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MEDICOLEGAL

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THE NATIONAL MAGAZINE



BEING LEGALLY AWARE IS ESSENTIAL
for safeguarding your medical practice and your future

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EDITOR MESSAGE

Mr. Jayawant Hirugade
MA Bachelor of Journalism



Dear Readers,

It gives me immense pleasure and pride to present to you the inaugural issue of "Medicolegal India Insights." This magazine aims to create awareness among doctors about growing medicolegal challenges in medical practice and provide practical guidance on safeguarding themselves while caring for patients.

In the modern era, doctors are not only caregivers but also professionals working within a complex legal and ethical framework. With the evolution of healthcare systems, rising patient awareness, stricter laws, and the rapid influence of social media, the medicolegal dimension of medical practice has become more significant than ever before. It is now essential for every doctor to pay equal attention to documentation, informed consent, communication, and legal preparedness along with clinical excellence.

Even the most sincere and dedicated doctors may, at times, face allegations of medical negligence or breach of duty – not because of intent, but due to procedural lapses or lack of proper documentation. In such situations, accurate medicolegal knowledge and timely precautionary measures can make all the difference. Through this magazine, we aim to guide our doctors with insightful articles, expert opinions, real case studies, and practical preventive strategies.

Our company, Rapid Medicolegal Services India Ltd., has been working in the medicolegal field for 10 years, providing legal protection and advisory support to doctors across India. Through this magazine, we'll share insightful articles, expert opinions, case studies, and preventive strategies to guide doctors.

Our mission is "To empower every doctor with medicolegal awareness, preparedness, and protection." We envision a healthcare ecosystem that's safer, transparent, and legally sound. Let's make medical practice a profession of confidence and compliance.

Medicolegal India Insights will serve as a valuable source of legal updates, expert perspectives, and preventive guidelines to strengthen the medical fraternity.



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Diwali



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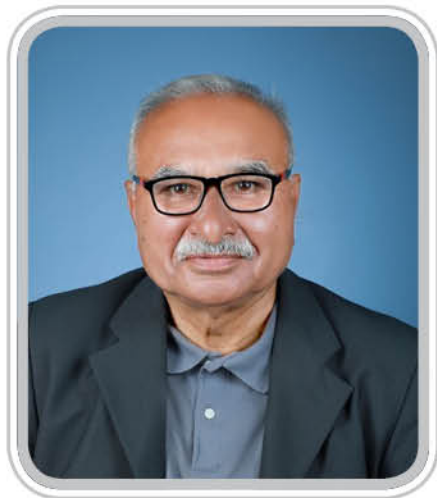
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A BRIDGE OF HUMANITY THROUGH HEALING

A name that has left a deep mark in the fields of medicine, law, and social service — Dr. Satish Patil. For over five decades, he has served humanity as a distinguished surgeon, giving new life to thousands of patients. Alongside his medical excellence, he pursued LLB and LLM, dedicating his work to medical law and doctors' rights. For the last 35 years, he has been tirelessly working for child rights and the welfare of underprivileged children. He has played a key role in the implementation of the Child Rights Charter and the Juvenile Justice Act.



Dr. Satish Patil

Surgeon, Medicolegal
Expert, and Social Worker



Surgery is not just a medical procedure, it is the purest expression of humanity.



In Conversation:

"Life is Service, Learning, and Humanity"

Question: Dr. Patil, could you tell us about your family and educational background?

Answer: I was born in April 1952 in a small village called Mhaisal in Sangli district. My family's financial condition was modest — my father worked in agriculture.

I completed my primary education at Vidyamandir Z.P. School, Rukdi, and secondary education at Inter Bharati Vidyalaya, Shahupuri, Kolhapur.

Later, I studied at Ferguson College and N. Wadia College, Pune, and earned my MBBS and MS (Surgery) from Dr. V.M. Medical College, Solapur.

I also completed LLB and LLM from

Shahaji Law College, Kolhapur, a Diploma in Hospital Management, and pursued Jurisidm and Communication from Shivaji University.

My educational journey was entirely shaped across Sangli, Kolhapur, and Pune.

Question: How has your journey in the medical field been so far?

Answer: I have worked in some of Mumbai's most prestigious hospitals — KEM, Sion, Cooper, Bombay, Jaslok, and Hinduja — for nearly ten years.

I also served as Resident Surgeon and Junior Consultant at Breach Candy Hospital.

Surgery, in my view, is a team effort — every member matters, from anesthetists to nurses and technicians. If even one person is missing, surgery cannot proceed.

Question: Why did you choose the medical profession?

Answer: Back then, very few students from villages pursued higher education. The brightest ones often chose medicine or engineering.

Although my father was a farmer, my natural inclination towards science and my curiosity pushed me toward medicine.

Question: What has your experience been like over the years?

Answer: Working in large hospitals gave me invaluable exposure. Over time, I realized that surgery isn't just about skill — it demands patience, empathy, and a deep sense of humanity.

The true reward comes when a patient

smiles after recovery — that smile is the greatest satisfaction a doctor can receive.

Question: What are your thoughts on new technologies like robotic surgery?

Answer: We must welcome science and technology.

Robotic and laparoscopic surgeries have improved precision, but they are often too expensive for the poor.

Such technologies benefit mainly the rich. If these treatments could be made affordable, I would wholeheartedly support their use.

Question: You often emphasize rural healthcare. Could you tell us more about that?

Answer: Rural areas lack the infrastructure available in cities, so doctors there must often make quick, practical decisions.

I call this "rural-based surgery" — performing operations with limited resources while keeping patient welfare at the center.

Through our trust, we run a small hospital near Lonavala and provide free healthcare to about 30 villages using three mobile medical vans.

Question: What's your view on medical research and innovation?

Answer: Research must always serve society's needs.

Rather than focusing only on high-cost technology, we should develop treatments that are accessible and affordable to the common man.

That's when medical science truly becomes humanitarian.

Question: There are increasing incidents of conflict between doctors and patients. What are your thoughts?

Answer: A patient approaches a doctor with hope, but not every illness can be cured.

Doctors must explain the illness, its risks, and the limits of treatment clearly from the beginning.

Transparency prevents conflict.

Even the Supreme Court has stated that an FIR cannot be filed against a doctor directly after a patient's death.

Each district has a medical committee, and unless negligence is proven, no arrest can be made.

Question: You have done significant work for the poor and underprivileged. Please tell us about it.

Answer: Many patients need surgery but can't afford it. In such cases, we always prioritize health over money.

We perform surgeries at affordable rates — and if necessary, free of cost.

Question: Your contribution to child rights has been remarkable. Could you share more about that?

Answer: Some children are orphans, while

others lack parental protection.

I've been working for such children for the past 35 years.

In 1989, UNESCO framed the Child Rights Charter, which India adopted in 1992.

Based on that, the Juvenile Justice Act came into effect in 2010.

I served as the Chairman of the Kolhapur Child Welfare Committee for around 18 years.

Our trust runs child care homes in Pune and Raigad, offering education, ITI and computer training, tailoring, and employment opportunities.

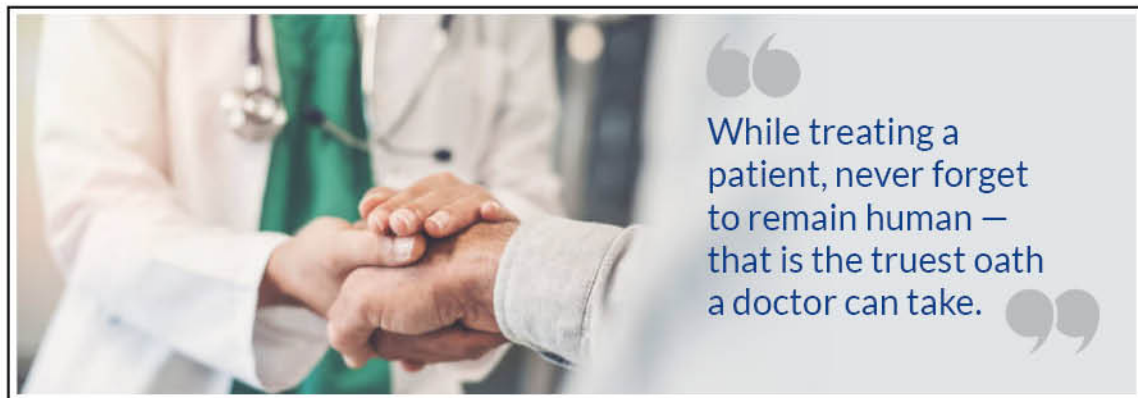
In the Lonavala region, we operate a 10–12-bed hospital and three mobile vans, providing free healthcare across 30 villages.

Question: How would you summarize your life's journey?

Answer: My life can be defined in three words — Service, Learning, and Humanity.

When a patient recovers, their smile is my true reward.

Being a doctor is not merely a profession — it's a responsibility and a commitment to uphold humanity.



While treating a patient, never forget to remain human — that is the truest oath a doctor can take.





CURRENT AND FUTURE CHALLENGES IN HEALTHCARE

A Medico-Legal and Technological Perspective

Healthcare in India stands at a pivotal juncture. Advances in medical technology, artificial intelligence (AI), and digital health are transforming the way care is delivered. However, alongside these advances, legal, ethical, and social responsibilities have grown significantly. Doctors, hospitals, and administrators must adapt to this evolving healthcare landscape.



Dr Anil Jayawant
MBBS

Key Current Challenges

► Aging Population and Lifestyle-Related Diseases

Chronic illnesses such as diabetes, obesity, cardiovascular diseases, and cancer are rising rapidly. Managing these conditions requires ongoing care, follow-ups, medication

supervision, and psychological support. Continuous documentation, effective communication, and detailed record-keeping are essential for quality care.

► Cost vs. Technology -

While advanced technology improves diagnostic and treatment precision, it

often comes with high costs that may be challenging for patients. This gap between expectations and financial capacity can lead to complaints, dissatisfaction, or legal disputes. Transparent billing, clear explanations, and written consent are crucial at every stage of treatment.

- ▶ **Doctor–Patient Communication Gap**
Over-reliance on technology has reduced direct human interaction. Patients may be influenced by “Google Doctor” information, which can differ from professional medical advice. Building trust through clear communication and patient education remains the most effective safeguard.
- ▶ **Administrative and Legal Responsibilities -**
Hospitals now face strict compliance requirements under biomedical waste regulations, the Clinical Establishments Act, TPA audits, data privacy laws, and more. “Documented evidence is protection” – this principle is more relevant than ever.

Technological Transformations in Healthcare

1. **Artificial Intelligence (AI) and Machine Learning:** - AI assists in diagnosis, reporting, and decision support. However, the question of “Who makes the final decision?” has legal significance. Proper documentation and disclaimers are essential when using AI.
2. **Robotic Surgery and 3D Printing:** - Surgical precision has improved, but patient consent must explicitly mention robotic assistance. Higher costs also increase the risk of disputes.

3. **Digital Health IDs and Electronic Health Records (EHRs):** - Access to health data has become easier, but data breaches or misuse can have serious consequences. Patient consent and cybersecurity compliance are shared responsibilities of doctors and institutions.
4. **Telemedicine:** Teleconsultations provide healthcare access to remote areas but carry risks such as incorrect advice, incomplete information, or prescription errors. Adhering to the 2020 Telemedicine Guidelines is mandatory.

Future of Healthcare – What and How It Will Change

1. **AI and Data-Driven Decision Systems:-**
Doctors must retain the role of the “final clinical decision-maker”; machines serve only as assistants, not decision-makers.
 2. **Home-Based and Short-Stay Hospital Models:-** Hospital stays will shorten, increasing the need for robust follow-ups and accountability.
 3. **Integration of AYUSH, Yoga, and Holistic Health:-** Alternative and complementary treatments will gain recognition, emphasizing coordinated care and interdisciplinary collaboration.
 4. **Centralized Emergency Management Systems:-** The COVID-19 experience highlighted the need for efficient bed management and ambulance coordination as a public health priority.
- ▶ **Medico-Legal Awareness: Key Considerations for Doctors**
 - ✓ Clearly outline technology, costs, and

potential risks in informed consent.

- ✓ Maintain secure digital records of all diagnoses, treatments, and clinical decisions.
- ✓ Implement password-protected access and privacy measures for patient data.
- ✓ Ensure transparent billing and open communication, as financial disputes are a leading cause of complaints.
- ✓ Follow clinical guidelines meticulously, as adherence provides the strongest legal defense.
- ✓ Future malpractice cases may include issues related to data misuse, AI errors, or incorrect telemedicine advice.

► Professional Balance and Self-Care for Doctors

- ✓ Doctors are not only caregivers but also decision-makers, mentors, and socially responsible professionals.

- ✓ Continuously update knowledge through CME programs and acquire digital skills.
- ✓ Develop communication and empathy to strengthen patient trust.
- ✓ Prioritize personal health to prevent stress and burnout.
- ✓ Leverage technology while maintaining a human touch in patient care.

Conclusion:

In the coming decade, healthcare will be technology-driven, data-centric, and legally regulated. Doctors must prioritize ethical transparency, effective communication, and meticulous documentation alongside delivering excellent medical care. While the future promises “smart healthcare,” its core will remain humanity, ethics, and the informed judgment of the physician.





BHARTIYA SAKSHA ADHINIYAM, 2023

(Indian Evidence Act)

CHALLENGES SIMPLICITY



Adv. Pranav S. Rampure

Practicing in Kolhapur and District Court, Kolhapur and High Court of Bombay Circuit Bench at Kolhapur.

“We, the People of India” these are the words that bring relief and pride to every citizen of India, as they mark the beginning of the Preamble to our Constitution. The Constitution guarantees each citizen the right to raise their voice against any law or act that infringes upon their rights. However, true relief comes only through the hands of the Judiciary. Therefore, every citizen seeking justice must possess at least a basic awareness of the laws that govern them.

The Indian Evidence Act is one of the fundamental pillars of the judicial system. Although it is less read or discussed by the general public, its application is deeply rooted in almost every aspect of the legal profession and everyday life. Often, we unknowingly apply its principles

in our daily transactions.

For instance, when you purchase groceries and receive a receipt, that receipt serves as **documentary evidence** under the Evidence Act. If you verbally tell the shopkeeper your grocery list, it constitutes **oral evidence**, while any customer who

witnesses the transaction becomes an eye-witness. Thus, in our daily activities, we constantly make use of the provisions of the Evidence Act without even realizing it. Now, if you have no receipt to prove payment, your case automatically becomes weak — all because of the absence of **documentary evidence**. This example itself demonstrates the vital role of evidence in law.

In my legal practice, I have often seen people approach me with cases that lack any kind of evidence. Such cases become challenging, as without proper evidence, obtaining relief from the judiciary is nearly impossible. Therefore, everyone must make it a habit to preserve evidence — written, electronic, or otherwise — in every transaction.

In 2023, the historic **Indian Evidence Act, 1872** was replaced and renamed as the **Bhartiya Saksha Adhiniyam, 2023**, coming into force on **1st July 2023**. This change was part of a broader legal reform, along with the introduction of **Bhartiya Nyaya Sanhita, 2023** and **Bhartiya Nagarik Suraksha Sanhita, 2023**. When these laws were enacted, there was a nationwide eagerness to study and understand them — especially the **Bhartiya Saksha Adhiniyam**, as it forms the foundation of the entire judicial process.

The **Bhartiya Saksha Adhiniyam, 2023** consists of **170 sections**, divided into **4 parts** and **12 chapters**. The key reforms focus on modernizing the law — notably, expanding the definition of “documents” to include **electronic records** such as data from smartphones, laptops, and other digital devices. The Act also incorporates **provisions for digital signatures** and removes outdated terminology, making it more relevant to the digital era.

This modernization does not create new challenges for citizens; rather, it simplifies

the process of proving facts and presenting evidence. For example, in the earlier grocery shop illustration, if a **CCTV camera** captures your purchase, that footage now qualifies as **electronic evidence** under the new Act. This reflects the **simplicity and practicality** of the reformed law.

Some Personal Advice (Especially for Medical Professionals)

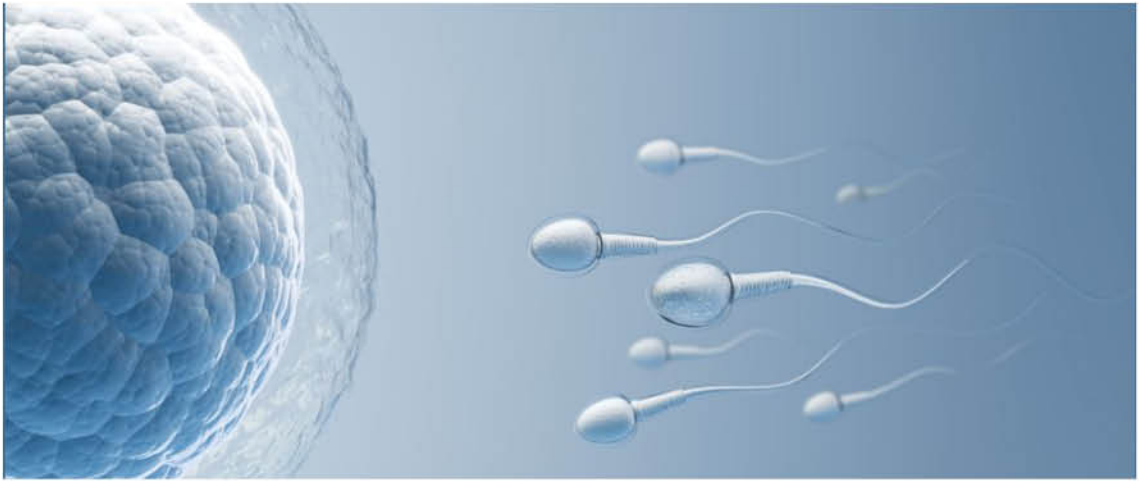
As per the provisions of the Evidence Act, maintaining proper records and documentation is crucial. Here are a few suggestions based on my experience:

- Always keep updated and accurate treatment records and related documents.
- Senior doctors should routinely verify treatment sheets prepared by their staff or junior doctors.
- While admitting any patient, obtain and preserve their Aadhaar card and other identification documents for verification.
- In case a patient absconds without clearing hospital bills, do not panic — file an online or offline complaint with the nearest police station.
- Ensure all hospital licenses and certificates are renewed on time.

These are simple yet essential practices that prevent complications and strengthen your legal position if any dispute arises. These suggestions are based on real issues observed in cases involving medical professionals.

Last Words

“The life of a human being depends on his heart; likewise, the life of your case depends on your evidence. If the heart fails, the human dies. If the evidence fails, the case dies.” 



Integrative Insights into **OLIGOSPERMIA**

A Clinical Exploration Through Ayurvedic and Modern Paradigms

Oligospermia, characterized by a reduced sperm count in semen, is a major contributor to male infertility, affecting nearly 15% of couples worldwide. Contemporary diagnostic advancements have improved the detection and classification of oligospermia, yet long-term management remains a challenge due to multifactorial etiologies.

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Ph.D. (Scholar)

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Ayurveda, the ancient science of life, addresses such conditions through the lens of Shukrakshaya (depletion of reproductive essence), providing a deep-rooted understanding of physiological, psychological, and environmental contributors. This article explores oligospermia through both modern and Ayurvedic perspectives, offering a comprehensive insight into its causation, clinical presentation, and therapeutic protocols.

Introduction

Infertility is defined as the inability to conceive after one year of unprotected intercourse. Male factors account for approximately 40–50% of all infertility cases, with oligospermia being among the most prevalent issues. According to the World Health Organization (WHO), oligospermia is defined as a sperm concentration of less than 15 million spermatozoa per milliliter of semen.

From a medical standpoint, the focus lies on identifying physiological dysfunctions, hormonal imbalances, or structural defects. In contrast, Ayurveda considers Shukra Dhatu (the reproductive tissue) as the culmination of a well-nourished metabolic process that starts from Rasa (plasma) and culminates in Shukra through a sequential transformation of tissues (Dhatu Parinam). A disruption at any level — be it digestive fire (Agni), doshic balance, or psychological stability — can impair the generation of quality reproductive tissue.

Understanding Oligospermia in Modern Medicine

1 Etiology

Oligospermia is a complex, multifactorial condition. Causes are broadly categorized into:

- **Pre-testicular causes:** Endocrine disorders (hypogonadotropic hypogonadism), hypothalamic or pituitary dysfunctions
- **Testicular causes:** Genetic abnormalities (Klinefelter's syndrome), varicocele, orchitis, testicular trauma
- **Post-testicular causes:** Obstruction of the vas deferens, ejaculatory duct obstruction
- **Lifestyle factors:** Smoking, alcohol, stress, sedentary habits, exposure to toxins, prolonged heat exposure (e.g., laptops on lap, saunas)
- **Environmental factors :** Pesticides, radiation, endocrine disruptors
- **Nutritional deficiencies :** Zinc, selenium, folate, Vitamin E and C

2 Diagnostic Modalities

- Semen analysis (volume, concentration, motility, morphology)
- Hormonal assays (testosterone, LH, FSH, prolactin)

- Scrotal Doppler ultrasonography
- Genetic testing (Y-chromosome microdeletion, CFTR mutations)
- DNA fragmentation index (DFI) to assess sperm integrity
- Testicular biopsy, in certain cases

3 Treatment Modalities

- **Pharmacological :** Hormonal therapy (e.g., gonadotropins, SERMs), antioxidants (CoQ10, L-carnitine, astaxanthin), anti-inflammatories
- **Surgical:** Varicocelelectomy, correction of obstructive lesions
- **Assisted reproductive technologies (ART):** Intrauterine insemination (IUI), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI)
- **Lifestyle interventions:** Weight management, abstinence moderation, stress reduction, cessation of smoking and alcohol

While these approaches may address immediate causes, they often do not offer holistic or long-term healing, especially in idiopathic oligospermia cases.

Ayurvedic Understanding of Oligospermia

Ayurveda regards fertility as a natural outcome of balance — in doshas, dhatus, malas, and manas. Shukra Dhatu, responsible for reproduction, is the most refined and delicate tissue in the body. It is formed through the prolonged transformation of the six preceding dhatus (Rasa to Majja). Any imbalance in Agni (digestive and tissue-level), doshas (especially Vata and Pitta), or improper lifestyle choices can lead to depletion (Kshaya) or vitiation (Dushti) of Shukra.

1 Conceptual Framework

- **Shukrakshaya** – Diminished quantity and quality of semen
- **Shukradushti** – Vitiation of reproductive

tissue due to doshic imbalances

- **Shukravaha Srotodushti** – Obstruction or dysfunction in the reproductive channels

2 Nidana (Causative Factors)

- Excessive sexual activity, night awakenings, physical exhaustion
- Suppression of natural urges (e.g., Vega Dharana)
- Consumption of incompatible foods (Viruddha Ahara) – e.g., milk with salty or sour foods
- Overuse of dry, spicy, fermented, or stale foods
- Emotional stress, anxiety, and depression
- Exposure to excessive heat and toxins

3 Lakshana (Symptoms)

- Reduced semen volume or ejaculation
- Thin, watery consistency of semen
- Loss of libido or sexual satisfaction
- General debility, fatigue, mental dullness
- Associated Vata disorders (e.g., insomnia, dry skin, constipation)

4 Chikitsa Sutra (Therapeutic Guidelines)

The treatment of oligospermia in Ayurveda aims to restore Agni, balance Doshas, nourish Shukra Dhatu, and detoxify Srotas. Management is done in a phased approach:

Ayurvedic Therapeutic Approach

A. Shodhana (Purification Therapies)

Before administration of Rasayana or Vajikarana drugs, detoxification is advised to eliminate accumulated doshas and improve receptivity.

- **Virechana (Purgation)**: Clears Pitta and toxins from the system
- **Basti (Medicated enemas)**: Especially effective in Vata-induced Shukrakshaya. Tikta Ksheera Basti or Yapan Basti are commonly used.

- **Nasya (Nasal administration)**: Useful in stress-related sexual dysfunctions

B. Shamana (Palliative Therapy)

Herbal and herbo-mineral medicines aimed at restoring doshic equilibrium and enhancing Shukra production:

- **Putranjivaka (Putrajiva roxburghii)**

A lesser-known but highly revered fertility-promoting herb in classical Ayurveda. Traditionally used in the form of Putranjivaka Churna or Ghrita, it is described as Putrajanana (progeny-promoting). It balances Vata and Pitta, supports healthy sperm production, and is particularly indicated in Shukrakshaya and stress-induced infertility. When combined with Shatavari or Ashwagandha, its efficacy is enhanced in oligospermic conditions.

- **Ashwagandha (Withania somnifera)**

A powerful adaptogen and Rasayana that enhances testosterone levels, reduces cortisol, and promotes spermatogenesis.

- **Shatavari (Asparagus racemosus)**

Balances Pitta, supports hormonal health, and nourishes reproductive tissues in both males and females.

- **Gokshura (Tribulus terrestris)**

A diuretic and urinary tract tonic; improves semen volume and sexual stamina by strengthening the genitourinary system.

- **Kapikacchu (Mucuna pruriens)**

Rich in L-DOPA, it boosts dopamine levels and enhances spermatogenesis, libido, and ejaculatory control.

- **Safed Musli (Chlorophytum borivilianum)**

A potent Vajikarana herb with aphrodisiac and nutritive properties, effective in improving sperm count and motility.

- **Vidarikanda (*Pueraria tuberosa*)**
Cooling and anabolic; helps in Shukra Dhatu formation and supports Ojas (vital essence) replenishment.

Formulations:

- Vrishya Vati, Chandraprabha Vati, Swarna Makshika Bhasma, Vrihani Gutika

C. Vajikarana Therapy (Aphrodisiac Treatment)

This is the specialty branch of Ayurveda focused on enhancing virility, potency, and reproductive capacity. Texts like Charaka Samhita dedicate entire chapters to Vajikarana.

- Objectives: Nourishment of Shukra, mental strength, sustained sexual stamina
- Often given post-detoxification to ensure maximum tissue absorption

D. Rasayana Therapy

- Rejuvenative therapies that revitalize the entire body, slow down aging, and strengthen immunity.
- Chyawanprash, Amalaki Rasayana, Shilajit, and medicated ghee preparations like Kalyanaka Ghrita are commonly used.

E. Ahara-Vihara (Diet & Lifestyle Guidelines)

- **Favor:** milk, ghee, fresh fruits (banana, dates, pomegranate), soaked almonds, rice, moong dal
- **Avoid:** fast food, reheated oil, alcohol, spicy and salty foods
- **Sleep hygiene:** sleeping by 10 PM; avoiding daytime sleep
- **Stress reduction:** Yoga, meditation, Pranayama (especially Nadi Shodhana and Bhramari)

- **Physical activity:** Moderate and regular, avoiding excess exertion

Clinical Outlook and Future Directions

Ayurveda offers a systems biology model to understand diseases like oligospermia, looking beyond laboratory values to assess tissue function, energy flow, and emotional health. Preliminary clinical trials and case studies suggest that Ayurvedic therapies not only improve sperm count and motility but also enhance mental well-being and hormonal regulation.

However, standardization of therapies, long-term randomized trials, and integrative protocols are essential for acceptance in global medical communities.

Conclusion

Oligospermia presents not just a physical ailment but a psychosocial challenge to the individual and couple. While modern medicine provides precise diagnosis and technologically advanced treatments, Ayurveda presents a nuanced, holistic strategy that addresses both visible and subtle contributors to male infertility.

An integrative, evidence-based approach that blends the strengths of both modern and traditional systems may offer a sustainable and person-centered pathway to managing oligospermia and enhancing reproductive health.



The author an Ayurvedic clinician and researcher with a focus on reproductive health, infertility, and women's wellness. He advocates for blending classical Ayurvedic wisdom with modern clinical practices to address contemporary health issues.

LEGAL RESPONSIBILITIES OF DOCTORS IN EMERGENCY CASES

“
DELAY
CAN COST
A LIFE... and
NEGLIGENCE
CAN COST
A CAREER.
”

An emergency situation is the most critical moment in medical practice. Every decision a doctor takes — or fails to take — can have life-or-death consequences, both medically and legally. In India, doctors have a moral, ethical, and legal duty to provide emergency medical assistance to any patient, irrespective of the patient's identity, ability to pay, or the hospital's registration status.



Legal Framework for Emergency Care

1. **Indian Penal Code (IPC) Section 304-A:**
A doctor may be held criminally liable if a patient dies due to negligence in treatment or delay in care.
2. **NMC (formerly MCI) Code of Ethics Regulation 2.4:**
No registered medical practitioner shall refuse to attend to a patient in an emergency, even if the case is outside their area of specialization or institutional setup.
3. **Supreme Court Judgment – Parmanand Katara vs Union of India (1989):**
The Supreme Court clearly stated that every doctor and hospital is duty-bound to give immediate first aid to any injured or emergency patient. Refusal to treat violates the Right to Life (Article 21) under the Indian Constitution.

Key Responsibilities of Doctors in Emergencies

1. **Provide Immediate Care:**
Start stabilization and primary treatment without waiting for formalities or consent delays.
2. **Do Not Refuse Treatment:**
Refusing to attend an emergency patient can amount to professional misconduct or even criminal negligence.
3. **Refer Properly:**
If the required facility is not available, issue a written referral note and ensure safe transfer to a better-equipped center.
4. **Maintain Accurate Documentation:**
Record every detail — time of arrival, vitals, examination findings, treatment given, and your medical reasoning.
5. **Obtain Consent:**
Whenever possible, take verbal or written consent from the patient's relatives, especially for any invasive procedure.
6. **Continue Basic Support:**
Even if referral is planned, ensure life-saving measures continue until safe transfer.

What Doctors Should Avoid

- ✓ Never refuse or delay treatment for reasons like “not my patient” or “police case.”
- ✓ Do not withhold care until payment or relatives arrive.
- ✓ Do not falsify or modify medical records after the event.
- ✓ Do not transfer unstable patients without proper stabilization or documentation.

Legal Protection Tips

- ✓ **Keep Detailed Records:**
Proper documentation is your strongest

legal defense.

- ✓ **Maintain Active Indemnity Insurance:**
Always ensure your professional indemnity policy is valid — it covers both financial and legal risks.
- ✓ **Communicate Effectively:**
Be calm, clear, and transparent with relatives. A good explanation can prevent escalation.
- ✓ **Teamwork Counts:**
Document care collectively with nurses and staff — shared accountability strengthens your defense in court.

Expert Insight Box



“Emergency duty is not optional — it’s a legal and ethical mandate. The law protects doctors who act promptly, sincerely, and transparently.”

Real-World Perspective

In most medico-legal cases, courts emphasize timely action and documentation over the outcome itself.

A doctor who acts promptly, records facts accurately, and demonstrates reasonable care is rarely held guilty of negligence.

Conclusion

In emergencies, a doctor is society’s first responder and final hope.

The law imposes duties but also provides protection — if you act in good faith and follow proper procedure.

“Save first. Explain later. Document always.”

**RAPID MEDICOLEGAL
SERVICES INDIA LTD**





PRESCRIPTION GUIDELINES

Every Doctor Should Follow

A prescription is not just a list of medicines—it is a professional communication between the doctor, patient, and pharmacist. Proper documentation ensures patient safety, adherence, and legal protection.



Dr Anil Jayawant
MBBS

1. Protect Patient Confidentiality -

Do not write examination findings, blood pressure, blood sugar, diagnosis, or other sensitive information on the prescription.

Maintaining confidentiality is also a legal safeguard.

Tip: Keep sensitive information only in the patient's medical records.

2. Prescription Format and Documentation

- ✓ Prefer computerized prescriptions wherever possible; user-friendly software is widely available.
- ✓ Avoid pharmacy-branded pads, as they may be seen as malpractice or promotion.
- ✓ Always retain a copy of the prescription in the patient's medical record.
- ✓ Whenever possible, use bilingual prescriptions (local language + English).

- ✓ Highlight special instructions (e.g., "Take in sitting position").
- ✓ Avoid vague instructions like "as required"; instead, specify minimum interval and maximum daily dose.

■ **Tip:** Clear guidance improves patient adherence.

4. Safety and Legal Precautions

- ✓ Instruct patients and pharmacists to show medicines if in doubt, reducing medication errors.
- ✓ For antibiotics, insist on dispensing the full course; note "Please provide the full course."
- ✓ If repeated dispensing is a concern, write: "Medicines to be supplied only once." Pharmacists can stamp prescriptions as "Supplied."
- ✓ Be extra careful with anti-diabetic, anticancer, and blood-thinning drugs.

5. Special Considerations for Patients

- ✓ **Children and elderly:** Avoid large tablets; prefer liquid formulations.
- ✓ **Bottle-fed babies:** Do not mix medicine with feeds.
- ✓ **Tablets/capsules:** Take in a sitting position with plenty of water.

- ✓ **Ointments/creams:** Do not dilute; discard leftovers.
- ✓ **Avoid painful injections** in children whenever possible.

6. Cost and Adherence

- ✓ Consider the cost, lifestyle, side effects, and ease of taking medicines.
- ✓ Inform family members or caretakers about the treatment plan.
- ✓ Offer generic medicine options to reduce cost without compromising treatment.

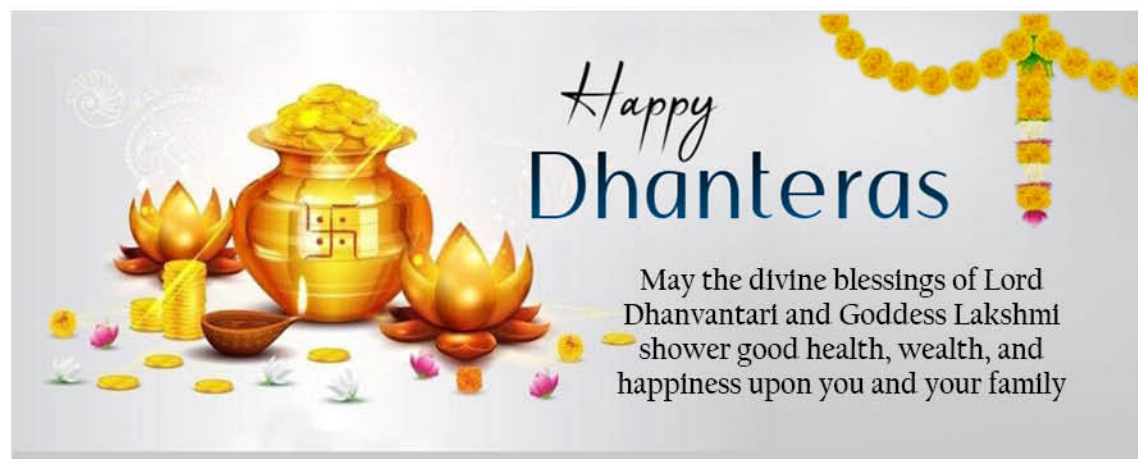
■ **Tip:** Clear instructions and cost-effective options improve adherence and outcomes.

7. Controlled or Scheduled Drugs

- ✓ Specify quantity supplied, frequency of purchase, and number of refills allowed.
- ✓ Pharmacists can use a "Supplied" stamp to prevent unauthorized reuse.

Summary

- A prescription should be accurate, clear, and safe.
- Proper documentation protects both patients and doctors legally.
- Remember: A well-written prescription = Safe patients + Trusted doctor.





MEDICO-LEGAL CASE STUDY

“The old method was still in use and there is nothing on record to prove such method was legally abandoned/ stopped” –
A reasonable standard of practice and not negligence holds National Commission

Manjulata Garg v/s Dr. R. C. Mishra & Ors.

National Consumer Disputes Redressal Commission, New Delhi

Judgment in favour of : Doctor

Facts of the case

1. The patient fell in the bathroom, had severe backache and consulted the neurosurgeon (OP1). She was immediately admitted to the hospital (OP3). X-ray and MRI were performed. The reports revealed severe osteoporosis and compression with fracture of the spine. The patient underwent surgery for trans-pedicular screw fixation between vertebrae and bone graft. Only 4 screws were fastened. After surgery, the patient remained hospitalized for a week and was discharged. She was taken home and within a few hours admitted to the ICU of the second hospital. On the very next day, the patient developed Hospital Acquired Respiratory Infection (HAI). The patient was later shifted to the third hospital and was re-operated successfully on the same vertebra and underwent bone cement augmentation.

- The patient became permanently disabled.
2. The patient filed a complaint before the consumer court. Unfortunately, she died during the pendency of the consumer complaint. A police complaint was also filed, and even a newspaper article was written alleging negligence.
3. The patient's attendants also filed a complaint before the State Medical Council and MCI. All the doctors (Ops) were exonerated, and a warning was issued to the neurosurgeon (OP1) “to maintain proper records and follow proper procedure”.

Patient's allegation/s of medical negligence

1. It was alleged that the surgery was performed without a second opinion and a pre- anaesthetic check-up. Further, the neurosurgeon (OP1) did not perform

repeat investigations to confirm the spine's compression site.

2. It was further alleged that the patient's bones were fragile, yet the neurosurgeon (OP1) did not bother to put the bone cement to fix the loose screws in position.
3. It was further pointed out that the surgery lasted for 3.5 hours which is unusually long.
4. It was alleged that the neurosurgeon (OP1) botched up the surgery by placing screws outside the pedicle into the lungs, which led to the development of pneumonia, but the neurosurgeon (OP1) tried to conceal this error.
5. It was also alleged that although the patient was critical, she was discharged forcefully from the hospital (OP3).

Doctor's defense

1. It was stated that the neurosurgeon (OP1) decided to perform trans-pedicular screw fixation based on the spine's position, and a D-Compressive laminectomy of the D11 lamina followed the screw fixation. It was further stated that the cement was not used to prevent possible cement embolism. It was pointed out that the patient's attendants were kept duly informed about the surgery and that suboptimal purchase of one screw at D10 was suspected.
2. It was further stated that the surgery lasted for 3.5 hours due to the obesity of the patient requiring repeated per-operative imaging on an image-intensifier.
3. It was stated that the surgery lasted for 3.5 hours due to the obesity of the patient requiring repeated per-operative imaging on an image-intensifier.
4. It was pointed out that during the postoperative period, the patient's attendant took DAMA and assured to take care of the patient at home under the guidance of another physician.
5. It was further pointed out that the patient's husband and son demanded Rs. 4,00,000 as compensation.
6. The patient's son was an anaesthetist; therefore, in good faith, the hospital (OP3) offered to reoperate the patient, but the patient was never brought back.

Findings of the Court

1. The court. After perusing medical records, found that the patient's attendants were informed about pre and post-surgery risks and the bone graft for stabilization of screws and healing and to avoid cement embolism.
2. The court further accepted the defence that "one screw-problem may be classified as 'mal-positioned' due to obesity and excessive fat, "which may have led to inadequate x-ray evaluation".
3. The court perused the medical records and observed that in view of the patient's osteoporosis, the neurosurgeon (OP1) rightly chose not to use bone cement to avoid cement embolism and instead used a bone graft for stabilization and healing. Furthermore, the court found from the medical literature that it was an age-old procedure of bone-strengthening; it was not legally abandoned or stopped and hence was an accepted method of treatment.
4. The court further observed that the patient's attendants took premature discharge, and after about 9 hours, they again got her admitted to the second hospital and drew an adverse inference against them.
5. The court perused the medical records of the second hospital where the patient was hospitalized post-discharge and found that the patient was seen by a colleague of the neurosurgeon (OP1) out of courtesy without charging fees till her discharge from the second hospital. The court appreciated this.
6. The court observed that the neurosurgeon

(OP1) not only followed the standard reasonable practice towards his professional colleague, the patient's son, an anaesthetist, and expressed surprise that he had raised such "frivolous allegation that pre-anaesthetic check-up was not done".

7. The court further observed that the MCI had exonerated the neurosurgeon (OP1) with a warning to maintain proper records and follow appropriate procedures. The court held that this warning should not be construed as medical negligence during surgery.
8. Hence the court did not hold the hospital and the neurosurgeon (OPs) negligent.

Suggested Precautions

1. Law accepts that there can be more than one option of treatment / performing intervention. The course chosen by the treating doctor must be scientifically acceptable and not discredited or abandoned by medical science or medical practice. There is no legal compulsion that only newer method must be used. After considering the relevant factors, the treating doctor can opt for an older method. This discretion vested with the treating doctor must be exercised for valid reasons and only in the patient's interest. This case illustrates the aforesaid aptly. The patient with osteoporosis underwent surgery for transpedicular screw fixation between vertebrae. The neurosurgeon (OP1) performed a bone graft also. Post-surgery x-ray revealed that one of the screw got loosened. The patient got discharged and later underwent bone cement augmentation at another hospital. The most prominent allegation against the neurosurgeon (OP1) was that he ignored osteoporosis, due to which the patient's bones were weak and fragile to hold the screws; the surgery was not indicated and was performed unscientifically; bone graft was used instead of cement augmentation which is currently being used extensively and successfully in spine surgeries; and these led to a permanent disability of the patient. The court rejected this allegation observing that the neurosurgeon (OP1) had taken "the decision based on the scientific situation of the spine"; "used bone-graft with his discretion to avoid cement embolism"; "the surgeon must balance the advantages and disadvantages of each fusion procedure when deciding which surgical procedure is most suitable for a patient." The court concluded, "The old method was still in use and there is nothing on record to prove such method was legally abandoned/ stopped. Therefore, in our view the OP-1 (neurosurgeon) used the accepted method was legally abandoned/ stopped. Therefore, in our view the OP-1 (neurosurgeon) used the accepted method of treatment and thus it was a reasonable standard of practice."
2. When the patient is a doctor or a close relative of a doctor, due courtesies must be extended. But there should be no relaxation in following the protocols and procedures given the current trend where doctors are increasingly suing doctors for medical negligence. This case, a rather unfortunate one, illustrates this aspect. The patient, the mother of an anaesthesiologist with osteoporosis and complaint of severe backache following a history of fall, underwent spine surgery. One of the screws got loosened post-surgery, and this was intimated to her son. Later, the patient's son took DAMA and admitted her to another hospital. She underwent bone cement augmentation at yet another hospital. It was alleged that the patient was treated negligently during and after the surgery, leading to permanent disability. The court

perused the hospital's medical records (OP3) and found that the neurosurgeon (OP1) had offered to re-operate the patient in good faith. Moreover, when the patient was hospitalized at another hospital, an associate of the neurosurgeon (OP1) continued to see the patient regularly and made complimentary visits. The patient's son filed a complaint before the consumer court and the police and got a newspaper article published alleging negligence. He claimed excessive amounts in legal proceedings. The court appreciated the ethical conduct of the neurosurgeon (OP1) and commented adversely on the patient's son thus: "We haven't expected, but surprised that the patient's son being an anaesthetist, how can raise frivolous allegation that pre anaesthetic check-up was not done."

3. Medicine is an imperfect science. A surgeon may have to leave a surgery incomplete, deviate from the agreed course during surgery, or the patient may suffer from intra-surgery complications. These are legally acceptable if the requisite pre-surgery precautions and intra-surgery and post-surgery remedial measures were taken when indicated, the patient / attendants were kept informed from time to time, and the aforesaid was appropriately documented in the patient's medical records.)In this case, given the history of patient's osteoporosis, the neurosurgeon(OP1), who performed trans-pedicular screw fixation of the spine, opted for a bone graft instead of cement augmentation. Furthermore, he chose not to tighten one screw. The neurosurgeon (OP1) pointed out in court from the medical records that bone graft was discussed with the patient's husband and son (an anaesthetist) before surgery, and the other problems were also disclosed to them as and when they occurred. The court appreciated

this court appreciated this conduct and rejected the allegations of negligence.)

4. Each day bring newer discoveries, technology, and equipment, a hospital / nursing home cannot be expected to have all the equipment or the newer ones. In case any equipment, technology, or investigation is mandatory in nature, and the same is not available with the hospital / nursing home, then the patient must be sent to another facility for the same. (In this case, the patient with osteoporosis underwent spine surgery and suffered a post-surgery complication of loosening a screw. One of the allegations was that the DEXA scan facility to ascertain bone density was unavailable at the hospital (OP3), which was negligence. The court rejected this allegation observing that medical literature clearly states that "DEXA scan is not mandatory in each case,")
5. The reason for an unusually prolonged surgery should be informed to the patient and duly documented in the medical records. (In this case, the patient, a case of osteoporosis, underwent spine surgery at the hospital (OP30). The surgery took almost 3.5 hours to complete. It was alleged that such a delay proved that some negligence was committed by the neurosurgeon (OP1), and therefore, the screw got loosened post-surgery, leading to the deterioration in the patient's condition. The neurosurgeon (op1) pointed out in the court that the surgery took time due to the obesity of the patient, which required repeated pre-operative imaging on an image- intensifier, and that this fact was duly informed to the patient's attendant. The court, on perusal of the medical records, accepted the defence.)
6. The treating doctor should specifically record the previous history of the patient, especially the treatment taken by the patient earlier. Past history of treatment taken has

a vital role to play in therapeutics as well as courts. (In this case, the patient, with a history of hypothyroidism and osteoporosis, fell in the bathroom. The neurosurgeon (OP1) performed spine surgery. Post-surgery, the patient did not get relief, approached several hospitals and became disabled after 2 years. In court. The neurosurgeon (OP1) pointed out the aforementioned history and also specifically pointed out that the patient had taken treatment somewhere else for 10 days before getting admitted under him.)

7. Surgeons should follow the pre-surgery protocols of performing the requisite investigations, reviewing the patient's medical history, and obtaining an opinion from other specialities if indicated. The patient's fitness to undergo the intervention must also be confirmed. Duly document the aforesaid in the medical records. (In this case, the patient with a history of hyperthyroidism and osteoporosis fell in the bathroom, underwent trans-pedicular screw fixation with a bone graft, and suffered from permanent disability after about 2 years. It was alleged that the neurosurgeon (OP1) who performed the surgery ignored the patient's history; and failed to obtain a second opinion and perform a repeat x-ray / MRI to confirm the earlier reports. The neurosurgeon (OP1) specifically pointed out in defence that pre-surgery investigations were performed, and a physician's opinion was also obtained. The court did not comment on this allegation.)
8. The treating doctor should discharge the patient only when the patient is fit to be discharged. At the time of discharge, the patient should be handed over the discharge summary / note / card, investigation reports and bills. (In the instant case, the patient underwent spine surgery, became disabled after 2 years and sued the neurosurgeon

(OP1). One of the allegations was that the patient was forcefully discharged from the hospital (OP3), and only the discharge summary was handed over. The Bed Head Ticket (BHT) and detailed bills were issued only after the legal notice was sent. The court did not comment on this allegation.)

9. Any failure, deficiency or shortcoming on the part of the patient / attendants to follow medical advice should be duly noted in the medical records. (In this case, the patient with osteoporosis underwent spine surgery. Post-surgery the bedside x-ray revealed that one of the screws got loosened. This fact was duly intimated to the patient's son, an anaesthetist. In defence, the neurosurgeon (OP1) very specifically pointed out that he had promised the patient to re-operate and reset the loose screw, but the patient was never brought back. The court did not comment on this aspect.)

ORDER: -

Dr. S. M. Kantikar, Presiding Member

The Underlying Facts as Alleged by the Complainant:

1. On 11.05.2011, Smt Manjulata Garg (since deceased herein referred to as "Patient") was taken to OP-1 i.e., Dr. R.C. Mishra for complaints of severe backache. Her husband informed the OP-1 about the Osteoporosis of the patient. After examination, the OP-1 advised to admit her immediately to the Kamayani Hospital (OP-3 - Hospital). It was alleged that the physician's opinion and neurological evaluation was not done and no proper pre-anaesthetic check-up was done by the Anaesthetist. The MRI dated 11.05.2011, done at Eisha Diagnostic showed collapse of D-10 vertebra and the X-Ray showed traumatic compression of D-11 vertebra and severe Osteoporosis.

However, the OP-1 did not bother to recheck/confirm the report by repeat X-ray or MRI. The patient was operated on 12.05.2011 at 5 PM. The operation took 3½ hours to complete. The OP-1 after operation informed the patient's husband that due to very weak/fragile bones, he did not fasten the screws to its full extent. Thereafter, patient's condition deteriorated and she remained at the hospital till 21.05.2011. It was alleged that during the said period about Rs.5,00,000/- was spent on treatment. The Patient further alleged that on 21.05.2011, the Opposite Parties forcefully discharged the patient, though her condition was critical and serious. Due to such abrupt act of the Opposite Parties, on the same day, the patient was taken to Rashmi Medicare Centre in Agra. She was admitted in ICU under care of Dr. Tarun Singhal. On the next day, it was informed that the patient was febrile and had respiratory distress. She developed hospital acquired respiratory infections with pleural effusion. The patient remained under treatment in Rashmi Medicare Centre till 04.06.2011. The patient was later on diagnosed as tubercular infection (TB) at Indian Spinal Injuries Centre (ISIC) in New Delhi.

2. There was no cure from the backache; it remained persistent at the site of surgery. Therefore, on 04.06.2011, she was admitted to ISIC, where Dr. Deepak Raina examined the patient and told that a wrong surgery has been performed at Agra and since the patient was suffering from Osteoporosis, such of surgery was not recommended. He further informed that 8 screws were necessary for fastening, but the OPs-1 & 2 fastened just 4 screws. It was with the intention to gain more money. At ISIC, X-Ray and CT Scan report revealed Osteoporosis and bilateral pleural collections, which was suggestive

of consolidation/collapse of the lungs. It was alleged that on 21.05.2011 the patient was thrown out of the hospital in a critical condition and only the discharge summary was handed to the patient's relative. The Bad Head Ticket (BHT) and detailed bills were issued only after legal notice.

3. At ISIC on 21.07.2011, the patient was re-operated on the same vertebra with bone cement augmentation under the supervision of Dr. Deepak Raina and Dr. K. Das. On 31.10.2011, post-operative check X-Rays and CT scan confirmed successful operation with intact screws.
4. Thus, it was not a reasonable degree of care/skill, but it was negligence of the Opposite Parties, who have ignored Osteoporosis and performed the operation unscientifically, which led to permanent disability of the patient. Being aggrieved, the patient filed a complaint before this Commission and prayed for Rs. 1,02,01,000/- from the Opposite Parties under different heads.

Defense:

5. The Opposite Parties filed their respective written versions. The preliminary objection that for want of the pecuniary jurisdiction of this Commission, the complaint has been filed based completely on illusionary highly inflated figures just to extract money illegally from the opposite parties. The OPs denied the allegations of negligence during treatment of the patient. It was also denied the forceful discharge of the patient from the Kamayani Hospital in critical condition. It was also denied that the operation was performed despite the patient's weak and fragile bones with severe osteoporosis.
6. The OP-1 in his reply submitted that, he was a visiting consultant Neurosurgeon at Kamayani Hospital Agra. The patient was a mother of an anaesthesiologist admitted

under his neurosurgery unit on 11.05.2011. The patient had a fall in the bathroom on 02.05.2011, about 10 days prior and took treatment somewhere. At the time of admission in the Kamayani Hospital, the patient's vitals were normal i.e., pulse 94/min & BP 120/70 mm of Hg. Despite having backache, she was moving her limbs spontaneously. The x-ray showed wedge-fracture D-11 with mild kyphotic deformity and MRI indicated the canal compression at D-11, without intrinsic cord changes. The motor movement in lower limb was adequate, but she did not co-operate for assessing exact power due to severe pain. She was a known case of hypothyroidism and osteoporosis as allegedly told by her son under treatment of a physician, as informed by her doctor-son. A decision for trans-pedicular screw fixation between vertebrae was taken and it was intimated to the patient's attendants. After the physician's assessment and anaesthetic clearance, she was operated under general anaesthesia (GA) on 12th May 2011 in evening. The operation lasted for three hours and a half due to obesity of the patient requiring repeated per-operative imaging on image-intensifier. The screw-fixation was followed by de-compressive laminectomy of D-11 lamina. No Dural injury was found and no CSF leak was noticed. Suboptimal purchase of one screw at D10 was suspected and it was intimated to the attendants after surgery. Locally available bone was used as graft and put along screw-head. Patient had difficulty in breathing on 14th May 2011, when she was examined by the In-house physician. The one regular physician was called on 15th May 2011 and treatment was modified from time to time. Bedside x-ray chest showed problem with one screw, soon after it was intimated to the

patient's relatives. On 21.05.2011, due to the patient's fever it was decided to change the antibiotics, but her son sought discharge from the Kamayani Hospital, assuring that he would manage the antibiotics at home in consultation with a physician of his own choice. After the discharge, the patient was taken home and, then, after 9 hours to Rashmi Medicare Centre for treatment of her fever. There Dr. Sanjay continued to see the patient regularly and made Gupta (neuro-surgeon) an associate of OP-122 complimentary visits. As one screw was loose, the OP-1 promised to re-operate and reset the loose screw, but the patient never brought back. The patient got discharge from Rashmi Medicare Centre on 27.05.2011. Therefore, there was no negligence, but filed a frivolous complaint.

7. The OP-2, Dr. Muneshwar Gupta, the Managing Director of OP-3 Kamayani Hospital filed the written version. He made similar submission as of the OP-1 on treatment aspect. He further submitted that maximum amount of ₹50,000 may be required for surgery, however as the complainant was mother of the doctor, the hospital charged nominal amount of ₹32,000 and same was reflected in the bill/ discharge report. He further submitted that as he is a Radiologist, he had no role in surgery. He further confirmed that the OP-1 informed the husband 3 of complainant that due to weak bones he did not pass on the screws in the full extent. During hospitalization postoperatively, the patient developed fever. Her doctor son expressed his desire, to take care of his mother at his house with the guidance of physician. Therefore, patient was discharged on making payment as billed 44,000, a full and final settlement. However, after 9 hours on the same day from the house, she was taken to the Rashmi hospital

and was admitted till 27.05.2011. During the first week of June 2011 the complainant's husband and her son approached the OP-1 with the information that one screw was loose and for not giving a desired result after treatment, demanded ₹4,00,000 as a compensation. They also threatened about dire consequences if not paid. Since the patient was mother of a doctor, in good faith OP-1 offered to re-operate 2 the patient. The OP-2 further submitted that the Complainant filed the complaint to claim Rs. 10,21,000/- without any basis to bring pecuniary jurisdiction of this commission. The complainant took different stands i.e. in the legal notice he claimed ₹ 44,000/- however in the complaint filed before the Commissioner of Police stated that Rs. 1,46,000/- as charged by the hospital and he quoted different figure of Rs.7,00,000 in the newspaper article. However interestingly the complaint mentioned an amount of Rs. 23,00,000/- as expenses but actually *44,000/- was spent at OP-3 hospital. He further submitted that the Disability Certificate was issued on 06.02.2013; i.e., 2 years after the surgery performed on 12.05.2011 by the OP-1. It cannot be relied as to attribute negligence of OPs.

8. The respective parties filed their evidence by the way of affidavits with medical literature on the subject.

Arguments:

9. The Counsel on both the sides filed brief synopsis with time line of treatment and events in the instant case.

Arguments from Complainant:

10. The learned counsel for the Complainant reiterated the facts and chronology. He submitted that the OP-1 ignored patient's hypothyroidism and osteoporosis. Only

physician evaluation was done but pre-anaesthetic check-up was not done. Same was held by the MCI ethics committee in its letter dated 19.01.2013. It was an elective operation, but the OP-1 never bothered to see the x-ray and MRI reports which showed disparity. [D-10 and D-11]. The compression was at D-10 and not D-11. The OP-1 never pointed out said difference and he himself also did not sure about which segment to operate, thus it was blatant negligence. He further argued that the patient's bones were weak and fragile due to severe osteoporosis as clearly depicted in X-ray, but OP-1 never bothered to put bone cement. The OP-1, himself had accepted after the operation that screws are loose and it needs to be re-positioned by bone cement technique. The Cement augmentation is being used extensively and successful in spine surgery to date.

11. No X-Ray of the spine was performed for five days after the surgery, which clearly shows malicious intent of the O.P. No. 1 who was trying to hide a botched up the surgery by placing screws outside the pedicle into the lungs. The misplacement of the screw was only revealed after patient developed pneumonia because of the screw perforating the pleura/lung. During the intervening period Dr Mishra has been trying to mislead and cover up his mistake by blaming screw placement into the lung due to the patient's osteoporosis and obesity. Therefore, as a result of his botched-up surgery, he discharged patient in a critical state. The Complainant relied upon the following articles:

- I. Thoracolumbar Burst Fractures, Short X Long Fixation: A Meta - Analysis;
- II. The Biomechanics of Long Versus Short Fixation for Thoracolumbar Spine Fracture

- III. Complications associated with thoracic pedicle screws in spinal deformity
 - IV. Polymethylmethacrylate Augmentation of Pedicle Screws Increases the Initial Fixation in Osteoporotic Spine Patients
 - V. Surgical Strategies to Improve Fixation in the Osteoporotic Spine: The Effects of Tapping, Cement Augmentations, and Screw Trajectory
 - VI. Hydroxyapatite coating improves fixation of pedicle screws
12. The OP-1 expressed his innate difficulty while placing pedicle screws in thoracic spine, shows his lack of skill. He further argued that the fracture, which was to be fixed by eight screws, was fixed by just four screws. The OP-1 has quoted osteoporosis of the bone in his defence of the screws cutting out. If he had suspected osteoporosis of the bone, why did he not insert more screws or used hydroxyapatites coated screws, or bone cement.
13. The Opposite Parties filed their respective written arguments. The learned Counsel for the OP-1 vehemently argued that Dr. R. C. Mishra is highly skilled surgeon and treated the patient as per standard of practice. The patient's son at the screws set for stabilisation and healing. He used bone graft to prevent possible cement embolism. In the instant case, the mal positioned screw of D10 may be due to obesity and excessive fat of the patient and therefore, the operation was lasted for 3 ½ hours. The OP-1 took the decision based on the scientific situation of the spine. The screw fixation was followed by D-Compressive laminectomy of D11 lamina. There was no dural injury. The OPs-2 & 3 argued that the Complainant deliberately made baseless claim of Rs. 1,02,01,000/- from the OPs-2 & 3. There was no expert opinion and the ethics Committee of MCI did not find any negligence on their part. The

learned Counsel for the Ops relied upon the following articles:

- I. Cement Embolism into the Venous System after Pedicle Screw Fixation: Case Report, Literature Review, and Prevention Tips
- II. Screening for Osteoporosis: U.S. Preventive Services Task Force Recommendation Statement
- III. Successful Short-Segment Instrumentation and Fusion for Thoracolumbar Spine Fractures
- IV. Outcome-Based Classification for Assessment of Thoracic Pedicular Screw Placement
- V. Outcome-Based Classification for Assessment of Thoracic Pedicular Screw Placement

Observations & Reasons:

14. We have perused the material on record, inter alia, the Medical Record, literature and standard text books on neurosurgery and gave our thoughtful consideration.
15. It is evident from the record that Dr. R.C. Mishra (OP-1) is highly skilled and qualified specialist - having vast experience of 29 years in Neurosurgery. He remained as Professor Head in various Medical Colleges. From the record the patient's attendant and her doctor son were apprised of the surgery and the pre & the screw for stabilization and healing. Therefore, OP-1 used bone-graft with his discretion to avoid cement embolism.
16. The contention of Complainant that such fractures have to be fixed at least two level above and two levels below to stable, or augment the fractured vertebrae with screw/ cage or cement. In the instant case admittedly the OP-1 fixed four pedicle screws, two above (short segment fixation) and two below for a fracture of vertebra

the spine. The O.P No. 1 in his defense relied upon article from the year 2000 and he claimed that he has been carrying out the good old treatment method. As per the article short segment fixation could be employed in a very small subset of patients with simple fractures, and those who were willing to wear a brace for four months. In our view the method of treatment adopted by OP-1 was as an accepted medical practice. Pedicle screw fixation is widely used in spine surgery for numbers of indications, such as degenerative disease, trauma, tumor, infection, and deformity. It reduces the range of motion of the stabilized spine, increases the fusion rate, and is generally considered to be safe with relatively low complication rate associated with the device. Therefore, the decision to perform short or long fusion remains individualized to each patient, and depends on a multitude of factors as discussed. The current study results suggest that either approach can achieve sufficient correction if performed appropriately. Thus, the surgeon must balance the advantages and disadvantages of each fusion procedure when deciding which surgical procedure is most suitable for a patient. From the article, 'Outcomes of Short Fusion versus Long Fusion for Adult Degenerative Scoliosis: A Systematic Review and Meta-analysis' The long-segmented fusion is used to fix the mobility of vertebra. In the instant case D11 is a stable vertebra, it was damaged; therefore, short segmented fusion was not a wrong method. Only 4 screws were used 2 at D10 and 2 at D12. Thus, cost of extra 4 screws was saved.

17. We further note that, the Patient's husband made separate complaints before the Director General of Police, Agra; Medical Council of India and Chief Medical Officer, Agra. The Ethical Committee of U.P Medical

Council vide order dated 09.02.2012 observed that the doctors were not guilty of medical unprofessionalism and misconduct and thus exonerated the opposite parties of all the charges. The appeal filed by the Complainant before the MCI which vide order dated 19.01.2013, upheld the decision of the U.P Medical Council and exonerated the OPs with a warning to the OP-1 to maintain proper records and follow proper procedure. The warning of MCI shall not construed as medical negligence during surgery performed by the OP-1.

18. The disability certificate of the Patient cannot be relied because it was issued on 06.02.2013 almost after 2 years of the operation performed by OP-1 on 12.05.2011.

Discussion: -

19. The main crux of the matter is whether the treatment adopted by OP-1 has deficiency and was it contrary to the reasonable practice in Neurosurgery?
20. We have gone through the medical literature on spinal surgeries. Whether Osteoporosis is contraindicated for spinal screw fixation surgery. It is an admitted fact that the DEXA Scan facility to ascertain the bone density was not available with Kamyani Hospital. From the medical literature DEXA scan is not mandatory in each case. Pedicle screw loosening is a common complication after spine surgeries. Traditionally, it was assessed by radiological approaches, both X-ray and CT scan, while reports using mechanical method to study screw loosening after spine surgery are rare. As stated, the patient's son (anaesthetist) informed OP-1 about Osteoporosis; we do not see OP-1 ignored the Osteoporosis. For proper fixation he chose not to use cement augmented screws. The OP-1 for reinforcing

the stabilization and healing used locally available bone-graft at the aforesaid screw-site. It was an age-old procedure of bone-strengthening better than use of bone cement. The old method was still in use and there is nothing on record to prove such method was legally abandoned/ stopped. Therefore, in our view the OP-1 used the accepted method of treatment and thus it was a reasonable standard of practice, no a deviation of practice. We put reliance upon the case *Achutrao Haribhau Khodwa and Ors. v. State of Maharashtra & Ors.*, in which Hon'ble Supreme Court noticed that 'in the very nature of medical profession, skills differ from doctor to doctor and more than one alternative course of treatment are available, all admissible'.

21. According to the literature and standard text books in Neurosurgery and Orthopaedics the cement augmentation has its own potential side-effects and irreversible neurological deficits or sometimes entails death. Moreover, sometimes re-absorption of screw chemicals of the augmented pedicle screw led to loosening. Sometimes the broken screw can't be taken out. In the instant case, four screws were used as two in D-10 & two in D-12. One screw-problem may be classified as 'mal-positioned' due to obesity and excessive fat, which led to inadequate x-ray evaluation. It is pertinent to note that three screws were retained during 2nd surgery at ISIC, thus meaning thereby Osteoporosis effect was not for the three screws...! In our view, the mistake of the patient's son that he took premature discharge from Kamayani Hospital, he took her home first and then, after about 9 hours, at 8 pm got her admitted in Rashmi Medicare Centre. The duty of care for the patient reflects as out of courtesy, the patient was regularly seen by colleague of

OP-1 Dr. Sanjai Gupta at Rashmi Medicare Centre. This fact is evident from the letter dated 26.10.2012, issued by Dr. Tarun Singhal of Rashmi Medicare Centre, which is reproduced as below:

To Whom It May Concern

This is to inform that Patient Mrs. Manjulata Garg W/o Mr. Ram Murti Garg was admitted in our Rashmi Medicare Centre from 21.05.2011 to 27.05.2011 under my care. Dr. Sanjay Gupta (MS. M.Ch. Neurosurgeon) was also looking after her, (who was in the operative team of patient Mrs. Manjulata Garg in Kamayani Hospital) till her discharge. He had visited her 2 complimentary without any charge.

22. The patient thereafter had developed hospital acquired respiratory infection with pleural effusion which has turned out to be TB at ISIC which cannot be attributed to the treatment given by OPs. We agree with the observations and the Order of MCI dated 19.0.2013 which exonerated the OP-1 with warning to maintain proper record and follow proper procedures before and after surgery in future. Such warning itself does not constitute medical negligence of the OPs.
23. The Hon'ble Supreme Court in *Kusum Sharma Vs Batra Hospital & Ors.* discussed that: the breach of expected duty of care from the doctor, if not rendered appropriately, it would amount to negligence. It was held that, if a doctor does not adopt proper procedure in treating his patient and does not exhibit the reasonable skill, he can be held liable for medical negligence. In the instant case we do not find any breach of duty of care from the OP-1 who treated the patient, who was in-turn a mother of one anaesthetist. To succeed in any medical negligence, claim the Complainant must

demonstrate that four essential ingredients of medical negligence are "4 D" namely 1) Duty of Care, 2) Dereliction (breach) of duty, 3) Direct Causation and 4) Damage proximate to the breach. In the instant case the Complainant conclusively failed to prove all those ingredients of medical negligence.

24. Let us carefully go through the three Discharge Summaries of ISIC: In the first discharge summary dated 07.06.2011, her general condition was satisfactory. She was evaluated for spinal injury. The X-ray chest revealed collection in right lung, which the chest physician examined and right ICD insertion was done and 200 ml of the pus drained. The patient was treated with IV antibiotics. Thereafter, the lung collection reduced significantly and she was discharged. There was no mention about neurological symptoms. In the second discharge summary dated 23.07.2011, the patient was admitted on 17.07.2011. It has recorded in the past history about pneumonitis / pleural effusion for which USG guided drainage was done. The right lung empyema noted for which ICD was inserted. The surgical treatment was advised for spine. After PAC and informed consent, the patient was operated on 21.07.2011, wherein implant removal with posterior stabilisation with cement, enhanced pedicle screw insertion D8-D12 was done under general anaesthesia. Post-operative treatment was uneventful and she was mobilised with brace. She was discharged with domiciliary care. The patient was advised to continue for AKT4 treatment. Thus, there was no neurological science in the instant patient.

The third discharge summary dated 23.07.2011 revealed that the patient was admitted in ISIC on 14.06.2012 for difficulty

in walking and loss of control over urination. The muscle power grade 3 was noted in right leg. The sensory were intact. She was diagnosed as Para paresis. She was advised for physiotherapy and managed with Neuro-physicians advice.

Therefore, collective reading of three discharge summaries, it is clear that the patient suffered neurological symptoms almost after one year of the surgery performed at ISIC. The MRI report dated 16.06.2012 showed mild atrophy of the cord at D8 to D11 suggesting myelomalacia. It is further to note that in the first two discharge summaries, there was no mention of TB or Anti Tubercular treatment (ATT) treatment. The third discharge summary was almost after one year and it revealed continuation of ATT treatment. Nothing is forthcoming about the AFB positive status or the diagnosis of TB. Moreover, nothing is on record to show when and where ATT with AKT4 started. All the discharge summaries of ISIC are silent on this issue. As per the medical literature, TB usually gets manifested 6 weeks after exposure of infection. Therefore, the Complainants arguments on this issue are unsustainable as we do not find any nexus between operation performed by OP-1 and further development of paraparesis and/or tuberculosis.

25. From the medical literature it is known that, the application of Augmented (cemented) pedicle screws fixation for osteoporotic multilevel lumbar degenerative disease (LDD) can achieve better stability and less screw loosening, but it also accompanied by longer operating time, higher incidence of Cement leakage (CL), Pulmonary Cement Embolism (PCE) and wound infections. Due to increase of level and bone cement dose

are accompanied by the rising incidence of CL remains a common complication of cement-augmented pedicle screw instrumentation (CAPSI). CL may cause severe complications such as nerve injury, vascular damage, pulmonary cement embolism (PCE), cardiac embolism, and anaphylactic shock. It should be kept in mind that the vertebral venous plexus (VVP) does not have valves, through which more chances of micro thrombi/ emboli carried to brain to cause severe damage.

26. We would like to rely upon the recent judgment (30-11-2021) of Hon'ble Supreme Bombay Hospital & Medical Research Centre vs. Asha Jaiswal & Ors., held no negligence of the treating doctor. In paragraph 32 and 34 of judgment observed as: -

32. In C.P. Sreekumar (Dr.), MS (Ortho) v. S. Ramanujam, this Court held that the Commission ought not to presume that the allegations in the complaint are inviolable truth even though they remained unsupported by any evidence. This Court held as under:

"37. We find from a reading of the order of the Commission that it proceeded on the basis that whatever had been alleged in the complaint by the respondent was in fact the inviolable truth even though it remained unsupported by any evidence. As already observed in Jacob Mathew case [(2005) 6 SCC 1: 2005 SCC (Cri) 1369] the onus to prove medical negligence lies largely on the claimant and that this onus can be discharged by leading cogent evidence. A mere averment in a complaint which is denied by the other side can, by no stretch of imagination, be said to be evidence by which the case of the complainant can be said to be proved. It is the obligation of the

complainant to provide the *facta probanda* as well as the *facta probantia*."

34. Recently, this Court in a judgment reported as Dr. Harish Kumar Khurana v. Joginder Singh & Others held that hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstances. However, in an unfortunate case, death may occur. It is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at the conclusion that death is due to medical negligence.

27. It is apparent from the record that the complainant vaguely demanded his claim *supra* (para 7). The OP-1 adopted the standard reasonable practice and also followed ethical principles to his 2 professional colleague the anaesthetist, whose mother was operated by OP-1. We haven't expected, but surprised that the patient's son being an anaesthetist, how can raise frivolous allegation that pre anaesthetic check-up was not done. We find the doctors treated the patient reasonably and there was no deficiency or negligence during the treatment. In our view the complaint was filed, simply to blame for untoward incident to get some compensation. The Complainant aims to turn the wheels of fortune in his favour by demanding such immense damages.

28. In the obtaining facts and the available evidence on record, it is not feasible to conclusively attribute non-adherence to duty of care and standard of practice, it is difficult to conclusively establish medical negligence / deficiency on the treating doctor and the hospital.

29. The Complaint is dismissed. The parties to bear their own costs.



IGNORANTIA

FACTI EXCUSAT

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Dr Ashish Khatod
BAMS, DCH

Ignorantia Facti Excusat, Ignorantia Juris Non Excusat. is one of the important principles of jurisprudence, which means "ignorance of fact is an excuse, ignorance of the law is not an excuse." This principle places the responsibility on each and every individual to know and follow the law. It is expected even from a citizen of foreign country who is visiting India as a tourist that he should know and obey all Indian laws. In simpler words, a person cannot avoid liability by claiming that they did not know the law. The court applies this principle while deciding any case.

Most of the medical practitioners are such persons who are the most scholar students of their class in their school and college. During school and college life, mostly they remain cut off from the other social subjects like law, social science, politics etc. and are drowned in the science textbooks. But after starting their medical practice, suddenly they have to deal with the common public daily where having knowledge of these neglected subjects becomes necessary.

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