCDRC Exonerates Orthopedic Surgeon, Holds No Medical Negligence in Treating Hip Bone Fracture

New Delhi: The National Consumer Disputes Redressal Commission (NCDRC) recently exonerated an Orthopedic Surgeon, associated with Hyderabad based Apollo Hospital from the charges of medical negligence while treating a patient suffering from fracture of hip bone.

It had been alleged by the complainant that the doctor adopted skeletal traction method instead of going for immediate surgery and this resulted in physical suffering of the complainant.

However, dismissing the complaint, the top consumer court noted that apart from the allegations, the complainant could not submit anything to prove deficiency on the part of the treating Orthopedic Surgeon.

The complainant, a retired IPS officer, sustained fracture of the hip bone after falling in his residence back in 2006. Immediately, he was taken to Apollo Hospitals, Hyderabad and Dr. Somashekhar Reddy, an Orthopedic Surgeon examined him.

After examining the X-ray, which revealed fracture of left Acetabulum, the treating doctor allegedly opined that there was no need for surgery and advised the patient only skeletal traction for eight weeks.

It was alleged that the skeletal traction resulted in retention of urine and the patient had to be put on Foley's Catheterization till August 2006. However, the pain in the hip joint persisted and the patient further developed chest pain and swelling in the left leg. Following this, the Cardiologist and the treating doctor examined the condition as Deep Vein Thrombosis (DVT) and consequently, the patient was treated for three weeks.

The condition deteriorated further and in December, the treating doctor examined the patient and X-ray revealed Osteoporosis and Avascular necrosis of the head of left femur and the neck of femur became smaller and irregular with adjacent cystic changes. Finally, the treating doctor advised the patient to undergo immediate surgery for total replacement of Hip failing which he would be completely bedridden.

It has been alleged by the complainant that even though the Cardiologist expressed the THR surgery at the earliest, the orthopedic surgeon delayed it without any reasons. Finally, the patient had underwent the surgery at Krishna Institute of Medical Science (KIMS).

He alleged that due to the delay and negligent treatment of the treating Orthopedic Surgeon at Apollo, he had to suffer a lot physically and he also incurred heavy expenses on treatment. Being aggrieved by the negligence of the treating doctor, the Complainant approached the consumer court and prayed for a compensation of Rs 26 lakhs.

The doctors and the hospital on the other hand, denied any negligence in treatment and submitted that the patient was suffering from multiple health ailments. They further submitted that the patient had consented for the treatment plan and accordingly skeletal traction was advised. As the patient was progressing in the treatment, THR was not advised at that stage, submitted the doctors and the hospital.

They further argued that because of several co-morbidities, the patient was not advised emergency hip surgery and the initial skeletal traction and medication would heal together all the acetabular bony pieces to form good bony bed for replacing acetabulum cup. Even though the elective THR was scheduled on 24.01.2007, the patient did not turn up for the surgery.

While considering the matter, the State Commission had concluded that there was no negligence on the part of the doctors and the hospital and had dismissed the complaint. Aggrieved, the complainant approached the NCDRC.

Taking note of the contentions made by both the parties, the NCDRC bench noted that apart from the self-serving evidence, "nothing is placed on record to hold that OP1 is guilty of medical negligence. Had the very same replacement been conducted by OP1 in the first instance the Complainant would have found fault with OP1 stating that he could have conducted traction and

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un-necessarily he conducted the hip replacement obviously in order to make money."

"The perception of the Complainant that traction ought not to have conducted is without any authority. We may state that he is unable to prove the deficiency in service on the part of the doctor or placed any medical authority to state that OP1 ought not to have conducted traction in the first instance," further noted the top consumer court as it found there was no merit in the complaint.

After perusing the medical literature concerning Hip fractures, and referring to top court judgment in the case of Achutrao Haribhao Khodwa & Others vs State of Maharashtra & Others, and in C. P. Sreekumar (Dr), MS (Ortho) vs S. Ramanujam, the NCDRC noted, "In the instant case, I note that the OP-1 treated the patient as per the standard of practice. Any hip fracture shall not be operated as on emergency basis. Initially the OP-1 adopted conservative management i.e., skeletal traction, it was the correct approach; it was neither deviation of treatment/procedure nor deficiency in service. Moreover, admittedly the patient had several co-morbid conditions which involves inherent operative risks."

Dismissing the appeal, the top consumer court observed, "In view of the foregoing reasons and the facts of the case, in my opinion, the treating doctors and hospital were not guilty of any medical negligence. Resultantly the Appeal is dismissed."

Ref: *https://medicaldialogues.in/news/health/medico-legal/ncdrc-exonerates-orthopedic-surgeon-holds-no-medical-negligence-in-treating-hip-bone-fracture-...Accessed on 05/04/2022*

5000 Mcg Dose of Trineurosol H Intramuscular Injection Administered Instead Of 1000 Mcg: Max Hospital Told To Pay Compensation

New Delhi: Holding the Delhi based Max Super Specialty Hospital guilty of negligence for administering wrong dosage of Trineurosol-H injection to a patient, the District Consumer Disputes Redressal Commission-II, New Delhi recently directed the Hospital to pay Rs. 20,000 as compensation to the Complainant. Such a decision was taken by the Commission as the Complainant alleged that the nurses in the OPD of the Hospital had wrongly administered high doses (5000 mcg) instead of 1000 mcg, which was originally prescribed.

Therefore, holding the Hospital guilty, the Commission directed, "Keeping in view all these facts, this Commission concludes that though OP1 has been negligent in providing service to the complainant, it would serve interest of justice by directing OP1 to be careful in future in providing proper care to their patients and OP1 is further directed to pay a sum of Rs. 20,000/- to the Complainant for the mental harassment caused to him within a period of three months from the date of this order failing which OP1 would be liable to pay interest @ 6%p.a from the date of the order till realization."

The history of the case goes back to 2014 when the complainant was suffering from some problem regarding high homocysteine which he came to know because of a blood test. Detection of high levels of homocysteine has been linked to cardiovascular disease where a person is more prone to endothelial injury which leads to vascular inflammation, chronic renal failure, congestive heart failure, acute and chronic myeloid leukemia, polycythemia vera, carcinoma with liver metastasis, liver disease drug induced cholestasis and protein malnutrition.

When the complainant approached Delhi-based Max Super specialty Hospital and consulted Dr. Rahul Naithani, DM Clinical Haematology (AIIMS), the consultant doctor prescribed several clinical tests such as Serum homocysteine, APTT, PT, D-Dimer, Vitamin B 12 and Folate levels.

After examining the test reports Dr. Naithani prescribed the Complainant Trineurosol-H intramuscular injection(1000 mcg) for next 7 days and thereafter once a week for 6 weeks. The complainant was also advised anti parietal cell antibody and anti-intrinsic factor tests and thereafter he was advised to meet Dr. Shanti Swaroop, gastroenterologist.

Accordingly, the injections were bought and the complainant was administered the injections for 3 consecutive days on 5th, 6thand 7th March 2014 in the nursing OPD of the Max Hospital.

On the fourth day, the nursing OPD was closed and therefore the complainant approached the emergency care unit, where the nurse noticed that the complainant had been wrongly administered high doses (5000 mcg) as the vial was of 5000 mcg and not of 1000 mcg. Thus, the contention of the complainant was that the nurses in the OPD negligently misread the instructions contained on the vial of the injection which had in clear terms

indicated that the bottle contained 5 ml of the drugs and only one ml of the drug(1000 mcg) was to be administered.

He further argued that since the dose is administered to the complainant for 5 times the prescribed dosage, the complainant had irritation, nausea, tremors and other related complications including severe pain at the time of administration of the injection.

In fact, even on March 8, the emergency care unit of Max hospital administered further one ml of the dose when it was duly informed by the complainant about him having been administered 15,000 mcg of doses.

Therefore, the Complainant approached the AIIMS trauma center and was advised for the test for Vitamin B12. The reports showed that Vitamin B12 was '1801' in one case as against the normal range of 187-1059 pg/ml.

As per the Complainant the doctor at AIIMS trauma center expressed shock over the manner in which the Complainant was handled and treated and given dosage of Vitamin B12 without first analysing the root cause of deficiency of Vitamin B12. It was argued by the Complainant that B12 can also be fatal, at times if not taken under medical supervision.

Therefore, alleging medical negligence against Max Hospital, the Complainant approached the Consumer Court and demanded an amount of Rs 1025000/ towards negligence, mental agony and harassment with 18% interest per annum and costs.

On the other hand, denying any kind of negligence, the hospital submitted that the patient had a deficiency of Vitamin B 12 and therefore he had been advised to get injections of vitamin B 12 1000 mcg daily intramuscularly for 7 days and thereafter once a week for 6 weeks. Further denying the non-availability of the injection in the Hospital pharmacy, the authorities contended that the Complainant purchased the said intramuscular injection from an unknown source and therefore its purity, originality and potency is not known and cannot be commented upon by the Hospital.

The Hospital also denied that the Complainant mentioned about any irritation, nausea tremor or related complications including pain at the time of administration of injection.

It was further argued that presuming that any high dose of Trineurosol-H was administered to the Complainant only a maximum of 15% is retained by the body and the higher dose is excreted out of the body immediately and even the 10-15% which is retained by the body is not harmful and eventually the result of the reading will come down. It was also submitted that Vitamin B12 is a safe medicine and it is extremely rare for the patient to get nausea, vomiting and diarrhea.

Taking note of the submissions of both the parties, the consumer court noted that the hospital had not filed any document in support of their averment that the Pharmacy stocked injection Trineurosol-H. At this outset, the Commission noted, "Irrespective of the fact that the said injection was purchased from the pharmacy of OP1 or from outside of OP1, it is the duty of the medical facility to take care to see what is being injected to a patient as also the quantity of injection."

In this regard, the Commission referred to the Supreme Court judgment in the case of Jacob Mathew vs. State of Punjab and Others., where the court had held that "A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or he did not exercise, with reasonable competence in the given case, the skill which he did possess."

However, the consumer court also noted that the Complainant had not placed on record any document in proof of the avertment that he either suffered from side effects of high dosage of the said injection of Trineurosol-H or he got treated for the same. In fact, the Complainant had also not produced any expert opinion on it.

Thus, the Commission opined, "At the most, it can be concluded that the Complainant suffered mentally on account of having high dosage of Vitamin B12 as is evident from the reports of the laboratories filed on record."

Therefore, holding the Hospital guilty, the Commission directed, "Keeping in view all these facts, this Commission concludes that though OP1 has been negligent in providing service to the Complainant, it would serve interest of justice by directing OP1 to be careful in future in providing proper care to their patients and OP1 is further directed to pay a sum of Rs. 20,000/- to the Complainant for the mental harassment caused to him within a period of three months from the date of

this order failing which OP1 would be liable to pay interest @ 6% pa from the date of the order till realization."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/5000-mcg-dose-of-trineurosol-h-intramuscular-injection-administered-instead-of-1000-mcg-max-...Accessed on 23 May 2022*

No Medical Negligence In Conducting Laminectomy: NCDRC Exonerates Orthopedic Surgeon, Hospital

New Delhi: Finding no evidence for proving negligence in performing laminectomy, the National Consumer Disputes Redressal Commission (NCDRC) recently exonerated the Orthopedic Surgeon Dr Abraham and other doctors at Kerala based Mariya Hospital Adoor.

Such a decision was taken by the top consumer court after it took note of the fact that the allegation of the complainant that the operation was performed at wrong site had no basis.

The bench noted that the cyst at D-5 level was noted after 8 months. The D-5 level is above the level of L-4 and L-5, the area of laminectomy operation and the spinal cord was not touched or operated. "There is no nexus or relation between the two sites (D5 and L4-5) and the lesions were entirely different. The MRI dated 9.1.2001 did or did not show any Cyst at D5 level," noted the top consumer court.

The petitioner alleged that she had problem at D-5 level, however the treating doctors at Mariya Hospital Adoor had wrongly performed operation at L-4 and L-5 level and removed portions of the vertebra causing injury to nerves which resulted paralysis below the hip. It was alleged that the doctors were not qualified to do neurosurgery.

As a result, the prolonged Physiotherapy was not fruitful. Following this, the patient allegedly consulted a Neurosurgeon at the Medical College, Thiruvananthapuram, who diagnosed a cyst at D5 level and removed the cyst by operation. Being aggrieved by the negligent treatment by the treating doctors at Mariya Hospital, the Complainant filed a Complaint before the District Forum, Pathanamthitta.

When the matter reached the District Forum, after perusing the entire medical record, the Forum had noted that the treating doctor was a qualified orthopedic surgeon. Further the surgery done by the doctor was conducted on the basis of a scanning report showing degeneration of L3-4 and L4-5 in the vertibral disks and mild bulging annulus of L3-4 and L4-5 intervertibral disks causing compression over the existing nerve root bilaterally and indentation over the thecal sac.

Taking note of the fact that there was no evidence to prove that the diagnosis and the surgery was wrong and improper, the Forum rejected the main allegation that all the complications of the Complainant including the paralysis was due to the negligent and improper Surgery by the treating doctors and the second surgery was necessitated due to the 1st surgery.

Besides, the District Forum had also noted that the available evidence showed that the two surgeries were done at different portions of the vertebra of the complainant based on two separate MRl scanning reports obtained between a gap of 7 months.

The two scanning reports disclosed different diseases at different portions of the vertebrae. So, it cannot be said that the 2nd disease revealed from the scanning report was an after effect or the consequence of the 1st surgery, the Forum had concluded.

After the Forum had dismissed the complaint, the Complainant moved to the State Commission, which again dismissed it. When the matter reached NCDRC, the top consumer court perused the medical record including X- Ray report, MRI, and noted that the reports showed degeneration at L3-4 and L4-5 intervertebral discs causing compression over the exiting nerve root bilaterally and indentation over the thecal sac. The X-ray revealed spondylitis L-5 pedicle with probable spinal stenosis at L4-5 and S-1.

Consequently, the Orthopedic surgeon conducted the laminectomy as per standard procedure with his expertise. The patient was discharged thereafter.

After 2 months, the patient came back with complaints of weakness in both lower limbs due to fall in the house two weeks back. X-ray was performed, no new fracture revealed and the doctor prescribed medicines. At this point, even though the treating surgeon had suspected possibility of cord edema and advised to go for Neuro checkup, the patient didn't follow the advice.

At this outset, the bench noted that the cyst at D-5 level was noted after 8 months. The D-5 level

is above the level of L-4 and L-5 the area of laminectomy operation and the spinal cord was not touched or operated. "There is no nexus or relation between the two sites (D5 and L4-5) and the lesions were entirely different. The MRI report dated 9.1.2001 did show any Cyst at D5 level," noted the top consumer court.

Therefore, finding no error in the earlier orders passed by the District and State Commission, the NCDRC bench dismissed the complaint and noted, "Thus, considering the entirety of the case in our considered view, it was a reasonable standard of practice adopted by the Opposite Party No.1 & there was no role of Opposite Party No.2 in performing laminectomy. There was neither negligence nor any deficiency/lapses during the laminectomy operation at L-4 and L-5. Thus, for the reasons stated above, we do not find any material irregularity and jurisdictional error in the Order passed by the Fora below warranting our interference u/s 21(b) of the Act."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/no-medical-negligence-in-conducting-laminectomy-ncdrc-exonerates-orthopedic-surgeon-hospit...Accessed on 23/05/2022*

Odisha HC Orders Probe Into Death Of Woman And Baby Due To Alleged Medical Negligence

Cuttack: The Odisha High Court passed an order, directing a probe into the incidence behind the death of a woman and her baby in 2015, who had allegedly died due to medical negligence.

As per the media report in the Live Law, the petition was filed by the father-in-law of the woman whose baby had passed away due to intrauterine infection and she had also died on 25th March 2015 during the course of her treatment.

The petition alleged that the death of the woman and the baby was caused due to medical negligence which was avoidable. The judgement was passed by the Division Bench of Chief Justice Dr S. Muralidhar and Justice Radha Krishna Pattanaik who observed that the pleadings in the petition presented disputed questions of fact with the opposite parties claiming that there was no medical negligence.

Also, the opposite parties claimed to have conducted an investigation into the maternal death of the woman. The court requested the State Commission for Women, Odisha (SCWO) to assist in the task so as to obtain an objective assessment of the materials on record. Giving directions, the court observed, "(i) A complete set of papers will be made available by the Registry of this Court to the Secretary, SCWO, Toshali Plaza, Satyanagar, Bhubaneswar not later than 1st June 2022."

"The SCWO will constitute an appropriate enquiry team to examine the papers and also visit and record statements of the Petitioner and his family members, the concerned treating doctors, the place of treatment, the medical case record and make an assessment as to the veracity of the claims of either party on the basis of the materials gathered. The SCWO can also take the assistance of a qualified medical professional for making its assessment," it said. Further, the court observed, "the report of the SCWO pursuant to the above directions be made available to this Court not later than 1st July 2022."

The court, while hearing the petition on 29th November 2021, had directed the setting up of the 'Maternal Death Review Board' for effective implementation of the Janani Suraksha Yojana. The then bench of Chief Justice Dr S. Muralidhar and Justice Bibhu Prasad Routray had observed that the issues raised in the petition had been comprehensively dealt with in a judgment of the Delhi High Court in Laxmi Mandal v. Deen Dayal Harinagar Hospital (2010), which was authored by Justice Muralidhar himself.

The Court had therein directed the State to present before it a comprehensive plan which will include payment of compensation for maternal death on account of the failure of the health care system in the individual case and for the conduct of a maternal death audit as was done in the case of Laxmi Mandal.

The counsel for the petitioner told the court that there were 38 other writ petitions pending before a Single Judge Bench of the Court which involved the same issue. Subsequently, the court held that the said writ petitions, the list of which were provided by the counsel to the Court, would be listed along with the present case.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/odisha-hc-orders-probe-into-death-of-woman-and-baby-due-to-alleged-medical-negligence-93422 Accessed on 26/05/2022*

Patient Dies From Japanese Encephalitis Due To Lack Of Treatment: HC Asks State To Pay Rs 10 Lakh Compensation

Agartala: Observing that a jail inmate belonging to Central Correctional Home in Sipahijala district had died due to lack of treatment while suffering from Japanese Encephalitis (JE), a division bench of Tripura High Court has directed the State Government to pay a compensation of Rs 10 lakh to the next of kin of the deceased inmate.

Such a decision has been taken by the HC bench comprising of Justice Arindam Lodh and Justice SG Chattopadhyay as it upheld the single bench order issued in January 2018. In that order, apart from awarding the compensation, the Single bench judge Justice Subhasish Talapatra had also advised the Jail authority to raise a corpus fund for treating the ailing convicts on emergency basis and improving the healthcare facilities, adds UNI.

PTI adds that the deceased Chandan Dey, who died due to medical negligence on the part of the correctional home, was serving imprisonment term at Central Correctional Home in Sipahijala district after being found guilty in a road accident.

As per the victim's advocate Samarjit Bhattacharjee, Mr. Dey hailed from West Tripura district and he was convicted for 18 months on the charge of rash and negligent driving in 2016. However, in April 2017, he fell ill in Agartala Central Jail, but was not provided adequate treatment.

Dey was shifted to Agartala Government Medical College (AGMC) in a critical state on June 9, 2017. But as his condition continued to deteriorate, he was referred to SSKM Hospital Kolkata on June 19, with the doctor advising the jail authorities to shift him at the earliest.

However, the prison authorities couldn't shift him to Kolkata immediately as they did not get the approval from the government for the expenditure. He died on June 23, 2017, in AGMC, which triggered a row across the state. His wife moved the High Court alleging negligence and that delay in providing treatment had caused her husband's death.

According to senior advocate Purushottam Roy Barman, who represented the family in the high court, Dey's family members had filed a writ petition before the high court seeking justice for the death of the sole bread earner.

Justice S Talapatra of the single bench, after hearing the case, had held the prison authorities responsible for the untimely death of Dey in January 2018 and asked the government to pay a compensation of Rs 10 lakh to the next of kin of the victim. Jail authorities, however, moved the division bench of the court, challenging the single bench order "A division bench comprising Justice Arindam Nath and Justice S Chattopadhyay on May 20 upheld the single bench's Order, asking the government to pay the compensation," Roy Barman added.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/patient-dies-from-japanese-encephalitis-due-to-lack-of-treatment-hc-asks-state-to-pay-rs-10-lakh…Accessed on 26/05/2022*

SC Upholds MCI Findings, Sets Aside Consumer Court Order Absolving Surgeon, Hospital of Medical Negligence in Laparoscopic Cholecystectomy

New Delhi: Upholding the report of the Ethics Committee of the erstwhile Medical Council of India, now National Medical Commission (NMC), the Supreme Court recently held a laparoscopic surgeon at Preet Surgical Centre & Maternity Hospital guilty of medical negligence while conducting a laparoscopic cholecystectomy back in 2004.

Such a decision was taken by the Apex Court bench comprising of Justices UU Lalit, S. Ravindra Bhat and PS Narasimha as it held that the opinions and the findings of the MCI were of "great relevance" and set aside the orders of the National Consumer Disputes Redressal Commission (NCDRC) which had earlier exonerated the doctor and the hospital.

Directing the doctor and the hospital to pay Rs 25 lakh as compensation the bench noted, "Having considered the matter in detail, we are of the opinion that the NCDRC has committed an error in reversing the findings of the SCDRC and not adverting to the evidence on record including the report of the MCI. The decision of the NCDRC deserves to be set aside and we hold that the complainants have made out a case of medical negligence against Respondents 1 and 2 and are entitled to seek compensation on the ground of deficiency of service."

The history of the case goes back to 2004, when the wife of the Complainant had developed

abdominal pain and after conducting USG, it was revealed that there were gall bladder stones. Consequently, the patient approached a laparoscopic surgeon at Preet Surgical Centre & Maternity Hospital. After due examinations, the surgeon performed a laparoscopic cholecystectomy and placed a drain in the patient's abdomen.

The next day, the patient complained of abdominal pain and distension. The drainage tube was showing a discharge of fluid which was slightly green in colour, which later on turned greenish-brown. However, even though the Complainant kept expressing his concern regarding the situation of the patient who later developed difficulty in breathing, the doctor went on assuring that the patient was alright.

Later the treating doctor informed the Complainant that the cause of the problem was acute pancreatitis and that there was nothing wrong with the surgery. However, the complainants remained unconvinced, especially because of the dirty brown discharge coming through the drain and the persistent pain, distension and breathlessness which were indicative of some major intestinal or bile duct injury, alleged the complainant.

Following this, the doctor decided to shift the patient to Dayanand Medical College and Hospital, Ludhiana. However, he declined the request of the Complainant to give detailed patient records and operation notes by stating that the patient's condition had been adequately explained to the doctor, to whom the patient had been referred to.

Meanwhile, as per the suggestion of the on-duty doctor during admission there was suspicion of an iatrogenic injury to the bile duct and possibly also to the intestine, during the previous surgery. After conducting CT scan it was revealed that there was moderate intra-abdominal and sub-phrenic collection.

The condition of the patient worsened and she went into multi-organ failure which led to her death. It was submitted by the Complainant that when he discussed the cause of death and the need for autopsy with the on-duty doctor of the second hospital, he was allegedly told that the patient died due to intraoperative injuries to the colon and bile duct resulting in Peritonitis, Peritoneal Collection, Septicaemia and Multi-Organ failure.

At such an outset, the Complainant approached the State Consumer Disputes Redressal Commission (SCDRC) and prayed for monetary compensation quantified at Rs. 62,85,160 for negligence and deficiency of services. However, the treating doctors and hospitals denied any negligence on their part.

After considering the entire medical record and evidence, the SCDRC held the treating doctor and the first hospital negligent and directed them to pay Rs. 15,44,000 jointly and severally and Rs. 10,000 as costs.

Meanwhile, during the pendency of the matter before the SCDRC, the Complainant had moved to the Punjab Medical Council against the professional misconduct of the Respondents, which was summarily disposed of. Following this, the Complainant had approached the Medical Council of India. After considering the matter, the Ethics Committee of MCI held the laparoscopic surgeon medically negligent and issued a strict warning to be more careful during the procedure and to be more diligent in treating and monitoring his patients during and after the operation.

On the other hand, after the order of the SCDRC, the appeal had reached the NCDRC, which set aside the order of the State Commission and held that negligence was not proved by the Complainants. Following this, the matter reached the Supreme Court.

The counsel for the appellants submitted several facts including the fact that the patient had two iatrogenic injuries during her first surgery, one to the colon and the other to the bile duct. Secondly, the counsel argued that instead of referring the patient to a nearer facility, the doctor had referred the patient to Ludhiana. Further, the counsel referred to the statement made by the doctor during the cross examination, where he had categorically stated that it did not occur to his mind that the injuries could take place. He also contended that the doctor at the second hospital negligently delayed the re-exploration surgery even after receiving the CT scan report.

On the other hand, the counsel for the doctor and hospital argued that presence of a biliary leak does not signify injury of a bile duct as it can occur from the liver bed from the cholecysto-hepatic duct or due to slippage of a clip from cystic duct stump which are not injuries. Second, for there to be a presence of a leakage from the large intestine, there

are some specific symptoms which were not shown and therefore leakage of the colon was ruled out. Finally, since there was no bile duct or colon injury, the presence of rent in the hepatic flexure of the colon may be either a result of delayed manifestation due to thermal injury because of the electro-cautery or it may be a rare case of injury to the hepatic flexure of the colon because of the drainage tube.

The counsel for the doctor at the second hospital pointed out that the only allegation against them was the delay in diagnosis of colonic perforation and corrective surgery. The counsel argued that this was proved to be incorrect as per the findings of the MCI, SCDRC and the NCDRC. She further pointed out that the condition of the patient was already critical when she was admitted to the second hospital and therefore immediate surgical intervention was not called for.

After considering the contentions, the Supreme Court took note of the fact that the substantive part of the NCDRC's decision referred only to judicial precedents on the question of medical negligence and NCDRC did not meet the specific allegations of negligence in the performance of the laparoscopic surgery. "There was sufficient material indicative of large bowel perforation after the laparoscopic operation. It is true that it may not have manifested immediately in the normal course. However, there were sufficient indicators to a diligent professional, to detect and take immediate steps for restitution. Instead of examining the material that was placed on record, NCDRC seemed satisfied with raising and rejecting the plea of res ipsa loquitur and holding that it is impermissible to assume that any sensible professional would intentionally commit an act which would result in an injury to the patient. In these proceedings for damages due to professional negligence, the question of intention does not arise. Unfortunately, the NCDRC did not even refer to the report of the MCI. In fact, a reference to the MCI report would have been sufficient to come to the right conclusion," the top court bench noted at this outset.

Referring to the MCI report, the Supreme Court bench noted that the MCI Ethics Committee sought the opinion of Experts - ex Professors and HODs of AIIMS, New Delhi and KGMC, Lucknow, which held deficiency in service. After going through the expert opinions the MCI Ethics Committee had noted, "that Dr. Gurmit Singh has failed to exercise adequate medical competence in treating the patient" as there was a large bowel perforation after the laparoscopic operation and the doctor had failed to suspect the occurrence of complications despite the following warning signs/symptoms.

Therefore, referring to the findings of the MCI, the top court bench noted that "so far as present proceedings are concerned, as they arise out of a claim for compensation on the basis of medical negligence, the opinion and findings of the MCI regarding the professional conduct of Respondent 1 have great relevance."

At this outset, the top court bench referred to the findings made by the erstwhile Medical Council of India and noted, "The above-referred findings of the MCI on the conduct of Respondent 1 leave no doubt in our mind that this is certainly a case of medical negligence leading to deficiency in his services. NCDRC, except referring to the general principles of law as laid down in the judgments of this Court has not attempted to draw its conclusion from the oral and documentary evidence available on record."

"Apart from the facts that clearly emerge from the report of the MCI, there is sufficient evidence to reiterate the same findings of deficiency. In the oral evidence, the following answers were elicited from Respondent 1 in the cross-examination which fortify the report given by the MCI," the bench further noted.

Holding the Laparoscopic Surgeon Dr. Singh and the first Hospital guilty, the bench noted, "Having considered the matter in detail, we are of the opinion that the NCDRC has committed an error in reversing the findings of the SCDRC and not adverting to the evidence on record including the report of the MCI. The decision of the NCDRC deserves to be set aside and we hold that the complainants have made out a case of medical negligence against Respondents 1 and 2 and are entitled to seek compensation on the ground of deficiency of service."

However, the bench exonerated Dr. Mishra of the second hospital and observed, "The State Commission as well as the National Commission and even the MCI have not found Respondents 3 and 4 negligent in performing their services, and we

are in agreement with such findings and therefore, confine our conclusion and directions to Respondents 1 and 2. To this extent, we reject the appeal of the complainant against all except Respondents 1 and 2."

Therefore, the bench directed Dr. Singh and the Hospital to pay Rs 25 lakh as compensation and stated in the judgment, "we are of the opinion that the interest of justice would be subserved if Respondents 1 and 2 are directed to pay to the complainants a total amount of Rs. 25,00,000 (Rupees Twenty-Five Lakhs only) with interest @ 6% per annum from the date of SCDRC order as compensation. Respondents 1 and 2 will be entitled to adjust any amount already paid or deposited in favour of the Complainants pending proceedings. The amount shall be deposited within a period of 6 months from today, failing which it shall carry an interest of 9% per annum."

Ref.: *https://medicaldialogues.in/news/health/medico-legal/sc-upholds-mci-findings-sets-aside-consumer-court-order-absolving-surgeon-hospital-of-medica…Accessed on 26/05/2022.*

1.25 Crore Compensation Slapped On Radiologist For Failing To Diagnose Structural Anomalies In Anomaly Scan

New Delhi: Holding a Nagpur based Radiologist guilty for his failure to detect structural anomalies of the foetus at 17-18 weeks, the National Consumer Disputes Redressal Commission (NCDRC) has directed him along with the scan center to pay Rs 1.25 crore to the parents of the deformed child for his welfare, future expenses for treatment and purchase of limb prostheses.

Such a decision was taken by the apex consumer court after it considered all the relevant facts, evidence on record and also took note of the opinion given by the AIIMS expert medical board." The amount shall be kept in the form of Fixed Deposit (FD) in any Nationalised Bank (preferably State Bank of India) in the name of Mst. Chidanand till he attains majority.The parents can draw periodic interest on the FD for the regular health check-up, treatment and welfare of their child. The Opposite parties shall pay Rs. 1,00,000/- towards the legal expenses," read the order.

Back in 2006, the Complainant, who was pregnant at that time, consulted Dr Sarita Bhonsule, Gynecologist and Obstetrician and remained under her follow-up for Ante Natal Care (ANC) till delivery. Consequently, the doctor referred the patient to M/s. Imaging Point for Ultra Sonography (USG) of pelvis. The USG was performed by the Radiologist Dr Dilip Ghike, who reported it to be normal. Three more ultrasounds were performed by the Radiologist during different stages of the pregnancy. However, all the USG were reported as "no obvious congenital anomalies in the fetal head abdomen and spine".

Finally, the Ob-Gyn conducted the elective Caesarian Section and after the birth of the child, the mother and all the attendants were shocked to see the "grossly-malformed male newborn." The newborn had agenesis of fingers, right leg below knee and left foot below ankle joint.

It was the contention of the complainants that all of this had happened due to the Radiologist who had performed the ultrasounds in an alleged negligent manner as it was possible to detect anomalies during 2nd, 3rd and 4th USG, most importantly at 17 to 18 weeks, which is also known as the anomaly scan.

After discharge, the baby had been diagnosed by several doctors including a child specialist, and doctors at Mediscan Chennai. In fact a Plastic surgeon with specialization in Hand Reconstructive & Microsurgery at Apollo First Med Hospitals had also been consulted. Further, an opinion had been sought an Ophthalmologist at Shankar Netralaya and an ENT Surgeon. These doctors had been consulted for multiple problems in the child including facial palsy with lagopthalmos and micrognathia, poor jaw opening, limb hypo-genesis syndrome having oro-mandibular disability, watery fluid and hearing problems.

During the follow up check up in Chennai, the child had been advised leg prostheses for walking and the doctors also suggested various activities for grasping and holding small objects. For his leg prostheses, the child was later taken to Otto Bock in Mumbai and the expert team there in decided to fit bilateral transtibial prostheses.

Referring to the detailed treatment history of the child, the Complainants had submitted that he will have to undergo at least seven surgeries, two for webbing thumbs, two for Squint in eyes, one for jaw correction, for facial Palsy and one for removal of tongue-tie. They also submitted that the Child also

needs speech therapy and the parents may need Psychiatric Counselling/Treatment.

Therefore, approaching the NCDRC, they prayed for total compensation of Rs 10,08,80,637.62 under different heads in support of their claim about future expenses.

On the other hand, the Radiologist denied any negligence in the reports of the USGs of the patient. Referring to the bills paid by the patient for the USGs, he further pointed out that neither the Gynecologist nor the patients had ever advised for anomaly scan, also known as target scan. He further submitted that because of genetic mutation, there are chances of major or minor congenital anomalies.

In order to support their arguments, the Complainants relied on several judgments including Nizam's Institute of Medical Sci v Prasanth S. Dhananka & Ors., Dr. Balram Prasad v Dr. Kunal Saha, Spring Meadows Hospital Vs. Harjot Ahluwalia, V.Kishan Rao Vs. Nikhil Super Spl. Hospital & Anr., and Anil Dutt & Anr. vs Vishesh Hospital & Ors.

The counsel for the Radiologist and the Scan Centre, on the other hand, referred to different medical textbooks and pointed out the vast differences between Level-I (Routine) scan and Level-II (Target / Anomaly) scan. Level-I sonographies are often referred to as a routine examination or a basic examination, and in contradistinction, a Level-II scan is referred to as a Target scan or an Anomaly scan and is a specialized study which is undertaken to detect birth defects in the foetus, submitted the counsel.

He also referred to the standard procedure for Level-I scan and pointed out that in such a scan the Radiologist primarily checks for Foetal Presentation, Amniotic fluid volume, Foetal Cardiac Activity, Placental position, Foetal biometry, Maternal Cervix, Maternal adnexae. Further referring to the charges for USG of the patient, the Counsel for the Radiologist submitted that the patient was charged for Level-I scan and not for Level II target scan.

Blaming the Ob-Gyn concerned, the Counsel for the Radiologist submitted that the treating Obstetrician was aware that the patient was elderly & had Gestational diabetes mellitus and therefore she should have been told alone the possibility of congenital malformations to baby as the incidence of congenital anomalies is 7-10 times more common in such patients. They also pointed out that the patient was obese which is one of the factors adversely affecting the detection rate.

After taking note of the submissions, the NCDRC bench noted that even though the 37 years old patient was overweight, she was not obese. Referring to the role of the Obgyn, the bench also noted, "The role of Dr. Sarita Bhonsule was limited, she had advised Triple Markers, which were reported as normal. However, admittedly she has sent the patient for USG without specifying routine or target scan. Thus, the defense of the Opposite Party No. 2 that he performed the Level-I scan every time is not as an accepted standard of practice."

Apart from perusing the 4 USG reports, the bench also took note of the two expert opinions/ submitted by the Radiologist. In both opinions, they have commented upon the qualification of Dr. Dilip Ghike, the infrastructure of Image Point and various aspects of USG during pregnancy. According to both, there were no deficiencies in service or deviation from the established line of management of the Opposite Parties. Dr. Dilip Ghike performed the scans as and when prescribed by the referring doctor and correctly diagnosed that there were no congenital anomalies in the head, abdomen and spine of the fetus. They also noted that there was no request either from the patient or the treating doctor for anomaly scan.

Besides the expert opinion, the bench had also called for an expert opinion from the Medical Board at AIIMS. The opinion dated 31.07.2009 revealed that the child's anomalies would be classified as "Limb reduction deficiencies". The Board also expressed that, 'Limb anomalies should be searched for in all standard obstetric ultrasound examinations performed in second trimester, in this case, on 08.01.2007 & 12.03.2007. The said report, however, does not comment on the limbs.' Finally, the Board was of the opinion that, 'limb reduction anomalies can be detected in standard obstetric ultrasound, but the detection rate is low as detailed above.'

After taking note of the reports, the NCDRC bench noted, "It is surprising to note that the Opposite Party No. 2 had performed only Level-I scan everytime. His contention was that the treating Gynecologist and even the patient did not ask for anomaly scan (Target scan level-II). We do not find

any merit in such vague submission. It appears that Opposite Party No. 2 is shifting the blame on the Gynaecologist. In our view, in absence of any referral from doctor, the ethical and legal duty casted upon Radiologist is to take proper history, ascertain the gestational age and perform the relevant USG scan (Level). In the instant case the Opposite Party No. 2 failed in his duty of care and surprisingly, he performed all Level-I scan." At this outset, the NCDRC bench also referred to the "Practice guidelines for performance of the routine mid-trimester fetal ultrasound scan" by the International Society for Ultrasound in Obst and Gyn (ISUOG) which clearly specify that for Limbs and extremities systemic approach by the Radiologist, it is necessary to know presence or absence of both arms/hands and both legs/feet and it should be documented.

Besides, the bench also referred to several Supreme Court orders specifying the duty of care expected from doctors. Such judgments include the orders in the case of Kusum Sharma and others v. Batra Hospital and Medical Research Centre & Others, Jacob Mathew v. State of Punjab & Anr., Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole & Anr, and A.S. Mittal vs. State of U.P.

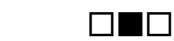
Referring to these judgments, the top Consumer Court held, "Thus, collectively considering the facts, evidence on record, opinion from AIIMS expert medical board and the precedents (supra) of Hon'ble Supreme court, we have no hesitation to conclusively hold the Opposite Party No. 2 liable for the negligence, who failed to diagnose the structural anomalies of the foetus at 17-18 weeks. The early and correct detection could have helped the parents to take a decision to continue or terminate the pregnancy within 20 weeks as per MTP Act, 1983. The unfortunate birth of anomelic baby could have been averted. It is a well settled principle of justice that in a case where negligence is evident, the principle of res ipsa loquitur operates and the Complainant does not have to prove anything as the thing (res) proves itself. In such a case, it is for the opposite party to prove that he has taken care and done his duty to repel the charge of negligence. Thus, to reduce such errors and patient grievances, there is need for overall national guidelines from academic bodies (ICMR) or the government (health)"

While considering the damages and deciding on the amount of compensation, the bench noted, "In this case, no doubt, the doctor (Opposite Party No. 2) could have helped the patient, had he been more careful in his reporting, though, how useful, it would have been considering MTP (Abortion) laws. It is not the intention of the Court or Commission to let go the Doctor for his mistake, which definitely need a rap on the knuckle, but that rap should not break his skull. Apparently, in the instant case, congenital anomaly is play of nature, one of nature's wraths, which human kind is facing since time immoral. In alleviating this wrath of nature, this Doctor cannot be sacrificial lamb which would make whole profession to work under proverbial Damocles Sword."

Taking note of the present age of the child, the expenses incurred for his treatment the bench awarded Rs 1.25 Crore compensation and ordered, "Based on the discussion above, the medical negligence is attributed to the doctor and his Imaging Centre. The Opposite Parties Nos. 1 and 2 are directed to pay, jointly and severally, Rs. 1.25 Crore to the Complainants. Out of the said amount, Rs. 1 Crore shall be the compensation to the disabled Mst. Chidanand for his welfare, future expenses for treatment and purchase of limb prostheses. The amount shall be kept in the form of Fixed Deposit (FD) in any Nationalised Bank (preferably State Bank of India) in the name of Mst. Chidanand till he attains majority. The balance amount of Rs. 25 lakh shall be paid to the parents of Mst. Chidanand (Complainants Nos. 1 and 2) towards the mental agony and allied expenses. The parents can draw periodic interest on the FD for the regular health check-up, treatment and welfare of their child. The Opposite parties shall pay Rs. 1,00,000/- towards the legal expenses."

The Order, in entirety, shall be complied within 3 months from today, failing which the entire amount shall carry interest @7% per annum till its realisation," read the order.

Ref.: *https://medicaldialogues.in/news/health/medico-legal/rs-125-crore-compensation-slapped-on-radiologist-for-failing-to-diagnose-structural-anomalies-i...Accessed on 03/06/2022*



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2) Handin RI- Bleeding and thrombosis. In: Wilson JD, Braunwald E, Isselbacher KJ, Petersdorf RG, Martin JB, Fauci AS, et al editors—Harrison's Principles of Internal Medicine. Vol 1. 12th ed. New York: Mc Graw Hill Inc, 1991: 348-53.

Reference from electronic media:

3) National Statistics Online - Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health /HSQ 20.pdf (accessed Jan 24, 2005): 7-18.

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131	Dr. Sanjeev Borade	Amravati	Ob & Gyn
132	Dr. Usha Gajbhiye	Amravati	Pediatric Surgeon
133	Dr. Kush Jhunjhunwala	Nagpur	Pediatrician
134	Dr. Anil Nandedkar	Nanded	Pediatrician
135	Dr. Animesh Gandhi	Rajnandgaon	Pediatrician
136	Dr. Ravi Barde	Nanded	Pediatrician
137	Dr. Pranita Barde	Nanded	Pathologist
138	Dr. Pankaj Barabde	Amravati	Pediatrician
139	Dr. Aditi Katkar Barabde	Amravati	Ob & Gyn
140	Dr. Shreyas Borkar	Wardha	Pediatrician
141	Dr. Vivek Morey	Buldhana	Ortho. Surgeon
142	Dr. Nitin Bardiya	Amravati	Pediatrician
143	Dr. Swapnil Sontakke	Akot, Akola	Radiologist
144	Dr. Deepak Kukreja	Indore	Pediatrician
145	Dr. Pallavi Pimpale	Mumbai	Pediatrician

S.N	Name	Place	Speciality
146	Dr. Susruta Das	Bhubneshwar	Pediatrician
147	Dr. Sudheer K A	Banglore	Pediatrician
148	Dr. Bhushan Murkey	Amravati	Ob & Gyn
149	Dr. Jagruti Murkey	Amravati	Ob & Gyn
150	Dr. Sneha Rathi	Amravati	Ob & Gyn
151	Dr. Vijay Thote	Amravati	Opthalmologist
152	Dr. Satish Agrawal	Amravati	Pediatrician
153	Dr. Ravi Motwani	Gadchiroli	Pediatrician
154	Dr. Ashwin Deshmukh	Amravati	Ob & Gyn
155	Dr. Anupama Deshmukh	Amravati	Ob & Gyn
156	Dr. Aanand Kakani	Amravati	Neurosurgeon
157	Dr. Anuradha Kakani	Amravati	Ob & Gyn
158	Dr. Sikandar Adwani	Amravati	Neurophysician
159	Dr. Seema Gupta	Amravati	Pathologist
160	Dr. Pawan Agrawal	Amravati	Cardiologist
161	Dr. Madhuri Agrawal	Amravati	Pediatrician
162	Dr. Subhash Borakhade	Akot	Pediatrician
163	Dr. Unmesh Luktuke	Jamshedpur	Pediatrician
164	Dr. Arunima Luktuke	Jamshedpur	Opthalmologist
165	Dr. Rupesh Kulwal	Pune	Pediatrician
166	Dr. Prashanth S N	Davanagere	Pediatrician
167	Dr. Abhishek P.V.	Hyderabad	Pediatrician
168	Dr. Kallem Venkat Reddy	Hyderabad	Pediatrician
169	Dr. Harsha Yandapally	Hyderabad	Pediatrician
170	Dr. Jyoti Agrawal	Amravati	Pediatrician
171	Dr. Sonal Kale	Amravati	Ob & Gyn
172	Dr. Gopal Belokar	Amravati	ENT
173	Dr. Vijay Rathi	Amravati	Pediatrician
174	Dr. M. Himabindu	Hyderabad	Dermatologist
175	Dr. Manish Jain	Gurgaon	Nepherologist
176	Dr. Shalu Gupta	Gurgaon	Ob & Gyn
177	Dr. Saurabh Ambadekar	Amravati	Pulmonologist
178	Dr. Anju Bhasin	New Delhi	Pediatrician
179	Dr. Prabhat Singh Baghel	Satana	Pediatrician
180	Dr. Aditi Singh	Satana	Ob & Gyn
181	Dr. Preeti Volvoikar	Gurgaon	Dentistry
182	Dr. Ajay Daphale	Amravati	Physician
183	Dr. Surita Daphale	Amravati	Pathologist
184	Dr. Sachin Kale	Amravati	Physician
185	Dr. Pradnya Kale	Amravati	Pathologist
186	Dr. Amit Kavimandan	Amravati	Gastroenterologist
187	Dr. Vinamra Malik	Chhindwara	Pediatrician
188	Dr. Shivanand Gauns	Goa	Pediatrician
189	Dr. Rishikesh Nagalkar	Amravati	Pediatrician
190	Dr. Rashmi Nagalkar	Amravati	Ob & Gyn
191	Dr. Amit Bora	Lonar	Pediatrician
192	Dr. Smruthi Bora	Lonar	Ob & Gyn
193	Dr. Shripal Jain	Karjat (Raigad)	Consultant Physician
194	Dr. Vinodkumar Mohabe	Gondia	Consultant Physician
195	Dr. Srinivas Murki	Hyderabad	Pediatrician
196	Dr. Rakesh Chouhan	Indore	Pediatrician
197	Dr. Naresh Garg	Gurgaon	Pediatrician
198	Dr. Raj Tilak	Kanpur	Pediatrician
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219	Dr. Veerendra Mehar	Indore	Pediatrician
220	Dr. Rajendra Vitalkar	Warud	Gen Practitioner
221	Dr. Kalpana Vitalkar	Warud	Ob & Gyn
222	Dr. Shweta Bhide	Nashik	Opthalmologist
223	Dr. Pramod Wankhede	Raigad	Pediatrician
224	Dr. Shrikant Dahake	Raigad	Gen Practitioner
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226	Dr. Aishwarya Gattani	Mehkar	Pathologist
227	Dr. Bhushan Katta	Amravati	Pediatrician
228	Dr. Mahesh Sambhare	Mumbai	Pediatrician
229	Dr. Rahul Salve	Chandrapur	Pediatrician
230	Dr. Devdeep Mukherjee	Asansol (W.B)	Pediatrician
231	Dr. Santosh Usgaonkar	Goa	Pediatrician
232	Dr. Ameet Kaisare	Goa	Opthalmologist
233	Dr. Sushma Kirtani	Goa	Pediatrician
234	Dr. Madhav Wagle	Goa	Pediatrician
235	Dr. Preeti Kaisare	Goa	Pediatrician
236	Dr. Varsha Amonkar	Goa	Pediatrician
237	Dr. Varsha Kamat	Goa	Pediatrician
238	Dr. Harshad Kamat	Goa	Pediatrician
239	Dr. Siddhi Nevrekar	Goa	Pediatrician
240	Dr. Dhanesh Volvoiker	Goa	Pediatrician
241	Dr. Pramod Shete	Paratwada	Pediatrician
242	Dr. Bharat Shete	Paratwada	Surgeon
243	Dr. Rekha Shete	Paratwada	Ob & Gyn
244	Dr.Pankaj Bagade	Amravati	Physician
245	Dr. Rajesh Shah	Mumbai	Pediatrician
246	Dr. Navdeep Chavan	Gwalior	Plastic Surgeon
247	Dr. Nehal Shah	Mumbai	Peditrician
248	Dr. Poonam Sambhaji	Goa	Pediatrician
249	Dr. Vijay Mane	Pune	
250	Dr. Shailja Mane	Pune	Pediatrician
251	Dr. Bhakti Salelkar	Goa	Pediatrician
252	Dr. Kausthubh Deshmukh	Amravati	Pediatrician
253	Dr. Pratibha Kale	Amravati	Pediatrician
254	Dr. Milind Jagtap	Amravati	Pathologist
255	Dr. Varsha Jagtap	Amravati	Pathologist
256	Dr. Rajendra Dhore	Amravati	Physician
257	Dr. Veena Dhore	Amravati	Dentistry
258	Dr. Satish Godse	Solapur	Physician
259	Dr. Ruturaj Deshmukh	Amravati	Pediatric Neurologist
260	Dr. Nadia Kosta	Hyderabad	Dentistry
261	Dr. Sumant Lokhande	Mumbai	Pediatrician
262	Dr. Ninad Chaudhari	Amravati	Pediatrician
263	Dr. Vijaya Chaudhari	Amravati	Ob & Gyn
264	Dr. Arundhati Kale	Amravati	Pediatrician
265	Dr. Sachin Patil	Nagpur	Pediatrician
266	Dr. Nisha Patil	Nagpur	Ob & Gyn
267	Dr. Pravin Saraf	Beed	Pediatrician
268	Dr. Pinky Paliencar	Goa	Pediatrician
269	Dr. Ashok Saxena	Jhansi	Pediatrician
270	Dr. Nilesh Toshniwal	Washim	Orthopedic
271	Dr. Swati Toshniwal	Washim	Dentistry
272	Dr. Subhendu Dey	Purulia	Pediatrician
273	Dr. Sangeeta Bhamburkar	Akola	Dermatologist
274	Dr. Aniruddh Bhamburkar	Akola	Physician
275	Dr. Nilesh Dayama	Akola	Pediatrician
276	Dr. Paridhi Dayama	Akola	Pediatrician

Hospital Members

1	Krishna Medicare Center	Gurugram	Multispecialty
2	Meva Chaudhary Memorial Hospital	Jhansi	Nursing Home
3	Usgaonker's Children Hospital	Goa	NICU
4	Chirayu Children Hospital	Nashik	Children Hospital
5	Yash Hospital	Satna	Children Hospital
6	Multi city Hospital	Amravati	Multyspecialty
7	Phulwari Mahila & Bal Chikitsalay	Gwalior	Mother & Child care
8.	Sarthak Hospital	Satna	Multispecialty
9.	Boob Nursing Home	Amravati	
10	SJS child Care Centre	Amritsar	
11	Paramitha Children Hospital	Hyderabad	Children Hospital

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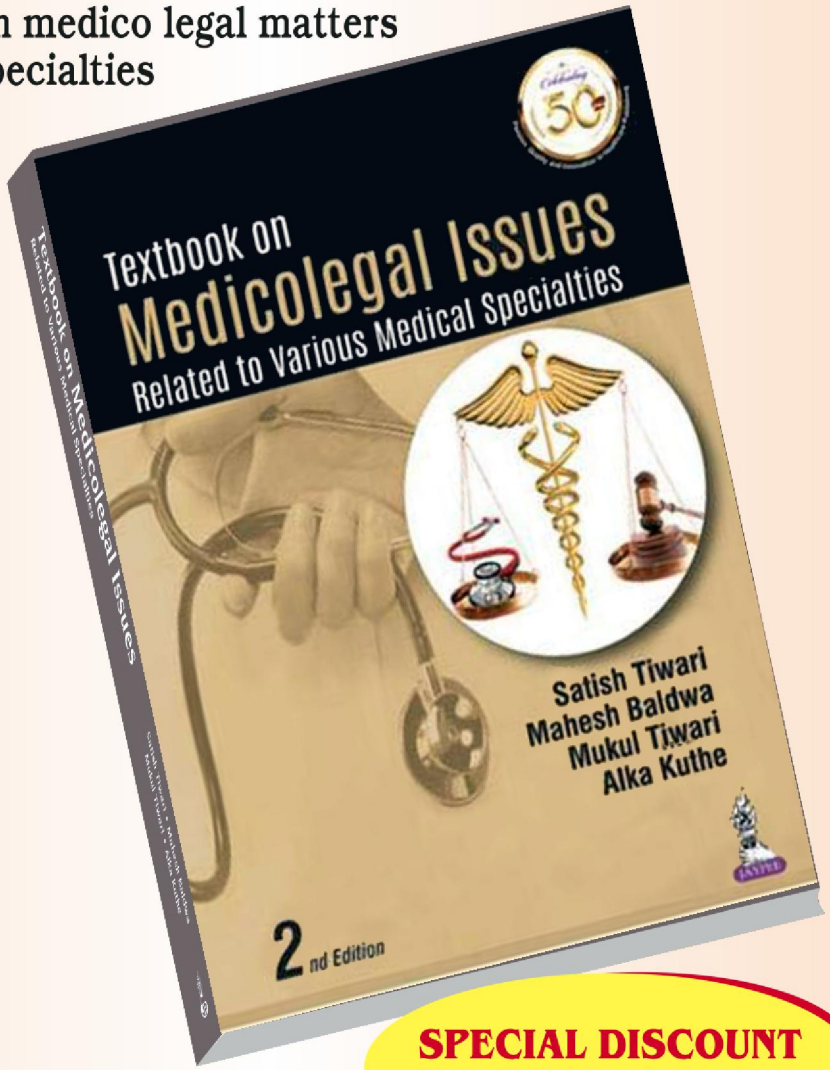

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