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National Medical Commission

Professional Conduct Review

(Lessons from Case Archives)

by

Ethics & Medical Registration Board

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2024

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Professional Conduct Review

(Lessons from Case Archives)

राष्ट्रीय आयुर्विज्ञान आयोग

National Medical Commission

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सत्यमेव जयते

आज़ादी का अमृत महोत्सव

राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

National Medical Commission
Ministry of Health & Family Welfare
Government of India

MESSAGE

It is a pleasure to know that the Publication Division of National Medical Commission, apex regulatory body for medical education and practices in India committed to maintaining high standards in medical education and ensuring the provision of quality healthcare services is bringing out its third edition of the booklet "Professional Conduct Review- Lessons from Case Archives" by EMRB prepared from learning of cases disposed by them.

It is well known that field of healthcare is one that demand commitment to ethical conduct and professional integrity. This booklet on professional conduct serves as a reminder of the ethical standards that guide our Doctors and the responsibilities they bear towards patients and society. I am confident that this edition will also motivate our Medical Practitioners towards the aim of Good medical practices.

I congratulate NMC for this effort and hope that it will publish more such publications in future helping overall betterment of society.

(Dr. B.N.GANGADHAR)

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INTERNATIONAL YEAR OF MILLETS 2023

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सत्यमेव जयते

आज़ादी का अमृत महोत्सव

राष्ट्रीय आयुर्विज्ञान आयोग
भारत सरकार
National Medical Commission
Government of India

From Editor's Desk

I am pleased to introduce the third edition of the booklet "Professional Conduct Review- lessons from case archives," a booklet that offers invaluable lessons drawn from real-life cases. In this edition, we continue our commitment to provide medical professionals with insights that are not only educational but also practical in navigating the complexities of ethical practice.

This volume is particularly special as it delves into real-world scenarios that medical professionals may encounter in their careers. The cases presented are not merely academic exercises; they reflect the challenges and dilemmas that are an intrinsic part of the medical field. By examining these instances, we aim to equip our readers with the knowledge and tools needed to uphold the highest standards of professionalism in their practice.

I believe that the lessons contained within these pages will serve as a valuable resource for medical practitioners. The experiences and reflections shared will help in fostering a culture of ethical excellence that is crucial for the long-term success and trustworthiness of the medical profession.

I encourage each reader to engage with the content, reflect on the cases, and apply these lessons in day-to-day practice. I hope this booklet will serve medical practitioners in their professional journey.

Yogender Malik

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CASE 1

Allegations of Improper Cardiac Procedures Performed Without Consent, Leading to Patient's Death

- **Keywords:** Mitral Stenosis, Tricuspid Regurgitation, Rheumatic Heart Disease, Criminal Medical Negligence.
- **Context:** Patient Care.

- **Abstract:**

Mrs. M, a 43-year-old female, was admitted to the Emergency Department of a private hospital in a metropolitan city with complaints of breathlessness, along with swelling in both lower limbs and the abdomen. An echocardiogram revealed severe mitral stenosis, tricuspid regurgitation, severe pulmonary hypertension, and mild ventricular dysfunction. Based on these findings, an elective surgery was planned, and the patient underwent the operation to address these conditions. However, ten days post-surgery, Mrs. M experienced hypotension, which progressed to multi-organ failure, leading to her demise. According to the family, there was no known history of cardiac or other significant illnesses, nor any previous surgical procedures. The family alleges that a thorough cardiac evaluation was not conducted, noting that an ECG was not performed upon admission. They further claim that the severity of the cardiac condition, pre-surgical counseling, and potential complications were

not adequately communicated. Additionally, the patient's husband asserts that Mrs. M had gallstone disease, which was not addressed during her hospital stay.

- **Case Summary:**

Mrs. M, a 43-year-old female, was admitted to the Emergency Department of a private hospital in a metropolitan city at 11:00 PM with complaints of breathlessness lasting for two hours, along with progressively worsening swelling in both lower limbs and the abdomen over the previous 2-3 days. According to her medical records, she had a history of Rheumatic Heart Disease, for which she underwent a surgical procedure called commissurotomy in 1993 to relieve narrowing of the mitral valve. Additionally, she had undergone Balloon Mitral Valvuloplasty (BMV) in 1997. Despite these interventions, Mrs. M continued to experience recurrent episodes of congestive heart failure in the past.

The following day, Mrs. M was transferred to the Cardiothoracic and Vascular Surgery Intensive Care Unit. An echocardiogram revealed severe mitral stenosis, severe tricuspid regurgitation, severe pulmonary hypertension, mild left ventricular dysfunction, and right ventricular systolic dysfunction. Doppler studies of the arteries in the lower limbs and carotid arteries were performed, and both yielded normal results. A coronary angiography was also conducted, which showed no significant abnormalities.

After these investigations, Mrs. M was assessed by an anesthetist for her fitness for surgery. Informed consent was obtained, and the

prognosis was explained to her family members. Three days after admission, Mrs. M underwent mitral valve replacement (MVR) and tricuspid valve repair (TVR).

On the first two post-operative days, Mrs. M remained hemodynamically stable with the support of inotropic medications and mechanical ventilation. However, on the third post-operative day, she experienced a drop in blood pressure. Suspecting intra-pericardial bleeding, she was promptly taken back to the operating theatre, where a pericardial clot was removed from the area overlying the right ventricle. A post-operative echocardiogram confirmed the normal functioning of both prosthetic valves.

On the fourth post-operative day, Mrs. M was successfully weaned off the ventilator and extubated. However, two days later, she developed respiratory distress and required re-intubation. Unfortunately, Mrs. M's condition continued to deteriorate, leading to further hypotension and multi-organ failure. Despite all possible medical interventions, Mrs. M could not be revived. Aggrieved by the death of his wife, the husband filed a police complaint against the treating doctors. As required by law, the police sought a medical opinion from the State Medical Council before filing an FIR.

- **Decision of State Medical Council (SMC):**

After reviewing all the medical records and obtaining expert opinions, the State Medical Council concluded that the patient's death, while unfortunate, was not due to medical negligence. Instead, it was attributed to her underlying medical condition, which had a guarded prognosis despite receiving adequate treatment. Based on

these findings, the State Medical Council determined that there was no prima facie case of medical negligence on the part of the doctors involved in the treatment of Mrs. M.

Aggrieved by the decision of the State Medical Council, the patient's husband appealed to the Ethics Medical Review Board.

- **Decision of The Ethical and Medical Review Board (EMRB), NMC:** The EMRB conducted a thorough review of the case, which included obtaining expert opinions and hearing statements from both parties involved. After careful consideration, the EMRB found no deficiency in the treatment provided to the patient and thus decided to uphold the decision of the State Medical Council.
- **Discussion:**

  The Bolam test is a legal standard used to assess whether a medical professional has provided an appropriate level of care in the treatment of a patient. According to this principle, a doctor is not considered negligent if their actions are in line with a practice accepted as proper by a responsible body of medical professionals skilled in that particular field, even if other professionals might hold a different opinion.

  Applying the Bolam test to this case: The patient had a 25-year history of severe valvular heart disease, including severe mitral stenosis, severe pulmonary hypertension, and right ventricular dysfunction. These conditions made her a high-risk candidate for valve replacement surgery. The decision not to perform simultaneous surgery for gallstones was informed by the significant risks associated with the cardiac surgery alone. According to the Bolam

test, the choice to focus solely on the life-threatening cardiac condition, rather than addressing the gallstones concurrently, would be supported by a responsible body of medical opinion. This approach would be deemed appropriate as it aligns with the standard of care that competent professionals would apply in similar circumstances.

The patient's consent for the valve replacement surgery was obtained after explaining the high risks involved, including the potential for surgical failure. This process aligns with the Bolam test, which dictates that patients must be fully informed of the risks before undergoing high-risk procedures. Although the outcome was unfortunate, the treatment provided adhered to the standard of care recognized by a responsible body of medical professionals. The patient's death was attributed to her severe and complex underlying medical condition, which carried a guarded prognosis despite receiving appropriate treatment.

By applying the Bolam test, the decisions made by the treating doctors, including proceeding with the surgery, not managing the gallstones, obtaining informed consent, and the overall treatment strategy were all consistent with what a reasonable body of medical professionals would consider acceptable. Therefore, the State Medical Council and EMRB's determination that there was no medical negligence is supported by the Bolam test, as the doctors' actions were in accordance with accepted medical practice.

- **Take home messages:**

1. In the landmark case of **Kusum Sharma & Ors. v. Batra Hospital and Medical Research Centre & Ors (2010)**., the Supreme Court of India deliberated on the standards of medical negligence. It emphasized that a medical professional would not be held negligent if they acted in accordance with a practice accepted as proper by a responsible body of medical professionals. The Court distinguished between negligence and an error of judgment. It clarified that not every medical mishap or adverse outcome amounts to negligence. An error in judgment by a doctor, if made in good faith and with reasonable skill and care, does not constitute negligence. Merely because a patient has suffered an unfortunate outcome does not automatically imply negligence on the part of the medical professionals. The case emphasizes that adverse medical or surgical outcomes alone do not prove negligence; rather, there must be a clear breach of duty that directly causes harm to the patient.
2. In the case of **Jacob Mathew vs. State of Punjab & Anr (2005)**., the Supreme Court of India addressed the issue of medical negligence, particularly in the context of criminal liability for medical professionals. It noted that to establish criminal liability, the negligence must be of a very high degree, characterized by a "gross" lack of care. Mere error in judgment or lack of proper care does not amount to criminal negligence. The Apex Court suggested that in cases of alleged criminal negligence, the investigating officer should obtain an independent and competent medical opinion before proceeding with FIR. The judgment highlighted the need to protect

medical professionals from frivolous or unjust accusations of negligence.

Reference:

1) Kusum Sharma & Ors. v. Batra Hospital and Medical Research Centre & Ors., (2010) 3 SCC 480

2) Jacob Mathew vs. State of Punjab & Anr. (2005) AIR SCW 3685.

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CASE 2

RMP as an Administrator – Role, Responsibilities and Implication of Medical Negligence

- **Keywords:** Administrative duties, Negligence.
- **Context:** Doctor in Administration.
- **Abstract:**

This case study explores the disciplinary actions taken by the State Medical Council (SMC) against a Dean and two other doctors for allegedly withholding internship completion certificates. The SMC ordered their removal from the medical register, citing non-compliance with directives. The doctors appealed to the Ethics and Medical Registration Board (EMRB) of the NMC, arguing that the issue was administrative, not clinical, and fell outside the scope of the Indian Medical Council Regulations, 2002. The EMRB, after reviewing legal and administrative expert opinions, found that the SMC's actions were beyond its jurisdiction, as the regulations did not apply to the doctors' administrative roles. The doctors were exonerated, and the EMRB recommended publicizing this to restore their reputations.

- **Case Summary:**

Several MBBS students lodged a complaint with the State Medical Council (SMC), alleging that the Dean, Dr. A, along with other administrator doctors Dr. B and Dr. C had failed to issue their

internship completion certificates and had withheld other certificates deposited at the commencement of their courses. In response, the SMC sought an explanation from the college and directed the concerned authorities to appear either in person or through legal representation.

The college submitted a detailed reply, clearly outlining the reasons for withholding the internship completion certificates. However, without considering the college's response, the SMC directed the Dean to appear before the Ethics Committee. The Dean, acting as the appellant, sent letters and emails requesting the Ethics Committee to convene a meeting after taking into account the Dean's explanations. Despite these efforts, the SMC, without reviewing the Dean's response, issued a directive to the college to release the internship certificates within 48 hours.

- **Decision of State Medical Council (SMC):** The SMC issued an order for the removal of Dr. A, Dr. B, and Dr. C's names from the medical register for a fixed duration because they did not comply with the order of the SMC. This decision was based on the assertion that they had failed to be presented before the Ethics Committee and failed to comply with the order to release the internship certificate, thereby committing contempt of court.

Aggrieved by the SMC's decision, the doctor administrators appealed to the Ethics and Medical Registration Board (EMRB) of the NMC. They contended that no opportunity for a hearing or show-cause notice was ever provided to them. Furthermore, there were no allegations of professional misconduct, incompetence, or criminal

offenses against the appellants, as the matter in question was purely administrative. The appellants emphasized that they did not act in their personal capacities as doctors or medical professionals when withholding the students' Internship Completion Certificates.

- **Decision of The Ethical and Medical Review Board (EMRB), NMC:** An internal meeting of the Ethics and Medical Registration Board (EMRB) was convened to discuss the SMC's order issued against the Dean in connection with the administrative matter at hand. The Board sought legal opinions regarding the applicability of the regulations cited by the SMC.

  Legal experts opined that the code 1.1.1 and 1.1.2 of the Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations, 2002, along with code 5.1, are primarily directive in nature and outline general duties of Registered Medical Practitioners (RMPs) in the context of patient care. They emphasized that these provisions do not constitute grounds for punishment as they do not pertain to clinical care pertaining to patient care. The legal experts recommended that the appeal should be resolved by providing a hearing to both parties involved.

  The Board also sought the opinions of administrative experts. One expert stated that the SMC's order, issued under the cited regulations (1.1.1, 1.1.2 and 5.1), was inapplicable to the specific facts of the case. Another expert concurred, emphasizing that the issue in question was purely administrative and did not fall within the scope of the Indian Medical Council Regulations, 2002 concerning professional conduct, etiquette, and ethics.

Hence, the EMRB, after taking into consideration all the facts of the case, the legal opinion, opinion of the legal experts and submissions of both the parties, EMRB passed the order stating that the Violation of regulations 1.1.1, 1.1.2 and 5.1 of Indian Medical Council (Professional Conduct, Etiquette and ethics) Regulations 2002 could not be made out against the Dean and the other administrator doctors by the EMRB because it was purely administrative in nature. The Dean and the administrator doctors must be exonerated of all the charges levelled against him. And to compensate for the loss of image suffered by the Dean, EMRB will widely publicise his exoneration.

- **Discussion:**

The transition of doctors into administrative roles within healthcare systems is becoming increasingly common due to the growing complexity of modern healthcare, which demands a combination of medical expertise and managerial skills. However, when doctors take on administrative positions, their roles and responsibilities shift, and they become subject to a different set of regulatory frameworks. It is important to clarify that the administrative functions performed by a doctor do not fall under the Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations, 2002.

As per the Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations, 2002 states that the code:

1.1.1 A physician shall uphold the dignity and honour of his profession.

1.1.2 The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Who- so-ever chooses his profession, assumes the obligation to conduct himself in accordance with its ideals. A physician should be an upright man, instructed in the art of healings. He shall keep himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient, prompt in discharging his duty without anxiety; conducting himself with propriety in his profession and in all the actions of his life.

5.1 Physicians as Citizens: Physicians, as good citizens, possessed of special training should disseminate advice on public health issues. They should play their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should particularly co-operate with the authorities in the administration of sanitary/public health laws and regulations.

The State Medical Councils (SMCs) have jurisdiction over Registered Medical Practitioners (RMPs) only in matters that are explicitly covered by these regulations as a medical professional providing care to a patient. Since the regulations primarily address professional conduct, medical ethics, and related duties, they do not extend to administrative actions taken by doctors in their capacity as administrators. This distinction is crucial for understanding the limits of regulatory oversight when doctors engage in non-clinical, administrative activities.

- **Take home messages:**

Administrative actions taken by doctors in their roles as administrators do not fall under the same regulations and should not be subject to the same disciplinary measures.

This case raises several ethical concerns involving the actions of both the medical college and the State Medical Council (SMC) such as fairness, transparency, student welfare, institutional autonomy, power dynamics, institutional autonomy in educational training and professional integrity.

The Ethics and Medical Registration Board (EMRB) applied a logical analysis of the alleged violation of Regulations 1.1.1, 1.1.2, and 5.1 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Upon close examination, the EMRB concluded that no ethical violations could be substantiated against the Dean and the other administrative doctors, as the matter was deemed to be purely administrative in nature rather than a breach of professional conduct or ethics.

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CASE 3

Improper Consent, Unqualified Specialist, and Lack of Documentation of Post-Operative Complications Following Surgery

- **Keywords:** Consent, Post operative complications, Surgery.
- **Context:** Patient Care.
- **Abstract:**

A 47-year-old female with abdominal distension was admitted to a private hospital under Dr. X, a general surgeon. She was diagnosed with a fibroid uterus and underwent an abdominal hysterectomy with bilateral salpingo-oophorectomy. Postoperative recovery allowed for her discharge in stable condition after eight days. However, the consent obtained by Dr. X was general, covering only surgery and anesthesia, without specifying the actual procedures performed. Following discharge, the patient experienced urinary incontinence, attributed to a bladder injury sustained during surgery. She was readmitted under Dr. X's care, catheterized, and advised to undergo corrective surgery after three months. The situation worsened, leading her to seek further surgical interventions at another hospital. The complainant alleged that the initial complication was neither promptly recognized nor effectively managed by Dr. X, prompting him to file a complaint with the state medical council seeking redressal for the oversight and inadequate care.

- **Case Summary:**

A 47-year-old female presenting with abdominal distension was admitted to a private hospital under the care of Dr. X, a general surgeon. She was diagnosed with a fibroid uterus, and elective surgery was scheduled. The consent form in Hindi listed the diagnosis as "pet mein gaanth, rasoli" (abdominal lump, fibroid), but did not disclose potential surgical complications. Conversely, the English consent form failed to specify the diagnosis, although it did note possible complications such as "post-operative septicaemia, bowel and bladder injury." The general consent provided was not tailored specifically to include the diagnosis or the surgical procedure planned. The patient underwent an abdominal hysterectomy with bilateral salpingo-oophorectomy and was discharged in a stable condition eight days later.

The patient returned to Dr. X, presenting with urinary incontinence. Upon evaluation, she was diagnosed with a bladder injury incurred during the initial surgery. Following diagnosis, she was catheterized and subsequently discharged with a recommendation for surgical intervention scheduled three months later to address the condition.

The patient continued to experience abdominal pain, prompting her to seek further treatment at another private hospital, Hospital Y. There, she underwent two surgical interventions: a repair of a vesico-vaginal fistula and an exploratory laparotomy with adhesiolysis and omentectomy to address acute intestinal obstruction. The patient's husband alleged that Dr. X did not promptly recognize and manage

the initial complication, necessitating their pursuit of care at another facility. Consequently, this issue was brought before the state medical council for review.

- **Decision of State Medical Council (SMC):** The State Medical Council observed that Dr. X failed to secure proper informed consent for the hysterectomy and bilateral salpingo-oophorectomy. Moreover, complications that arose from the surgery were not documented in the medical records during the patient's subsequent admissions. As a consequence, the Council issued an advisory warning to Dr. X, urging him to ensure that comprehensive informed consent is obtained prior to any future surgeries, while also emphasizing the importance of meticulous documentation and clear communication regarding patient care and potential complications. Dissatisfied with the decision, the patient's husband appealed to the EMRB, NMC.
- **Decision of The Ethical and Medical Review Board (EMRB), NMC:** The EMRB, after reviewing the case, upheld the State Medical Council's (SMC) decision and issued a formal warning to Dr. X. The warning stressed the importance of improving his consent practices and ensuring the maintenance of thorough, accurate medical documentation in accordance with standard medical protocols and ethical guidelines.
- **Discussion:**

Written consent was obtained; however, it was incomplete and lacked crucial details. The consent form, written in Hindi, referred to the condition as "pet mein gaantth, rasoli" (abdominal lump, fibroid)

instead of the more accurate "bacchedaani mein rasoli" (fibroid in the uterus). Additionally, the consent was generic, failing to mention the specific procedures planned, such as the hysterectomy and bilateral salpingo-oophorectomy. This critical omission appeared in both the English and Hindi versions of the consent form. Despite being an elective procedure with sufficient time, the surgeon missed the opportunity to adequately explain the planned surgery to the patient.

Bladder injury is a recognized complication during pelvic surgeries, including hysterectomy, and typically manifests a few days post-operation. Although, Dr.X, diagnosis of bladder injury was correct in the subsequent admission but failed to explain the future course of action, possible further complications, did not attempt to ally the patients anxiety and concerns. The documentation of this was very poor.

The matter was further complicated by concerns over the qualifications of Dr. X, a general surgeon, performing the hysterectomy and bilateral salpingo-oophorectomy. It was raised that Dr. X might not have been appropriately qualified to conduct these specific procedures, which typically fall within the expertise of a specialized gynecologist. This issue added to the grievances brought before the state medical council.

Although, this procedures fall within the domain of gynaecological surgery, and an OBG specialist is specifically trained and qualified to manage both the surgery and its potential complications. A general surgeon may not have the same level of expertise in managing gynaecological conditions and their associated risks. However, in the

present care the surgeon took the decision to operate the case by himself. In such a scenario, the surgeon will be assessed as per 'the Standard of care' applicable to that of the gynaecologist specialist. In this case, the common complications could have happened even in the hands of OBG specialist. Just, because the experienced surgeon did the operation does not overtly qualify for negligence. In a resources limited settings where an OBG specialist may not be readily available, the following considerations will be taken by the SMC and EMRB to guide decision-making, 1) Assessment of Expertise: If a general surgeon is the only available option, they should have demonstrable experience and competency in performing such gynecological procedures, 2) Informed Consent: Patients should be fully informed about the situation, including the qualifications of the operating surgeon, the potential risks, and the possible need for referral to a specialized center if complications arise. Comprehensive and specific informed consent is crucial and 3) Referral Systems: If possible, arrangements should be made for referral to a facility where an OBG specialist is available, especially in cases where complications are more likely or where the procedure is complex. All these were considered before the SMC and EMRB took decision.

- **Take home messages:**

1. Written informed consent should be comprehensive and specific to the procedures being performed. **The Samira Kohli v Prabha Manchanda (2008)** case is a cornerstone in Indian medical law, underscoring the importance of informed consent, patient autonomy, and the doctor's duty of care. The Supreme Court's decision mandates

that consent must be informed, specific to the procedure, and obtained before treatment unless in an emergency. This ruling has significantly shaped the legal framework governing patient rights in medical practice in India.

2. **The Supreme Court in Nizam Institute of Medical Sciences v. Prasanth S. Dhananka (2009)** held that the hospital had failed to obtain proper informed consent, as the risks involved in the surgery were not adequately communicated to the patient. The court awarded compensation to the patient for the medical negligence. The judgment clarified that consent given for a specific medical procedure cannot be assumed to cover other procedures unless it is an emergency. Doctors must respect the scope of the consent provided and cannot perform additional procedures without explicit permission unless the situation is life-threatening. The court acknowledged that in cases of medical emergencies, where obtaining consent is not feasible, doctors must make every effort to carry out essential procedures to save the patient's life, in alignment with Article 21's Right to Life and Liberty of the Indian Constitution.

3. The Apex court in **Dr.Laxman Balkrishan Joshi Vs. Dr. Trimbak Bapu Godbole (1969),** held that the duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding whether treatment to give or a duty of care in the

administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

4. It is crucial to maintain consistent and accurate documentation across all patient records, including OPD cards, IPD cards, and discharge summaries. Meticulous procedure records are vital to prevent discrepancies and potential litigation. In medical record documentation, thorough and accurate record-keeping is your strongest defense in the court of law. Inadequate documentation weakens your defense, while the absence of documentation leaves you defenceless.

References:

1. Samira Kohli v Prabha Manchanda 2008 Air Sc 855
2. Nizam Institute of Medical Sciences v. Prasanth S. Dhananka, 2009 (6) SCC 1
3. Dr.Laxman Balkrishan Joshi Vs. Dr. Trimbak Bapu Godbole and Anr. AIR 1969 SC 128

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CASE 4

Issuing False Medical Certificate

- **Keywords:** Telemedicine Consultation, Medical Certificate, Unethical Conduct.
- **Context:** Professional conduct and ethics.
- **Abstract:**
- Dr. X, a postgraduate in anesthesia with intensive care training, advised Mr. Q on the treatment and excision of a cyst on his back without conducting either an in-person or telemedicine consultation. Without properly examining the patient, Dr. X recommended the Mr.Q, needs hospital admission and issued certificates from various hospitals on different occasions, though Mr. Q was never registered at any of these hospitals. Dr. X claimed to have provided telemedicine consultation but did not specify the mode of communication and was unaware that Mr. Q was in prison at the time. He asserted that his advice and issuance of medical certificates were in the patient's best interest; however, he could not substantiate these claims with medical records or demonstrate the establishment of a valid doctor-patient relationship.
- **Case Summary:**

Dr. X, a trained anesthesiologist certified as an intensivist by the Australian board, with extensive experience in ICU and pulmonary

critical care, issued three prescriptions and a medical certificate for Mr. Q over an eight-week period. These documents were issued in absentia (without examining either in-person or on tele-consultation). Dr.X, Claimed that he issued these prescriptions and one medical certificate at the request of police and jail personnel, as well as Q's alleged wife. The prescriptions, written on Dr. X's letterhead from three different hospitals, included references to the patient's past illnesses and additional medical issues that arose during the COVID-19 pandemic. Each prescription mentioned teleconsultation as the mode of consultation, although the mode was not specified and no identity proof was taken. Dr. X, also claimed that he was not aware the Mr. Q was in prison.

Dr. X made conflicting statements regarding the issuance of the prescriptions and medical certificate. On one occasion, he claimed that the certificate was provided at the request of police and jail personnel, yet later asserted that he was unaware the patient, Mr. Q, was in prison. These contradictory statements raise serious concerns about the accuracy and legitimacy of the consultations and the documentation provided.

Notably, the prescriptions lacked the registration numbers of the respective hospitals, despite being issued under their names on Dr. X's personal letterhead. The medical certificate, issued on the letterhead of the third hospital 'C', recommended the admission and surgical removal of an infected sebaceous cyst but had diagnosed it as cancerous without examination in any mode of consultation. The certificate also mentioned that the surgery would be performed by a

surgeon Dr. Y under Dr. X's anesthetic care. Further, Dr. X was using a designation, the Director Pulmonology in the hospital for which he did not possess any recognised degree or qualification. The state police challenged the authenticity of the medical prescriptions and certificate in court.

Following an internal inquiry, Hospital "C" determined that Dr. X's conduct was inappropriate and subsequently removed him from its panel. A complaint was then filed with the State Medical Council (SMC). Upon investigation, the disciplinary committee found Dr. X guilty of professional misconduct, specifically for issuing a false medical certificate, and recommended that his name be removed from the medical register for a period of 365 days.

- **Decision of State Medical Council (SMC):** The State Medical Council, based on the disciplinary committee's report, observed that Dr. X had issued three prescriptions and one medical certificate on the letterheads of three different hospitals. Dr. X admitted that he had never known or met anyone by the name of Mr. Q, making it clear that he issued these certificates without examining the patient, either in person or via telemedicine. The medical certificate advised Mr. Q to undergo admission and surgery for a septic infected sebaceous cyst on the back, a recommendation that was questionable given Dr. X's registration as an MD in anesthesia, a field typically not responsible for advising surgical admissions. It was also noted that Dr. X used the designation "Director Pulmonology" in the hospital, despite lacking a recognized MCI/NMC degree in that specialty. The committee determined that the prescriptions and medical certificate

were issued not for legitimate medical reasons but for extraneous considerations. The State Medical Council concluded that Dr. X's conduct had brought disrepute to the medical profession by issuing false medical certificate. Consequently, they recommended the removal of Dr. X's name from the state medical register for a period of 365 days due to these egregious acts of professional misconduct. However, the Dr.X, appealed to EMRB against the SMC decision.

- **Decision of The Ethical and Medical Review Board (EMRB), NMC:** In light of the evidence presented, the EMRB observed that Dr. X failed to adhere to the Telemedicine Practice Guidelines of 2020 and issued false medical certificates without examining the patient, either in person or through telemedicine consultation. Consequently, the board concluded that the decision made by the State Medical Council regarding Dr. X's unethical conduct and unprofessional behavior is valid and justified. Therefore, the EMRB upheld the State Medical Council's decision to remove Dr. X's name from the state medical register for a period of 365 days.
- **Discussion:**

  As per Indian Medical Council (professional conduct etiquette and ethics) regulation 2002; Code **1.3.3** A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate, he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical

certificate shall be prepared as in Appendix 2 of the IMC regulation 2002.

Further, Code 7.7 clearly indicates that Registered medical practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give certificates, notification, reports and other documents of similar character signed by them in their professional capacity for subsequent use in the courts or for administrative purposes etc. Such documents, among others, include the ones given at Appendix –4. Any registered practitioner who is shown to have signed or given under his name and authority any such certificate, notification, report or document of a similar character which is untrue, misleading or improper, is liable to have his name deleted from the Register.

Telemedicine communication guidelines 25.03.2020 should be followed as directed. Code 3.2 of the Telemedicine Practice Guidelines 2020 clearly articulates that the Telemedicine consultation should not be anonymous. Both patient and the RMP need to know each other's identity. A RMP should verify and confirm patient's identity by name, age, address, email ID, phone number, registered ID or any other identification as may be deemed to be appropriate. The RMP should ensure that there is a mechanism for a patient to verify the credentials and contact details of the RMP.

Code 3.7.4 of the Telemedicine Practice Guidelines 2020 clearly articulates that the Prescribing medications, via telemedicine consultation is at the professional discretion of the RMP. It entails the same professional accountability as in the traditional in-person

consult. If a medical condition requires a particular protocol to diagnose and prescribe as in a case of in-person consult then same prevailing principle will be applicable to a telemedicine consult. RMP may prescribe medicines via telemedicine ONLY when RMP is satisfied that he/ she has gathered adequate and relevant information about the patient's medical condition and prescribed medicines are in the best interest of the patient. Prescribing Medicines without an appropriate diagnosis/provisional diagnosis will amount to a professional misconduct.

In the present case, Dr. X issued a medical certificate in a careless manner, without conducting an in-person or telemedicine consultation, failing to verify the facts, omitting signatures and identification marks, and neglecting to establish a proper doctor-patient relationship, which led to erasure of his name. The certificate and prescriptions issued by Dr. X were deemed misleading and improper because, despite holding a degree in anesthesia, he advised admission and surgery under his care for a jail inmate. Additionally, he failed to produce any records indicating a request from the jail authorities for a medical opinion on Mr. Q. This strongly suggests that the medical certificate and prescriptions were issued for extraneous considerations. This is clearly termed as misconduct under the code of medical ethics.

- **Take home messages:**

1. Medical certificates should only be issued after a thorough evaluation, either in person or via telemedicine consultation, and the establishment of a doctor-patient relationship. Under no

circumstances should a doctor issue a medical certificate without proper examination and documentation.

2. Doctors must understand that a medical certificate is a legal document that certifies they have personally examined either in person or vis telemedicine consultation and identified the patient. Under no circumstances should they issue certificates due to external considerations or undue pressure from any individual. It is imperative that doctors exercise professional judgment when issuing medical certificates.

3. The format provided by the MCI/NMC Professional Conduct Rules for issuing medical certificates must be strictly followed, with proper documentation ensured. All physicians and Registered Medical Practitioners (RMPs) must register their basic and additional qualifications, as recognized by the NMC, with the respective state medical councils. Additionally, all physicians and RMPs must refrain from using misleading claims or designations.

4. A medical certificate should only be issued after a thorough examination of the patient, either through an in-person consultation or a verified telemedicine consultation. Ensure that the examination is documented accurately in the patient's medical records. Verify the identity of the patient through official identification documents before issuing a certificate.

5. Include the patient's identification details in the certificate, such as name, age, and any distinguishing marks if relevant. Document all findings, diagnoses, and the reasoning behind issuing the certificate

in the patient's medical record. Maintain detailed notes that can be referenced in the future, if needed, to justify the issuance of the certificate.

6. Use your professional judgment when issuing medical certificates. Avoid making any claims or statements in the certificate that cannot be substantiated by medical examination or that may be misleading. Issuing false medical certificates is considered a serious form of professional misconduct. It compromises the integrity of the medical profession, and can have legal consequences. Doctors who engage in this practice risk disciplinary action, legal penalties, and damage to their professional reputation. It is essential for doctors to adhere strictly to ethical and legal standards when issuing medical certificates, ensuring that they reflect accurate and truthful medical evaluations.

7. Issuing a false medical certificate can lead to serious legal consequences; therefore, it is essential to exercise caution and adhere to strict ethical standards when issuing any medical certificate. As per the Sec 234 of the Bhartiya Naya Samhita 2023, Whoever issues or signs any certificate required by law to be given or signed, or relating to any fact of which such certificate is by law admissible in evidence, knowing or believing that such certificate is false in any material point, shall be punished in the same manner as if he gave false evidence.

8. Ensure that all your basic and additional qualifications are registered with the respective state medical council as recognized by

the NMC. Only use the qualifications and designations you are officially entitled to.

References:

1. Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002. Available online at https://www.nmc.org.in/rules-regulations/code-of-medical-ethics-regulations-2002/ last visited on 27 Aug 2024.
2. Telemedicine practice guidelines 2020. Available online at https://esanjeevani.mohfw.gov.in/assets/guidelines/Telemedicine_Practice_Guidelines.pdf last visited on 27 Aug 2024

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CASE 5

Proper Documentation and Adherence to Standard Operating Procedures (SOP) are Essential, Even in Defending Against Frivolous Complaints

- **Keywords:** Endoscopic Retrograde Cholangiopancreatography (ECRP), Magnetic resonance cholangiopancreatography (MRCP), Exploratory Laparotomy.
- **Context:** Patient Care.
- **Abstract:**

This case report discusses a medical negligence complaint by Mrs. R against Dr. A, Dr. B, and Hospital X, following the death of her husband, Mr. K., who was admitted with chest discomfort. Mr. K underwent an Endoscopic Retrograde Cholangiopancreatography (ERCP), which led to complications and his death three days later. Mrs. R claimed the ERCP was unnecessary, while the doctors justified it based on medical evidence. The State Medical Council initially deemed the procedure unwarranted, recommending temporary erasure of name of the doctors from the medical register. Aggrieved by the decision of the SMC, Dr. A and Dr. B appealed to the EMRB. The National Medical Commission's Ethics and Medical Review Board (EMRB) later exonerated them, concluding the ERCP was appropriate and managed according to protocol, leading to the

case's closure. This case underscores the complexities of medical negligence claims and the necessity of thorough reviews.

- **Case Summary:**

Mr. K, a 50-year-old with a history of high-altitude travel, hypertension, hypothyroidism, diabetes, and a recent fever, was admitted to the hospital with chest discomfort and a cough. During his hospitalization, a gastroenterology consultation led Dr. A to perform a gastric endoscopy, revealing H. pylori infection and gastric enteritis. Further tests, including a Magnetic Resonance Cholangiopancreatography (MRCP), identified a dilated common bile duct (CBD) with a lower-end calculus and stricture, prompting the decision to perform an Endoscopic Retrograde Cholangiopancreatography (ERCP) two days later after taking informed consent.

After the ERCP, Mr. K developed abdominal pain, and his condition worsened, leading to his admission to the Medical Intensive Care Unit (MICU) and a surgical consultation with Dr. B. Dr. B suspected a retroperitoneal leak, confirmed by X-ray. An exploratory laparotomy, placement of a retroduodenal drain, and a feeding jejunostomy were subsequently performed after obtaining the necessary informed consents. Despite these efforts, Mr. K could not be revived and passed away two days after the laparotomy.

Mrs. R filed a police complaint against Dr. A, Dr. B, and the administrators of Hospital X, accusing them of medical negligence. She alleged that the MRCP, ERCP, and laparotomy were unnecessary, arguing that her husband had been admitted with only

chest symptoms. The police sought State Medical Council opinion before proceeding with the filing of an FIR.

- **Decisions of State Medical Council (SMC):**

  The State Medical Council, after hearing the case and having three expert panellist opinion, concluded that the ERCP was unwarranted given Mr. K's pulmonary symptoms and that the subsequent surgical exploration was unnecessary. They suggested that conservative treatment or the placement of a percutaneous drain could have been viable alternatives. As a result, they recommended the temporary removal of Dr. A and Dr. B from the state medical register for 15 days. Aggrieved by the decision of the SMC, Dr. A and Dr. B appealed to the EMRB.

- **Decision of The Ethical and Medical Review Board (EMRB), NMC:**

  The Ethics and Medical Review Board (EMRB) held a hearing after consulting three experts. After reviewing the submissions, relevant records, and expert opinions, the EMRB concluded that the patient had a longstanding history of dyspepsia, and a CBD stone detected on MRCP necessitated the ERCP procedure. While complications from ERCP are documented in less than 1% of cases, they are a known risk. The ERCP was performed three days after admission, following the stabilization of the patient, but unfortunately, the patient's condition rapidly deteriorated thereafter. A CT scan of the abdomen could not be performed due to the patient's unstable condition, preventing the grading of any potential retroduodenal perforation. The management of such perforations,

whether through conservative means or surgery, typically depends on their severity. Given that retroduodenal perforations do not immediately present with perforation peritonitis symptoms and the lack of a CT scan, the surgeon's decision to proceed with an emergency exploratory laparotomy was deemed justified. Based on these findings, the EMRB exonerated the treating doctors, Dr. A and Dr. B, and the case was closed.

- **Discussion:**

This case presents a complex clinical scenario involving multiple comorbidities, including hypertension, hypothyroidism, diabetes mellitus, a history of recent high-altitude travel, fever, and cough. The patient, Mr. K, initially presented with chest discomfort and a cough, which could suggest a range of differential diagnoses, including cardiac, respiratory, or gastroesophageal conditions. The detection of H. pylori infection and gastric enteritis further complicated the case, adding layers of complexity to both diagnosis and management. These comorbidities and clinical findings significantly influenced the course of treatment and the potential outcomes of any medical interventions.

In this context, Dr. A's decision to perform an Endoscopic Retrograde Cholangiopancreatography (ERCP) was based on the presence of a dilated common bile duct (CBD), abnormal liver function tests (LFTs), and a confirmed stricture on Magnetic Resonance Cholangiopancreatography (MRCP). The ERCP was performed after obtaining informed consent, a critical step in ensuring that the patient and his family were aware of the risks and

benefits involved. Unfortunately, Mr. K developed complications post-ERCP, which Dr. A managed according to established medical protocols by promptly referring the patient for surgical evaluation.

Dr. B, the surgeon, decided to proceed with an emergency exploratory laparotomy in response to a suspected retroperitoneal leak, given the patient's rapid deterioration and inability to undergo a CT scan. This decision was made in line with the actions that a reasonable and competent body of surgeons would take under similar circumstances, prioritizing the patient's immediate need for surgical intervention over less invasive alternatives like percutaneous drainage.

The medical decisions made by Dr. A and Dr. B were consistent with standard medical practices, given the patient's complex clinical presentation. The complications that arose, while unfortunate, are recognized risks associated with the procedures performed.

The case demonstrates the differing conclusions that can arise from various regulatory bodies. The initial ruling by the State Medical Council against the doctors was overturned by the EMRB upon further review, emphasizing the need for considering the patient's multiple comorbidities, the thorough documentation of medical care, the informed consent process, and the adherence to the standard of care throughout the treatment. This case needs to looked from the context of criminal medical negligence in India because FIR was filed against the treating doctors.

From a legal perspective, applying the Bolam test -which is a standard used to determine medical negligence, supports the actions taken by Dr. A and Dr. B. The Bolam test, established in **Bolam v.**

Friern Hospital Management Committee (1957), states that a medical professional is not negligent if they acted in accordance with a practice accepted as proper by a responsible body of medical professionals skilled in that particular area, even if other practitioners might have taken a different approach. If it can be demonstrated that a responsible body of medical professionals would have taken similar decisions under the same circumstances, then the actions of Dr. A and Dr. B would not constitute medical negligence.

- **Take home messages:**

1. The critical role of thorough documentation, the ethical necessity of informed consent, the importance of a multidisciplinary approach, comprehensive approach to the case and the need for prompt management of known complications.
2. The case also highlights the variability in regulatory body decisions and reinforces the relevance of the Bolam test in defending against allegations of medical negligence. This case reaffirms that if a medical professional's actions are supported by a responsible body of their peers, and the care provided aligns with accepted medical standards, it is unlikely to be deemed negligent, even if adverse outcomes occur. This case needs to looked from the context of criminal medical negligence in India because FIR was filed against the treating doctors.
3. The case of **Suresh Gupta v. Government of NCT, Delhi (2004)** is a landmark judgment in the context of criminal medical negligence in India. The case revolves around the death of a patient during surgery, allegedly due to the negligence of the doctor. The

Suresh Gupta case highlights the need for a clear demarcation between civil and criminal liability in cases of medical negligence. The Apex court emphasized that a medical professional can only be held criminally liable if their conduct shows a disregard for life and safety of the patient, amounting to gross negligence.

4. The case of **Kusum Sharma & Ors. v. Batra Hospital and Medical Research Centre & Ors., (2010)** is a significant Supreme Court judgment concerning medical negligence in India. It further clarifies the legal principles surrounding the liability of medical professionals in cases of alleged negligence. The Apex Court laid down several important principles to be considered when determining medical negligence such as Medical Negligence cannot be presumed merely because a treatment has not been successful or a patient has died during treatment. A higher degree of negligence is required to establish criminal liability (gross negligence), whereas civil liability can be established on the balance of probabilities.

5. The Apex court's decision in **Martin F.D'Souza vs. Mohd. Ishfaq (2009)** stated that simply because the patient has not favourably responded to a treatment given by doctor or a surgery has failed, the doctor cannot be held straight away liable for medical negligence by applying the doctrine of Res Ipsa Loquitor. It is further observed therein that sometimes despite best efforts the treatment of a doctor fails and the same does not mean that the doctor or the surgeon must be held guilty of medical negligence unless there is some strong evidence to suggest that the doctor is negligent.

6. In any medical negligence case, the medical record and comprehensive documentation serves as a critical defense in cases of

alleged medical negligence, demonstrating that the decisions made were well-considered and based on sound medical judgment.

References:

1. Bolam v Friern Hospital Management Committee [1957] 1 WLR 583

2. Suresh Gupta v. Government of NCT, Delhi, (2004) 6 SCC 422

3. Kusum Sharma & Ors. v. Batra Hospital and Medical Research Centre & Ors., (2010) 3 SCC 480

4. Martin F.D'Souza vs. Mohd. Ishfaq (2009) 3 SCC 1

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CASE 6

Allegations of Incomplete Preoperative Workup and Negligence in Postoperative Management, Resulting in Loss of Life

- **Keywords:** Incomplete preoperative workup, Carcinoma gall bladder.
- **Context:** Patient Care.
- **Abstract:**

A 35-year-old woman presented with abdominal pain and, upon ultrasound examination, was diagnosed with acute calculous cholecystitis. She was admitted to a private hospital, where she underwent an open cholecystectomy under spinal anesthesia in the morning. Postoperatively, she received three units of blood transfusion. By the evening, she developed respiratory distress and was referred to a nearby medical college emergency department for further management. Upon arrival at the emergency room, she was found to have low oxygen saturation and a feeble pulse, necessitating intubation and ventilatory support. Despite all clinical interventions, she succumbed to death four hours after admission. Subsequently, the patient's husband filed a negligence case against the operating surgeon, alleging a deficiency in surgical care.

- **Case Summary**

A 35-year-old female patient presented with severe abdominal pain lasting for several hours. She was initially taken to a nearby

clinic, where an abdominal ultrasound was recommended. The scan revealed features consistent with acute calculous cholecystitis. Her primary physician referred her to a nearby private hospital for further management. Upon arrival at the hospital, she was advised by Dr. X, a physician, to undergo an open cholecystectomy.

After obtaining informed consent and completing preoperative tests, the patient underwent the open cholecystectomy in the morning, performed by Dr. Y. However, Dr. Z served as the anesthetist for the procedure. During surgery, dense omental adhesions were encountered in the Calot's triangle, requiring careful dissection. The cystic artery and duct were ligated and divided, and the gallbladder was successfully removed. The specimen revealed a large stone and a thick-walled gallbladder, raising a suspicion of malignancy.

Postoperatively, the patient was closely monitored, and her vital signs remained stable. She received three units of blood transfusion by the evening. However, approximately six hours after the surgery, she suddenly developed respiratory distress and hypotension. She was promptly referred to the emergency department of a nearby medical college for further management. Upon arrival at the emergency department, the patient exhibited a feeble pulse and continued respiratory distress. Endotracheal intubation was performed, and she was placed on ventilatory support. Despite all clinical efforts, her condition deteriorated, and she succumbed to death around midnight.

The patient's husband alleged gross negligence on the part of the operating team, citing the following points: a) The surgery was performed by a physician rather than a qualified surgeon, b) The preoperative workup was incomplete, leading to an unexpected intraoperative discovery of carcinoma of the gallbladder, c) A laparoscopic approach was not considered, and the surgical specimen was not sent for histopathological examination (HPE), d) An intraoperative vascular injury resulted in severe bleeding, necessitating multiple blood transfusions, and e) Postoperative management was inadequate, as evidenced by the delayed referral when the patient's condition became critical. The overall gross negligence, according to the husband, ultimately led to the death of his 35-year-old wife.

In response to the allegations, the treating team presented the following points: a) Dr. X, a physician, was the primary attending doctor for the patient; however, the surgery itself was performed by Dr. Y, a freelance surgeon affiliated with their hospital, b) The abdominal ultrasound (USG) did not reveal any signs of malignancy, and it is clinically challenging to suspect malignancy in such cases based solely on imaging and initial presentation, c) Given the presence of a large gallbladder stone and features of acute calculous cholecystitis, an open cholecystectomy was deemed necessary. This surgical approach was thoroughly explained to the patient's attendants. The surgical specimen was also sent for histopathological examination (HPE) as a standard procedure, d) There was no significant intraoperative or postoperative bleeding. Blood transfusions were administered due to the patient's pre-existing low

hemoglobin levels rather than any surgical complication and e) The patient was referred to a higher center at an appropriate time. Unfortunately, she suffered a sudden cardiac event, which led to her death, and this event could not be managed even at the higher center.

- **Decision of State Medical Council (SMC):** On detailed evaluation of the case and physical hearings, SMC opined that there was an evidence of medical negligence in this case and passed an order to remove the names of Dr X, Dr Y & Dr Z from the registry for a period of 7 days.
- **Decision of Ethics and Medical Registration Board (EMRB), NMC:** Appeal of Dr X, Dr Y & Dr Z against the SMC order was considered & evaluated at NMC under the expert panel and NMC upheld the decision of SMC.
- **Discussion:**

A 35-year-old female patient underwent an open cholecystectomy for acute calculous cholecystitis. Dr. X, the attending physician, communicated with her family, but the surgery was performed by Dr. Y, a freelance surgeon, without disclosing this to the patient or her family. During the operation, gallbladder malignancy was suspected, and the patient received three units of blood postoperatively. Unfortunately, her condition worsened within six hours, leading to her transfer to a higher center, where she ultimately succumbed despite all efforts to save her.

The use of freelance (ghost) surgeons highlights a broader issue within the medical profession. Patients have the right to know who will be performing their surgery and to establish a relationship with

their surgeon, which is essential for trust and effective communication. The practice of delegating surgeries to freelance surgeons without the patient's knowledge erodes this trust and can lead to significant ethical and legal challenges. Pre-operatively, it violates informed consent and breaches the patient's trust, undermining their autonomy. Peri-operatively, it leads to a lack of accountability and potential substandard care, as the ghost surgeon may not feel fully responsible for the patient. Post-operatively, it disrupts continuity of care, obscuring patient rights and complicating legal recourse if complications arise. These practices not only erode the integrity of the patient-surgeon relationship but also expose healthcare providers to significant legal risks, including claims of malpractice, battery, and breach of trust. Transparency, proper consent, and strict accountability are essential to address these concerns and uphold ethical standards in medical practice.

Furthermore, the postoperative administration of three units of blood, followed by the patient's rapid decline and subsequent death, suggests possible clinical mismanagement. This sequence of events warrants a thorough investigation, including histopathological examination of the surgical specimen and possibly a postmortem examination, to provide clarity on the cause of death and to assess the appropriateness of the medical care provided.

- **Take home messages:**

1. In **Maharaja Agrasen Hospital v. Master Rishabh Sharma (2019),** have clearly said that to establish medical negligence, it is essential to demonstrate that

(1) a duty of care existed,

(2) there was a breach of that duty,

(3) the breach caused damage or harm, and

(4) the harm was foreseeable and led to compensable loss.

Let's apply these principles to the roles of Dr. X, Dr. Y, and Dr. Z in the case. Dr. X may have been negligent in not ensuring that the patient and her family were fully informed about who would perform the surgery, thus potentially breaching the duty of care. However, his role in directly causing harm seems less significant compared to the other actors. Dr. Y appears to be most directly implicated in the potential negligence. The failure to disclose his involvement as the operating surgeon, taking informed consent, explaining the procedure, combined with any surgical or post-operative mismanagement, could be seen as a breach of duty leading to foreseeable harm. Dr. Z's role would depend on whether he fulfilled his duties during anesthesia and post-operative care.

2. In **Savita Garg vs. Director, National Heart Institute (2004)**, it has been observed by the Apex court that once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack

of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities, which is 'Vicarious liability' This is a rule in tort law that holds a defendant liable for the torts committed by another party.

Hence, It is the responsibility of the hospital to verify the credentials of all doctors and nurses working within their facility, whether they are full-time employees, part-time staff, or hired on a case-by-case basis. The hospital or the institute is responsible and no distinction could be made between the two classes of persons i.e. the treating doctor who was on the staff of the hospital and the nursing staff and the doctors whose services were temporarily taken for treatment of the patients. On both, the hospital as the controlling authority is responsible and it cannot take the shelter under the plea that treating physician is not impleaded as a party, the claim petition should be dismissed

3. The primary operating surgeon and the anaesthetist should personally explain and counsel both the patient and their family members about the surgical procedure, including any potential complications that could arise during or after the surgery. This approach not only enhances the patient's understanding and consent but also helps to manage expectations and reduces anxiety, fostering

a collaborative environment that is vital for the patient's overall well-being and for minimizing the risk of legal or ethical issues.

References:

1. Maharaja Agrasen Hospital v. Master Rishabh Sharma AIRONLINE 2019 SC 1757
2. Savita Garg (Smt.) vs. Director, National Heart Institute (2004) 8 SCC 56

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CASE 7

Ethical Breach: Misrepresentation of Medical Qualifications and Alleged Endorsement of Quackery

- **Keywords:** Non-specialist, fraud, misrepresentation.
- **Context:** Patient care.
- **Abstract:**

Allegations have been made that Mr. Q, who runs a private clinic and claims to possess an MBBS qualification, is actually a quack. Dr. A and Dr. M were involved in providing Mr. Q with their stamps and letterheads. Furthermore, both Dr. A and Dr. M falsely represented themselves as overqualified on their letterheads. The State Medical Council (SMC) responded to this unethical conduct by removing the names of Dr. A and Dr. M from the State Medical Register for 30 days. The SMC also recommended prosecuting Mr. Q and directed all parties to refrain from such unethical practices in the future. Dr. A has appealed the SMC's order to the Ethics and Medical Registration Board (EMRB) of the National Medical Commission (NMC).

- **Case Summary:**

In a case involving a private clinic, it was alleged that Mr. Q, who claimed to be a registered doctor with an MBBS qualification, was actually a quack. Further allegations were made that Dr. A and Dr. M had provided Mr. Q with their stamps and letterheads. Moreover,

both Dr. A and Dr. M had falsely presented themselves as holding higher qualifications than they actually possessed.

The State Medical Council (SMC) found that Mr. Q was not registered with the SMC and did not hold an MBBS degree. Dr. M, although registered with the SMC with qualifications of MBBS and DCH, had falsely appended the qualifications of MD Pediatrics and Fellowship in Neonatology, which he did not possess. This constituted a misrepresentation of qualifications. Similarly, Dr. A, a foreign medical graduate registered with the SMC with an MD Physician degree (equivalent to an MBBS in India), had been using the suffix "MD," misrepresenting his qualification, as in India, "MD" is reserved for those holding a postgraduate medical degree.

- **Decision of State Medical Council (SMC):**

  The SMC recommended that Mr. Q be prosecuted and ordered the removal of Dr. A and Dr. M's names from the State Medical Register for 30 days due to their unethical conduct. They were also directed to cease such practices in the future.

- **Decision of Ethics and Medical Registration Board (EMRB), NMC:**

  Dr. A appealed the SMC's decision to the Ethics and Medical Registration Board (EMRB) of the National Medical Commission (NMC). After reviewing the case, the NMC issued a warning to Dr. A, advising him not to use any suffix suggesting specialist qualifications without holding the requisite recognized credentials.

- **Discussion:**

The primary legal issue revolves around Mr. Q, who, despite claiming to be a registered medical doctor, was found to be unregistered with the State Medical Council (SMC) and without an MBBS degree. Practicing medicine without valid registration is a violation of both the Indian Medical Council Act, 1956, and the National Medical Commission Act, 2019, which mandate that only individuals with recognized qualifications and valid registration can practice medicine in India. Section 34 of The National Medical Commission Act, 2019 clearly stipulates that only individuals who are enrolled in the State Register or National Register are permitted to practice medicine as qualified medical practitioners in India. This includes holding any medical office intended for physicians or surgeons, signing or authenticating legally required medical or fitness certificates, and providing expert testimony in court on medical matters. Any person who contravenes these provisions shall be subject to punishment, which may include imprisonment for up to one year, a fine of up to five lakh rupees, or both. These provisions ensure that only qualified and duly registered professionals are allowed to practice medicine, thereby safeguarding public health and maintaining professional standards.

Dr. A and Dr. M were found to have misrepresented their qualifications, violating both ethical and legal standards expected of medical practitioners. Such misrepresentation breaches the Medical Council of India's Code of Ethics Regulations, 2002 (now governed by the National Medical Commission Act, 2019), which could result

in disciplinary actions. However, they claimed in their defense that Mr. Q had used their names, prescription pads, stamps, and seals without their knowledge or consent. Hence, the Ethics and Medical Registration Board (EMRB) could consider issuing a warning against Dr. A and Dr. M only.

- **Take home messages:**

1. According to Regulation 1.1.3 of the MCI Code of Ethics, a registered medical practitioner is prohibited from misrepresenting their qualifications. As per the code 1.1.3 No person other than a doctor having qualification recognized by Medical Council of India and registered with Medical Council of India/State Medical Council (s) is allowed to practice Modern system of Medicine or Surgery. A person obtaining qualification in any other system of Medicine is not allowed to practice Modern system of Medicine in any form.
2. MCI Code of Ethics 7.9 Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical, surgical or psychological indication.
3. MCI Code of Ethics 7.10 A registered medical practitioner shall not issue certificates of efficiency in modern medicine to unqualified or non-medical person. The foregoing does not restrict the proper training and instruction of bonafide students, midwives, dispensers, surgical attendants, or skilled mechanical and technical assistants and therapy assistants under the personal supervision of physicians.
4. A physician shall not claim to be a specialist unless he/she has a special qualification in that branch, according to the code 7.20 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics)

Regulations, 2002. In view of this clause, Registered Medical Practitioners should register their additional qualifications with the respective Medical Councils. Both Dr. A and Dr. M violated this regulation by misrepresenting their qualifications. Dr. M falsely claimed to hold an MD in Pediatrics and a Fellowship in Neonatology, while Dr. A used the title "MD" without holding a recognized postgraduate medical degree in India. This act of misrepresentation not only deceives patients but also undermines the trust in the medical profession.

5. Apex court in **Poonam Verma vs Ashwin Patel & ors 1996** clearly stated that a person who does not have knowledge of a particular System of Medicine but practices in that System is a Quack and a mere pretender to medical knowledge or skill, or to put it differently, a Charlatan. Hence, do not engage an unqualified person to provide care in your hospital. However, considering the federal structure of the Indian constitution and the fact that health is a state subject, the apex court has also laid down that ayurveda, siddha, unani and homoeopathy practitioners can prescribe allopathic medicines only in those states where they are authorised to do so by a general or special order made by the state government concerned **(Math et al 2016).** This also has been emphasized in the supreme court decision **Dr. Mukhtiar Chand & Ors. vs. State Of Punjab (1998).**

References:

1) Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Available online at https://www.nmc.org.in/wp-content/uploads/2017/10/Ethics-Regulations-2002.pdf Last accessed on 30 Aug 2024

2) Poonam Verma vs Ashwin Patel & ors 1996 SCC (4) 332

3) Math SB, Moirangthem S, Kumar CN. Public health perspectives in cross-system practice: past, present and future. Indian J Med Ethics. 2015 Jul;12(3):131-6.

4) Dr. Mukhtiar Chand & Ors. vs. State Of Punjab & Ors. (1998) 7 SCC 579.

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CASE 8

Delay in the Management and Referral of Postpartum Hemorrhage (PPH)

- **Keywords:** High risk pregnancy, Postoperative, Shock, PPH, Referral.
- **Context:** Patient care.
- **Abstract:**

A 33-year-old woman at 35 weeks of gestation, gravida 6 with a history of 5 previous abortions (G6, A5), was admitted to an urban private hospital due to multiple high-risk factors. She delivered twins via lower segment cesarean section (LSCS). She developed postpartum hemorrhage (PPH), initially managed with uterotonics. However, over the next 5 to 6 hours postoperatively, the patient had repeated episodes of hypotension and vaginal bleeding, which were conservatively managed. Despite these interventions, the patient's condition continued to deteriorate. An ultrasound was performed, leading to a decision for re-exploration, during which an abdominal hematoma was drained. The patient remained in critical condition and was continuously monitored in the operating theater by the anesthetist for the next four hours. During this period, she developed respiratory distress, became hemodynamically unstable, and showed further signs of deterioration, necessitating re-intubation and mechanical ventilation. Unfortunately, the patient's condition continued to worsen, and she subsequently passed away. The patient's husband has accused the attending doctor of negligence,

specifically citing the failure to transfer the patient to another hospital for intensive care unit (ICU) management.

- **Case Summary:**

The patient, a 33-year-old pregnant woman (G6 A5), was undergoing post-IVF treatment and carrying twins, with the first twin in a breech presentation. She was receiving insulin therapy for gestational diabetes mellitus (GDM) and treatment for cholestasis of pregnancy with deranged liver function tests (LFTs) under the care of Dr. X at an urban private hospital. At 35 weeks of gestation, she was admitted, and a decision was made to perform a lower segment cesarean section (LSCS) due to the twin pregnancy, breech presentation of the first twin, GDM, and cholestasis with deranged LFTs. Informed consent was obtained.

Dr. X performed the LSCS, successfully delivering the twins. However, the patient developed postpartum hemorrhage (PPH), which was initially managed conservatively in the operating theater using uterotonics. The patient was then transferred to the recovery room. Approximately 2.5 hours after surgery, Dr. Y, the duty doctor, recorded that the patient experienced a bout of vaginal bleeding and a significant drop in blood pressure. Dr. X was contacted by phone and instructed Dr. Y to continue conservative management, including bimanual uterine massage, administration of Inj. Prostodin, 20 units of Syntocinon, and a unit of blood transfusion. The anesthetist was informed and treated the patient with Inj. Mephentermine(Sympathomimetic), Inj. Effcorlin (Steroid), and one

unit of Voluven (Synthetic colloid). The patient's blood pressure stabilized, and her husband was informed of her condition.

Two hours later, the patient again experienced vaginal bleeding and showed signs of shock. Blood clots were removed from the vagina, and Dr. X was informed again by phone. Despite continued conservative management, the patient's condition did not improve. Dr. X arrived at the hospital two hours later, conducted an examination, and performed an ultrasound, which revealed abdominal blood collection adjacent to the uterus and abdominal wall. The patient was then taken back to the operating theater for re-exploration under general anesthesia. The patient's relatives were informed, and consent for the procedure was obtained. By this time, the patient's hemoglobin had dropped from approximately 13 g/dL preoperatively to 5.2 g/dL postoperatively. The hematoma was drained, and Dr. X left the operating theater and the hospital.

The patient was not transferred to the ICU but was instead monitored on the operating table by the anesthetist. She was extubated an hour after the laparotomy. Following extubation, the patient experienced respiratory distress, and she was treated with nebulization, 4 L/min oxygen via Ventimask, and transfusions of blood and fresh frozen plasma (FFP).

Two hours after extubation, while still in the operating theater, the patient's condition deteriorated further, with signs of hemodynamic instability and drowsiness. She was re-intubated and placed on a ventilator. The anesthetist informed Dr. X by phone, who returned to the hospital and decided to transfer the patient to a higher center for further management. The husband was informed of her

critical condition and the need for transfer, to which he consented. However, the transfer was delayed by another two hours. Records indicate that the patient suffered a cardiac arrest while being moved from the operating table to a stretcher. Despite all efforts, the patient succumbed.

The patient's husband alleges that he was not informed of his wife's deteriorating condition and the need for intensive care support until it was too late, when she was already on a ventilator in the operating theater. He was also unaware that the hospital did not have an ICU and was not given the opportunity to seek a second opinion. The post-mortem report cited hemorrhagic shock as the cause of death, with additional findings suggestive of pulmonary edema.

- **Decision of State Medical Council (SMC):** The SMC concluded that the extent of blood loss during the postpartum period was significantly underestimated. Additionally, it was observed that the consultant in charge, who was the operating gynecologist surgeon, left the patient in an unstable condition following the re-exploration surgery. This was deemed to reflect a concerning lack of diligence on the part of the attending doctor. Based on these findings, the SMC ruled against the doctor
- **Decision of the Ethics & Medical Registration Board (EMRB), NMC:** Dr. X, the appellant, approached the EMRB to appeal the decision made by the SMC. After considering the submissions from all concerned parties, including the appellant doctor and the complainant, as well as reviewing all available records and expert opinions, the EMRB made the following observations:

1. The ongoing hemorrhage appears to have been the primary factor leading to the deterioration of the patient's general condition. Timely implementation of additional conservative measures to manage postpartum hemorrhage (PPH), such as increasing the dose of uterotonics, intrauterine balloon tamponade, and an early surgical intervention upon the failure of conservative management, should have been considered sooner.
2. Given the patient's high-risk status, as was already identified, the delivery should have been conducted in a fully equipped facility with adequate ICU support and the capability for massive blood transfusions without delay.
3. Proper monitoring of fluid balance during resuscitation measures, both intraoperatively and postoperatively, is critical. In this case, it appears that such monitoring was deficient, as evidenced by post-mortem findings of alveolar damage leading to pulmonary edema.
4. Considering the numerous high-risk factors, the patient could have been transferred to a tertiary care center at the earliest opportunity if the source of the ongoing hemorrhage could not be promptly identified.

In light of these observations, the EMRB of the NMC decided to uphold the decision of the SMC

- **Discussion:**

Postpartum hemorrhage (PPH) is the leading cause of maternal death, accounting for approximately 35% of all maternal fatalities worldwide. The incidence of PPH is 2%–4% following vaginal deliveries and about 6% after cesarean sections. In this case, the

patient had a high-risk pregnancy, with a significant likelihood of developing PPH. Despite this, the management was conducted at a facility that lacked the necessary ICU capabilities to handle such critical situations. There was a delay of approximately 4 to 5 hours between the initial recognition of PPH and shock and the appropriate management steps. During this period, the patient's hemoglobin level dropped significantly—by around 7 to 8 g/dL, from approximately 13 g/dL preoperatively to 5.2 g/dL. The patient exhibited signs of severe PPH, including tachypnea and tachycardia. Given the ongoing hemorrhage and repeated episodes of hypotension, an earlier surgical intervention should have been pursued. The resuscitative measures did not keep pace with the clinical deterioration and the substantial blood loss.

The vasopressors administered had only a temporary effect on stabilizing blood pressure. However, hemorrhagic shock cannot be effectively managed unless the bleeding is controlled and a massive blood transfusion protocol is initiated. Moreover, even after the second surgery, when the patient remained critical, hemodynamically unstable, re-intubated, and on a ventilator for nearly 4 hours, the operating gynecologist left the patient in an unstable condition following the re-exploration surgery, which was considered to demonstrate a significant lack of diligence on the part of the attending doctor. Despite the patient's critical condition, she was never transferred to the nearest well equipped tertiary hospital, which was only 5 kilometers away.

- **Take home messages:**

1. The Bolam Test, originating from the UK case **Bolam v Friern Hospital Management Committee (1957),** is a legal standard used to assess whether a medical professional has acted in accordance with a practice accepted as proper by a responsible body of medical professionals skilled in that particular art. It essentially determines whether the doctor's actions were consistent with what other competent professionals would have done in similar circumstances. Applying the Bolam Test in this case, it appears that the actions taken by the operating gynecologist may fall short of the standard of care expected by a responsible body of medical professionals. The decision to manage a high-risk case in a facility without adequate ICU support, coupled with delays in intervention, the failure to promptly transfer the patient to a tertiary care center, and the decision to leave the patient after the re-exploration surgery while she remained in an unstable and critical condition, likely represents a deviation from the standard of care. While applying Bolam's test, a fundamental legal doctrine, the care provided by a medical professional is assessed whether it is in alignment with that which would have been provided by other similarly placed medical professionals; i.e. 'reaches standard of a responsible body of medical opinion'
2. It is now a settled principle of law that a medical practitioner will bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor the very lowest degree of care and competence judged in the

light of circumstances in each case is what the law requires **(Rao 2009)**

3. According to **FOGSI guidelines 2022,** surgical intervention to control PPH should be initiated immediately after the failure of drug therapy, ideally within the "golden hour." It is essential to have a clear understanding of the facility's capabilities in managing PPH and to establish effective mapping and linkage of low-resource centers with tertiary care facilities to minimize morbidity and mortality related to PPH.
4. Communication and documentation of a patient's deteriorating condition should be conducted frequently, ensuring that the information is clear, comprehensive, and addresses all aspects of the patient's status. This is particularly crucial for critically ill patients, allowing the family or attendants the opportunity to discuss concerns or seek a second opinion. Additionally, it would be prudent to obtain an emergency second opinion from a colleague of same specialty. This practice allows for a fresh perspective on the case, which can be especially valuable after a long day of work. Such additional input can be lifesaving and may also be critical in the context of potential legal challenges.
5. Proper medical record documentation is vital in medical negligence cases, serving as a cornerstone of evidence. The key elements of effective documentation are: a) Document every communication, b) Ensure the documentation is communicated, c) Good documentation provides a strong defense, d) Poor documentation weakens the defense, and e) No documentation leaves no defense.

In the absence of proper records, healthcare providers may have no way to prove that appropriate care was provided, making it challenging to present a credible defense. Medical experts and courts heavily rely on medical records as objective evidence of the care delivered, and without them, demonstrating adherence to the standard of care becomes nearly impossible.

References:

1. Bolam vs Friern Hospital Management Committee (1957) 1 WLR 582.
2. Rao SJ. Medical negligence liability under the consumer protection act: A review of judicial perspective. Indian journal of Urology. 2009 Jul 1;25(3):361-71.
3. FOGSI Guidelines: PPH Prevention and Management: Updated PPH Guidelines 2022. Available from https://www.fogsi.org/wp-content/uploads/tog/pph-prevention-and-management-updated-sept-2022.pdf

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CASE 9

Mismanagement of Previous LSCS Leading to Uterine Rupture, Maternal, and Neonatal Mortality

- **Keywords:** Previous LSCS, Vaginal Birth After Cesarean (VBAC), Rupture uterus, PPH, Maternal mortality.
- **Context:** Patient care.

- **Abstract:**

Mrs. X, a 33-year-old woman, Gravida 2 Para 1, with a history of a previous lower segment cesarean section (LSCS), was admitted to an urban private hospital at 41 weeks for post-term delivery. Despite clinical indications suggestive of cephalopelvic disproportion (CPD), labor was induced using Prostaglandin E2 (PGE2) gel, followed by augmentation with oxytocin. The labor management was inadequate, as the attending physician persisted with attempts at vaginal delivery, disregarding clear signs of obstructed labor and impending uterine scar dehiscence. This mismanagement led to a uterine rupture, necessitating an emergency LSCS. Tragically, both the mother and baby expired during the surgery. It was later revealed that the patient's delivery was handled by a doctor with only an MBBS degree, who was not qualified or registered as an Obstetrician.

- **Case Summary:**

Mrs. X, a 33-year-old woman, Gravida 2 Para 1, with a history of a previous lower segment cesarean section (LSCS) and hypothyroidism, was admitted to an urban private hospital at 40 weeks 5 days for delivery at term. She was discharged by Dr. A with instructions to return for follow-up after a few days or upon the spontaneous onset of labor, with a plan for VBAC (Vaginal Birth After Cesarean). Notably, Dr. A is not a registered Obstetrician.

The patient was readmitted at 41 weeks. Despite clinical findings suggestive of Cephalopelvic Disproportion (CPD), labor was induced with PGE2 gel under Dr. A's instructions. The labor was monitored by Drs. B, C, and D during rounds. Drs. A and B are MBBS graduates, while Drs. C and D are MBBS graduates and qualified Obstetricians. During rounds, Drs. C and D identified CPD and informed Dr. A, but Dr. A disregarded their concerns and ordered the augmentation of labor with Oxytocin. Epidural anesthesia was administered by an anesthetist.

While Dr. B was on duty, Oxytocin was escalated to 5 units/24 drops. When signs of obstructed labor emerged, Dr. B informed Dr. A, who advised continuing Oxytocin for another 2 hours. After 2 hours, signs of scar dehiscence, uterine rupture, and fetal distress were recorded. A decision was made to proceed with an LSCS, but there was a significant delay in its execution. After approximately 40 minutes, LSCS was still not performed, and the patient began to experience giddiness, difficulty breathing, and signs of shock.

Ultimately, the patient suffered a uterine rupture and was taken for an emergency LSCS. Tragically, a stillborn baby weighing 4.06 kg was delivered. The patient had severe uterine rupture, bleeding, and adhesions, and despite efforts in the operating theater, she could not be stabilized and expired.

- **Decision of State Medical Council (SMC):** The observations of the State Medical Council (SMC) were as follows:

1. The primary risk factors were the patient's history of a previous LSCS, a pregnancy that was postdated by 9 days, and the presence of cephalopelvic disproportion (CPD). VBAC should not have been attempted in this postdated pregnancy, given the twofold increase in the risk of LSCS scar rupture. Additionally, VBAC was initiated without confirming the indication for the previous LSCS.
2. Vaginal birth should have only been initiated after obtaining comprehensive consent, including for Cesarean Section, as VBAC failure or complications would necessitate an immediate Cesarean Section as the only viable treatment option.
3. The induction of labor was poorly monitored, and appropriate responses to emerging signs of distress were not made. As a result, the patient experienced uterine rupture and subsequently died due to the failure to adhere to standard care and treatment guidelines. The specialist who attended to this patient should have decided on a Cesarean Section much earlier, given the evident risks.

Based on these observations, the SMC concluded that there was negligence on the part of Drs. A, B, C, and D: Dr. A's name was removed from the medical register for 3 months, and a fine of Rs

10,000 was imposed for falsely displaying an unregistered Member of the Royal College of Obstetricians and Gynaecologists (MRCOG) membership, in violation of the code of medical ethics. Dr. B was fined Rs 10,000 for posing as an obstetrician. Dr. C's name was removed from the medical register for 3 months. Dr. D's name was removed from the medical register for 6 months.

- **Decision of Ethics and Medical Registration Board (EMRB), NMC:** The doctors approached the Ethics and Medical Registration Board (EMRB) and appealed against the decision of the State Medical Council (SMC). After hearing submissions from all concerned parties, including the appellant doctors, and after reviewing all available records and expert opinions, the EMRB made the following observations:

1. The patient had a history of a previous Cesarean section, was known to have hypothyroidism, and was carrying a postdate pregnancy with a baby weighing 4.06 kg. Additionally, the presenting part of the baby (head/vertex/cephalic) was noted to be above the pelvic brim during several pelvic examinations, suggesting cephalopelvic disproportion (CPD). Given these conditions, VBAC (Vaginal Birth After Cesarean) should have been avoided.
2. There was a clear failure to recognize signs of scar dehiscence and uterine rupture in this case, leading to maternal and neonatal mortality. The doctors who made the decisions to proceed with VBAC and induction of labor (Dr. A) and who performed the Cesarean section (Dr. B) held only MBBS degrees, as noted in the SMC order. They were therefore not qualified to manage such a high-risk patient.

3. A prudent obstetrician would not have discharged the patient near the expected date of delivery (EDD) and would not have waited for the spontaneous onset of labor well beyond the EDD if labor was to be induced for VBAC. The last ultrasound was performed at 38 weeks, and labor was induced almost three weeks later. A prudent obstetrician would have considered performing an ultrasound before induction to assess fetal well-being and the quantity of amniotic fluid.

In view of these observations, the EMRB of the National Medical Commission (NMC) made the following decisions: The SMC was directed to remove the names of Dr. A and Dr. B from the State Medical Register for a period of one year. Dr. C and Dr. D were issued warnings to exercise greater care in the future.

- **Discussion**:

In the present case, although consent was obtained for VBAC (Vaginal Birth After Cesarean) following a previous LSCS, the consent did not adequately inform the patient of the potential for VBAC failure and the subsequent need for an emergency LSCS. Furthermore, consent for the induction and augmentation of labor was not obtained. This case was complicated by post-term pregnancy and cephalopelvic disproportion (CPD), both of which are indications for elective LSCS, as VBAC carries uncertain safety in pregnancies complicated by post-term conditions. Expert opinion suggests that VBAC and induction should not have been attempted in this scenario.

There was also misrepresentation of qualifications: Both Dr. A and Dr. B were practicing as obstetricians without the appropriate qualifications, which is unethical. The decision to attempt induction and proceed with VBAC was made by Dr. A, who was not a registered or trained obstetrician, holding only an MBBS degree. Similarly, Dr. B, who performed the Cesarean section, also held only an MBBS degree and was not a specialist in Obstetrics and Gynecology. In such complicated and high-risk cases, especially in urban areas where qualified obstetricians are available, these patients should have been referred to a specialist. In the present case Dr C and Dr D, had advised about the CPD and also to consider the alternative management plan of LSCS.

LSCS should have been performed much earlier when signs of scar dehiscence or uterine rupture were evident, such as fetal heart rate bradycardia, documented at around 80-90 beats per minute nearly two hours before the LSCS was eventually undertaken. By the time the LSCS was performed, it was too late, as the patient was already in shock due to significant blood loss. Additionally, there is no record of a blood transfusion being administered

- **Take home messages:**

1. The Bolam test, derived from the case **Bolam v Friern Hospital Management Committee (1957)**, is a legal standard used to assess medical negligence. The decision to attempt VBAC, failure to recognize and appropriately respond to signs of scar dehiscence and impending uterine rupture and further, a significant delay in performing the emergency LSCS after signs of fetal distress and

uterine rupture clearly indicates that these conditions does not meet the Bolam standard, as most responsible obstetricians would not consider this practice acceptable.

2. **FOGSI Good Clinical Practice Guidelines – 2024** (Birth After Cesarean Section) clearly indicates that the management of any high risk and complicated case should be done under supervision of a Qualified specialist. All mothers with previous cesarean section must be counseled in the antenatal period on the risks and benefits of both TOLAC/VBAC and Emergency Cesarean Section after review of previous records and assessment of integrity of scar. Trial of Labor after Cesarean (TOLAC) is contraindicated in women with previous upper segment classical cesarean section, complex cesarean scars (inverted T-shaped or J-shaped scars), previous history of rupture uterus, history of myomectomy with entry into the uterine cavity and in the presence of any other contraindication to vaginal birth such as placenta previa and cephalopelvic disproportion. There should be careful and continuous monitoring of the labor to ensure prompt identification of maternal or fetal compromise, labor dystocia, or uterine scar rupture. Any deterioration should call for immediate emergency cesarean section.

3. Violation of Code of Ethics: According to Clause 7.20 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, a physician shall not claim to be a specialist unless he or she has the appropriate qualifications in that branch. In this case, Dr. A and Dr. B were practicing as obstetricians without the necessary specialist qualifications, which constitutes unethical practice. Due to their lack of expertise, they were unable to fully

appreciate the complex nature of the case, ultimately leading to negligence. This violation not only breaches ethical standards but also contributed to the tragic outcome for both the mother and the baby.

4. Apex Court in **Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole & Anr (1969)**., laid down that a Doctor when consulted by a patient owes him certain duties, namely,

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

(b) a duty of care in deciding what treatment to give; and

(c) a duty of care in the administration of that treatment.

A breach of any of these duties gives a cause of action for negligence to the patient.

Further, apex court has emphasised that a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. Hence, a doctor's duty of care includes the responsibility to self-assess their competence and skills before accepting a case. Recognizing one's limitations and referring patients when necessary is crucial to providing safe and effective care, ensuring adherence to ethical and legal standards in the medical profession.

References:

1. Bolam vs Friern Hospital Management Committee (1957) 1 WLR 582.

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   https://upload.indiacode.nic.in/showfile?actid=AC_CEN_12_13_00007_1956102_1517807321142&type=regulation&filename=10.Ethics%20Regulations-2002.pdf

4. Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole & Anr. AIR 1969 SC 128,

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CASE 10

Vicarious Liability in Healthcare: The Consequences of Unqualified Practitioners on Patient Safety

- **Keywords:** Medical Termination of Pregnancy, Dilatation and curettage, Unqualified practitioner.
- **Context:** Patient care.
- **Abstract:**

A 30-year-old female patient, after undergoing a medical abortion that resulted in an incomplete abortion, was referred to a private hospital for ultrasonography (USG). The USG revealed retained products of conception (RPOC), and the patient was advised to undergo dilatation and curettage (D&C). She was admitted to the same hospital for the procedure. Although the hospital was managed by a qualified physician, the attending gynecologist was unavailable that day and sent a colleague to perform the D&C. The procedure was completed by this colleague, and the patient was discharged the same day.

The following day, the patient began experiencing vomiting and severe, recurrent vaginal bleeding. She was referred by the primary hospital to another private hospital, where a subsequent USG revealed perforations in the uterus and bowel loops. Due to financial constraints, she was further referred to a government tertiary care center for comprehensive management. The patient has since filed a

complaint, alleging negligence by the private hospital where the initial D&C was performed, with the police and the State Medical Council.

- **Case Summary:**

A 30-year-old female patient took medication for a medical abortion, which resulted in an incomplete abortion. Despite the procedure, she continued to experience persistent vaginal bleeding and was subsequently referred for ultrasonography (USG). The USG, conducted at a private hospital, revealed retained products of conception (RPOC). She was advised to undergo dilatation and curettage (D&C) and was admitted to the same hospital for the procedure. The hospital, managed by a qualified physician Dr. X, employed a gynecologist and anesthetist on a part-time basis. On the day of the scheduled D&C, the gynecologist was unavailable and sent a colleague to perform the procedure. The D&C was conducted by this colleague, and the patient, who was stable at the time, was discharged the same day.

The following day, the patient began experiencing vomiting and severe, recurrent vaginal bleeding. She contacted the hospital by phone and was advised to return the next day. Upon her visit the next day, in a deteriorated condition, she was referred to another private hospital where a subsequent USG revealed perforations in the uterus and bowel loops. Due to financial constraints, she was referred to a government tertiary care center for further treatment and remained hospitalized for one month, undergoing various procedures.

The patient filed complaints with the police and the State Medical Council, alleging negligence by the private hospital where the initial D&C was performed. An inquiry revealed that the individual who performed the procedure was not a qualified medical professional and was posing as a doctor with a fraudulent degree (MBBS (ASM)). The hospital had allowed this individual to perform the procedure without verifying their credentials.

- **Decision of State Medical Council (SMC):** After considering the arguments from both parties, the State Medical Council concluded that the extensive morbidity experienced by the patient was a direct result of the procedure performed by an unqualified individual. This was classified as criminal negligence, and the unqualified person responsible was found liable for punishment under various provisions of the Indian Penal Code (IPC) and Section 27 of the State Medical Council Act, 1997. Additionally, the Dr. X, who owned the private hospital was found guilty based on her vicarious responsibility. It was recommended that her name be removed from the State Medical Register for 15 days, as she failed to verify the credentials of the person performing the procedure. Furthermore, a warning was issued to both the gynecologist who sent the unqualified practitioner and the anesthetist involved in the D&C procedure.
- **Decision of Ethics and Medical Registration Board (EMRB), NMC:** Dr. X, the owner of the hospital, appealed the decision of the State Medical Council (SMC) to the Ethics and Medical Registration Board (EMRB). After thoroughly reviewing her submissions,

examining all the medical records, and consulting parallel expert opinions, the EMRB decided to uphold the SMC's decision.

- **Discussion:**

In this case, the procedure was performed by an unqualified individual, resulting in uterine perforation and bowel injury. The hospital's owner failed to verify the credentials of the person performing the surgery, which is a significant administrative lapse that endangered the patient's life. Further, this is a serious offence under the Medical Termination of Pregnancy Act, 1971 (Amended 2021). The Sec 5 of the MTP Act, 2021 clearly states that the termination of pregnancy done by a person who is not a registered medical practitioner shall be an offence punishable with rigorous imprisonment for a term which shall not be less than two years but which may extend to seven years. This calls for serious criminal charges and the people associated with them can also be considered abetting the offence under MTP Act, 2021.

The qualified doctors involved were found guilty of associating with an unqualified person in violation of Regulation 1.6 of the Indian Medical Council (Professional Conduct, Etiquette & Ethics) Regulations, 2002. Which is "Highest Quality Assurance in patient care" - Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education. Physician shall not employ or allow unqualified person to attend, treat or perform operations upon patients. Further the code - 7.9 Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical,

surgical or psychological indication. Additionally, the consent obtained for the D&C procedure and anesthesia had several deficiencies. The consent form did not adequately detail the potential complications associated with the procedure, the type of anesthesia to be used, or the names of the surgeon and anesthetist. Furthermore, the document was not countersigned by any doctor, further indicating a lack of proper procedural protocol.

- **Take home messages:**

  Criminal Offence: This case highlights the severe legal consequences for violating the provisions of the MTP Act, 1971 (Amended 2021), and underscores the importance of ensuring that only qualified and registered medical practitioners perform medical procedures, especially those related to pregnancy termination. The legal charges could result in significant penalties, including imprisonment, fines, and professional sanctions. The hospital owner, who allowed an unqualified person to perform the D&C without verifying their credentials, could be charged with abetment of the illegal act.

  Civil Medical Negligence: The Apex court in Poonam Verma vs Ashwin Patel (1996) Practicing allopathy without being qualified in that system constitutes negligence per se, aligning with the legal maxim - Sic utere tuo ut alienum non laedas (a person is held liable at law for the consequences of his negligence)

  Credential Verification: Always ensure that any procedure, especially surgical ones like D&C, is performed by a qualified and

appropriately credentialed medical professional. Failure to do so can lead to severe complications and legal consequences. The physician must not allow any unqualified individuals to attend, treat, or perform any operations on patients. Adherence to ethical guidelines, such as those outlined in the Indian Medical Council Regulations or NMC Regulations, is essential to maintaining professional integrity and patient safety.

Vicarious Liability: The Apex Court, in **Smt. Savita Garg vs The Director, National Heart Institute (2004)**, clearly established that hospitals, as institutions, are expected to provide efficient and effective services. If a hospital fails to fulfill its duties through its doctors, whether they are employed on a job basis or on a contract basis, the hospital itself must be held accountable. The responsibility cannot be evaded by failing to implicate a specific doctor. Similarly, in **Maharaja Agrasen Hospital vs Master Rishabh Sharma (2019)**, the Apex Court reaffirmed that a hospital is vicariously liable for acts of (tort) negligence committed by the doctors engaged or empanelled to provide medical care. It is commonly understood that when a patient seeks treatment at a hospital, they do so based on the hospital's reputation, trusting that the hospital authorities will exercise due and proper care.

It is important to discuss cross-system practice, even though it is not directly relevant to the present case. The Supreme Court has cautioned that cross-system practice can be considered a form of medical negligence. However, it is permitted only in states where the

concerned governments have authorized it through a general or special order **(Math et al., 2015)**.

Furthermore, the Court has ruled that employing traditional medical practitioners who lack the necessary skills and competence to provide allopathic treatment in hospitals, and allowing them to treat emergency patients, constitutes gross negligence **(Poonam Verma vs. Ashwin Patel, 1996)**. In the event of an adverse outcome, the hospital authorities bear full responsibility **(Math et al., 2015)**. It is also noteworthy that the Medical Council of India (MCI) code of conduct ethics does not endorse such practices.

Informed Consent: The Apex Court, in **Samira Kohli v. Prabha Manchanda (2008)**, emphasized that performing surgery without obtaining "Real consent" constitutes an unauthorized invasion and interference with the patient's body. This act is considered a tortious offense of assault and battery, thereby amounting to a deficiency in service. This documentation should be thorough and properly signed by all relevant parties.

References:

1. The Medical Termination of Pregnancy Act, 1971 (Amended 2021)
2. Smt. Savita Garg vs The Director, National Heart Institute 2004 (8) SCC 56
3. Maharaja Agrasen Hospital vs Master Rishabh Sharma AIRONLINE 2019 SC 1757
4. Math SB, Moirangthem S, Kumar NC, Nirmala MC. Ethical and legal issues in cross-system practice in India: Past, present and future. Natl Med J India. 2015 Nov 1;28:295-9

5. Poonam Verma vs Ashwin Patel & Ors 1996 AIR 2111
6. Samira Kohli v Prabha Manchanda 2008 Air Sc 855

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Ethics & Medical Registration Board

Regulate professional conduct and promote medical ethics in accordance with the regulations made under NMC Act 2019:

- *Provided that the Ethics and Medical Registration Board shall ensure compliance of the code of professional and ethical conduct through the State Medical Council in a case where such State Medical Council has been conferred power to take disciplinary actions in respect of professional or ethical misconduct by medical practitioners under respective State Acts;*
- *Develop mechanisms to have continuous interaction with State Medical Councils to effectively promote and regulate the conduct of medical practitioners and professionals*

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