



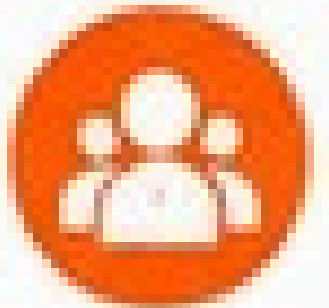
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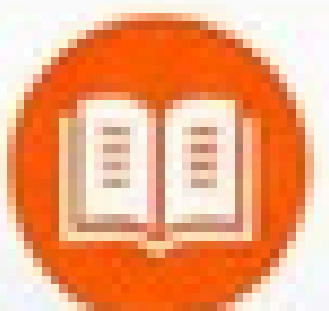
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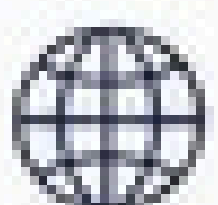
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Mr. Jayawant Hirugade
MA, Bachelor of Journalism

"Knowledge
protects practice,
awareness
prevents risk,
and responsible
practice
builds trust"



EDITOR'S MESSAGE



Dear Readers,

Medicine is a noble profession built on trust, compassion, and a commitment to human well-being. However, in today's complex healthcare environment, medical professionals must also navigate the intricate landscape of laws, regulations, and professional responsibilities.

Medicolegal India Insights is our effort to bridge the gap between medical practice and legal awareness. We aim to provide practical, reliable, and contemporary insights that help doctors and healthcare institutions protect their practice, ensure patient safety, and uphold the highest ethical standards.

Each issue will bring you real-world medico-legal cases, expert opinions, legal updates, documentation guidance, and risk management strategies relevant to daily clinical practice.

Our mission is simple to empower the medical fraternity with knowledge and awareness so that they can focus on what they do best: healing lives, with confidence and peace of mind.

I extend my heartfelt gratitude to our contributors, readers, and well-wishers for their trust and support. Together, let us build a safer, more informed. and legally aware healthcare ecosystem in India.

Warm Regards,

Mr. Jayawant Hirugade
MA, Bachelor of Journalism

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CONFIDENTIAL

POLICY FOR ISSUE OF DEATH CERTIFICATE IN CASUALTY

A Medico-Legal Guide for Doctors and Hospital

Department: Casualty, Medico Legal Document

Medical Record to be kept for 30 years or more/ less till declaration by Judiciary/ till the case is for hearing in the court

Document number:

Reference: NABH 6th Edition, Chapter----, Standard----, Objective element-----



DR. ANIL JAYAWANT
MBBS, DHM

Policy and Procedure for PATIENT BROUGHT DEAD TO CASUALTY

CONFIRM ABSENCE OF LIFE (Death but not the cause of death)

- Check temperature (by back of hand/ thermometer), Pulse, Respiration, Fixed dilated pupils not reacting to torch light, no heart sounds, no response to pain
- Heart activity may be prolonged for some time. Take ECG record till straight line.
- Document date, time of examination along with signature and name
- Declare death if no signs of life

- Declare death but do not issue death certificate till about half an hour.
- You may issue death certificate under written policy of hospital.

Note: On duty medical officer can issue death certificate under certain conditions mentioned below.

1. Patient has taken treatment in the same hospital within ----days (To be decided by the hospital) and a file is with the relatives. Patient's file is photocopied for hospital records.

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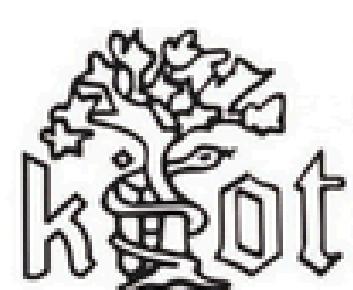


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2. Patient is a known case of chronic incurable disease and was admitted repeatedly in the same hospital and declared as terminally ill
3. Old age, chronic incurable disease, emaciated due to disease and bed ridden, known to the treating doctor who can vouch for incurable condition in writing and ready to sign the document within 24 hours

Note: On duty medical officer should not issue death certificate under certain conditions mentioned below.

- Decomposed body
- Post mortem rigidity
- Post mortem lividity
- Not a known case of hospital
- Consultant refuses to agree issue of death certificate
- Suspicious behavior of persons accompanying the dead body
- Persons are aggressive and demanding death certificate immediately
- Marks of injury on the body, signs of bleeding, disfigurement externally
- Blood coming out of natural orifices or unnatural area of the body
- Smell of poison, kerosene, petrol etc.
- Not having government approved photo identity AADHAAR
- History of how the person found this dead body
- Unknown person
- Political, police, mob or administrative pressure to issue death certificate
- Married lady (Less than 7 years of marriage)
- Any child brought dead
- Transgender

Whatever may be the circumstances, the doctor in casualty issuing death certificate is responsible for law enforcement authority.

Declaration

- Record when the body is brought
- Who are the accompanying persons
- The way the body is brought
- If possible, vehicle number
- Record the statements of accompanying persons

Register as Medico Legal Case

Refer to the conditions above and then declare as Medico-Legal Case.

Good communication and doctor's Legal Case. Good communication and doctor's efforts will pacify the persons who have brought the dead body.

Police memo

- Write in detail about the incidence of bringing dead body.
- Follow certain principles: Who has brought the body, when the body was brought, why the body was brought to this hospital, from where the body is brought, how the body was brought to the hospital. Such detail information in writing will help the judiciary and doctor will not be blamed by the judiciary.
- The carbon copy should be legible.
- It is necessary to sign, write name, record date and time.
- Send the write up to the police station and obtain signature of the attending policeman that the copy is received. Check: Signature, Name, Date, Time and Buckle number
- It is a medico legal case. It should be numbered by the hospital authority.
- Preserve the acknowledgement copy with the original document.

Care of dead body

- If policeman is coming immediately, then you may keep the body temporarily in the casualty bed.
- Do not allow anyone to do anything with the body.
- Do not remove clothes, tubes, linen etc.
- You may stop oxygen, IV lined and ventilator.
- Do not wipe out the froth coming from nose or mouth.
- Valuables are to be kept as it is on the body. It is the duty of police to hand over valuables to the relatives.

Proper documentation

- Document everything in detail.
- Record the information given by the relative or the accompanying person and obtain signature along with identification.
- You as doctor are responsible for safe keeping of the body by proper instructions to the hospital staff till it is handed over to the police with signature.
- Do not allow anyone for tampering of the evidence.



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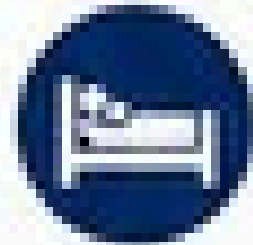
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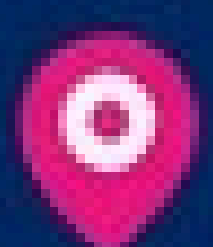


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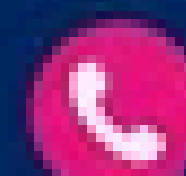
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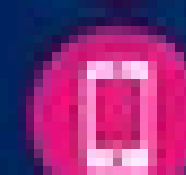
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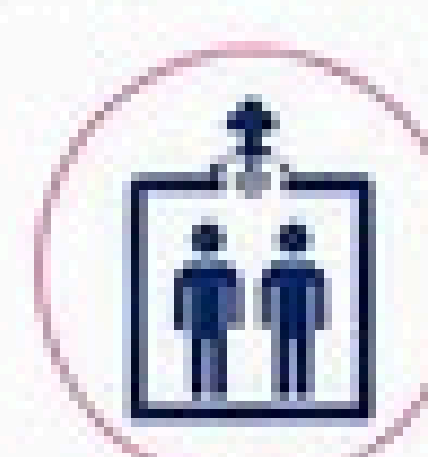
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“Every Medicolegal Case Is Not Just a Legal Battle — It Is a Lesson in Safer Medical Practice.” –

“Every signature, every record, and every decision can become evidence.”

MEDICO-LEGAL CASE STUDY

Doctor admits to not recording / removing broken guide wire left in patient's body assuming it's biocompatible – Court holds him liable

Thumu Latha v/s Prathima Institute of Medical Science & Ors.

Telangana State Consumer Disputes Redressal Commission, Hyderabad

Judgment in favour of: Patient

Facts of the case

1. The patient experiencing severe back pain consulted a hospital. After a series of tests, the doctors diagnosed her with renal calculi (kidney stones) and advised Percutaneous Nephrolithotomy (PCNL) for the left kidney. The patient approached the hospital (OP1) and underwent PCNL, performed by the urologist (OP2). Unfortunately, her pain and suffering did not subside. Therefore, the urologist (OP2) performed an X-ray, which revealed the presence of a foreign body in her left kidney.

Patient's allegation/s of medical negligence

1. It was alleged that due to the negligent surgery, a foreign body was left in the kidney of the patient, causing immense pain and suffering.

Doctor's defense

1. The urologist (OP2) stated that pieces of guide wire broke off in the patient's body, but these were biocompatible with the human body and posed no danger or harm. Therefore, there was no necessity to remove it as alleged, and hence no cause for complaint.
2. It was specifically stated that the patient was informed of this fact orally, but the same was not recorded.

3. It was also pointed out that if foreign particles were present in the body, there would be an immediate infection or abscess requiring surgery. The post-operative CT scan report showed no calculus, pus, or swelling, and the kidney was functioning properly.
4. It was further pointed out that the patient came for a follow-up once, did not raise any complaints, and did not consult the urologist (OP2) afterwards for alleged pain or suffering.

Findings of the Court

1. The court, upon reviewing medical literature, noted that guide wires are essential in urology and that their fragmentation is possible. However, prompt action to remove them is crucial to prevent complications.
2. Upon reviewing the medical records, the court found that the urologist (OP2) did not document having informed the patient about the retained guide wire. Furthermore, the necessary steps to remove the foreign body were also absent from the discharge summary. Therefore, the court concluded that the urologist (OP2) had failed to inform the patient about this incident.
3. Hence, the court held the hospital and the urologist (OPs) negligent.

Suggested Precautions

1. If any mishap / adverse event occurs during treatment or intervention, it should not only be promptly disclosed to the patients / attendants but also recorded specifically in the medical records. Appropriate corrective steps must be taken. Furthermore, the corrective steps that need to be taken in future must also be shared with the patients / attendants and duly documented in medical records such as the prescription and discharge summary. (In this case, the patient underwent PCNL but experienced pain due to remnants of the guide wire in the left kidney tissues. In court, the urologist (OP2) stated in defence that the remnants of the guide wire were biocompatible; he had orally informed the patient about this fact but “did not record the same in any of my medical file” and that the patient was “trying to take advantage of the said professional disclosure”. The court refused to accept this defence and observed that at least the corrective steps should have been recorded in the discharge summary. The court held that this was sheer negligence.)
2. It is important to use high-quality equipment, devices, consumables and disposables. Inspect them regularly and replace any that are worn-out. This protocol reduces the risk of adverse events during their use. (In this case, the post-PCNL CT scan revealed a broken guide wire used during the procedure. On perusing the medical literature, the court, opined that guide wires are indispensable in urology, and their fragmentation is possible. However, the urologist (OP2) was held negligent for failure to take immediate action for its complete removal.)



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MEDICAL PRACTICE UNDER CONSUMER LAW

Understanding Consumer Complaints, Medical Negligence & Legal Protection

In today's healthcare environment, every doctor must be clinically competent as well as legally conscious. With the evolution of consumer protection law, patients now have a powerful legal remedy against medical services, alleging deficiency in service or negligence



LEGAL POSITION IN INDIA

The Supreme Court in Indian Medical Association V.P. Shantha (1995) held that medical services rendered for consideration fall within the definition of "service" under the Consumer Protection Act. This position continues to hold good.



WHAT CAN LEAD TO A CONSUMER COMPLAINT?

- Failure to provide expected standard of care
- Diagnostic or treatment errors
- Inadequate monitoring or follow-up
- Lack of informed consent
- Failure to communicate material information.
- Poor or incomplete documentation
- Delay in diagnosis or treatment
- Deficiencies in hospital services
- Incorrect medical records or certificates
- Negligence by doctors, nursing staff or other healthcare personnel



RECENT 2026 CASE EXAMPLES

AIIMS Rishikesh Case (August 2026): The Uttarakhand State Consumer Commission upheld medical negligence where a patient was incorrectly diagnosed as HIV positive. The Commission ordered AIIMS Rishikesh to pay \$50,000 compensation plus 10,000 towards litigation expenses



NCDRC Order (4 August 2026): In a case of a 36-year-old woman who developed paralysis after treatment, the National Consumer Disputes Redressal Commission held the hospital and two doctors liable for deficiency in service and directed payment of 15 lakh as compensation

“ Good clinical care is important,
but good documentation protects it.



WHY DOCUMENTATION MATTERS

In consumer litigation, medical records are the most crucial evidence. Ensure your records are



Active



Complete



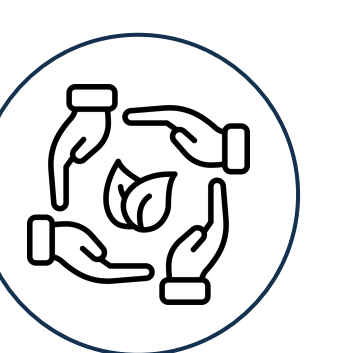
Legible



Timly



consistent



properly Preserved

IMPORTANT DOCUMENTS INCLUDE:

- Case papers & clinical notes
- Consent forms
- Investigation reports
- Prescription & medication records
- Referral & consultation notes
- Operation/procedure notes

- Nursing records
- Discharge summaries
- Follow-up advice
- Communication with patients/relatives
- Emergency & casualty records



WHERE CAN A CONSUMER COMPLAINT BE FILED?

Under the Consumer Protection Act, 2019, complaints can be filed at District, State or National Commission depending on the value of services paid.

COMMISSION	PECUNIARY JURISDICTION
District Commission	Up to 50 lakh
State Commission	Above 50 lakh to 2 crore
National Commission	Above 2 crore



An unsuccessful treatment outcome by itself does not mean negligence. The key is whether the doctor acted in accordance with the accepted **standard of care**

5 PRACTICAL STEPS FOR DOCTORS

- 1

Document every important clinical decision

Record findings, diagnosis, treatment plan and reasons for decisions
- 2

Take proper informed consent

Explain procedure, risks, alternatives and benefits as per the case.
- 3

Communicate clearly

Share appropriate information with patients and relatives.
- 4

Never alter records. Improperly

Follow proper procedures for corrections. No overwriting. or backdating.
- 5

Seek medico-legal advice early

In case of adverse events, legal notice or complaint, take professional advice.



Practice medicine with **compassion**, document with **clarity** and protect your profession with **knowledge**.



26-WEEK PREGNANCY WITH UNCERTAIN TIFFA TEST AND NO MTP OPTION – A DOCTOR'S WORST DILEMMA



Sree Karuna Nursing Home & Scanning Centre & Anr.

v/s Kayala Trinadha Siva Sankara Reddy & Ors.

National Consumer Disputes Redressal Commission, New Delhi

Judgment in favour of: **Doctor**



Facts of the case

1. During her sixth month of pregnancy, the patient approached the gynecologist (OP1) for a routine medical check-up and was advised to undergo an abdominal Targeted Imaging for Fetal Anomalies (TIFFA) scan to detect any potential congenital deformities in the fetus. The TIFFA scan reported “no sonographically evident major congenital anomalies.” However, the patient gave birth to a child without a left arm.

Patient's allegation/s of medical negligence

1. It was alleged that the child was born without a fully formed left arm due to the negligence of the radiologist and the gynecologist (OPs). A thorough examination and proper verification of the reports would have highlighted the significant deformity in time, allowing the patient to take the necessary steps.
2. It was further alleged that the doctors (OPs) did not explicitly state in their report that the scan was not 100% reliable during the 26th week of pregnancy. This omission to record the haziness of the fetus's movement in the scan report indicated a clear deficiency in service.
3. It was also alleged that the doctors (OPs) failed to inform the patient about the advanced stage of her pregnancy and deprived her of her right to timely care abortion.
4. It was claimed that the doctors (OPs) admitted their negligence before the village elders and promised compensation, but later they refused.

Doctor's defense

1. In defence, it was stated that the appropriate timeframe for scanning potential deformities during the TIFFA scanning test is between 18 and 20 weeks of pregnancy. However, the patient approached the scanning centre during her 26th week of pregnancy. This advanced stage made it impossible to examine the fetus effectively for any deformities. The fetus's flexed position and crowded posture and 26 weeks hindered the 100% detection of congenital deformities despite the advanced technology available.
2. It was further stated that the TIFFA scan report merely made certain observations and did not provide a conclusive finding that ruled out all possibilities of congenital deformities of the fetus.
3. It was noted that the scanning was performed only at the patient's persistent request, and the patient had been informed of its uncertainty. The scanning report also included the phrase “to the extent visualized.”

Findings of the Court

1. Upon reviewing the medical records, the court observed that the TIFFA scan, an advanced ultrasound, is usually performed between 18 and 23 weeks of pregnancy to assess fetal anatomy and assist in managing the pregnancy. In this case, admittedly, the patient approached the radiologist (OP2) for a TIFFA scan during her 26th week of pregnancy, which was beyond the recommended timeframe for optimal results. The court also took cognizance of the fact that this information was communicated to the patient and the report specifically mentioned “to the extent visible.”

2. The court also specifically commented that the option of medical termination of pregnancy or not is “a matter of the legal right of the Complainant-patient and is not to be determined in a case alleging medical negligence like the present one.”

3. Hence, the court did not hold the gynaecologist and the radiologist (OPs) negligent.

Suggested Precautions

1. Doctors encounter various dilemmas in their practice daily where no clear and acceptable solutions are available. In these situations, doctors should weight the medical facts, the patient's health and preferences, and the legal framework to guide their clinical judgment and patient care. Keep the patient informed and document appropriately in the medical records. (In this case, the patient in her sixth month of pregnancy approached the gynaecologist (OP1) for a routine check-up and underwent a TIFFA scan. The scan reported no anomalies; however, the child was born without a left arm. It was alleged that more confirmatory tests and information could have facilitated the decision to perform MTP. The court, on perusing the medical records, observed that due to inherent limitations of TIFFA scan in such an advanced stage of pregnancy, which was beyond the recommended timeframe of 18 to 23 weeks, it was challenging for the doctors (OPs) to get optimal results and draw a definitive conclusion. The court took note of the fact that this information was communicated to the patient, and the TIFFA scan report specifically stated: “to the extent visible.”)

2. If patients, attendants, or local social workers attempt to pressurize you into admitting your fault and compensating the patient.

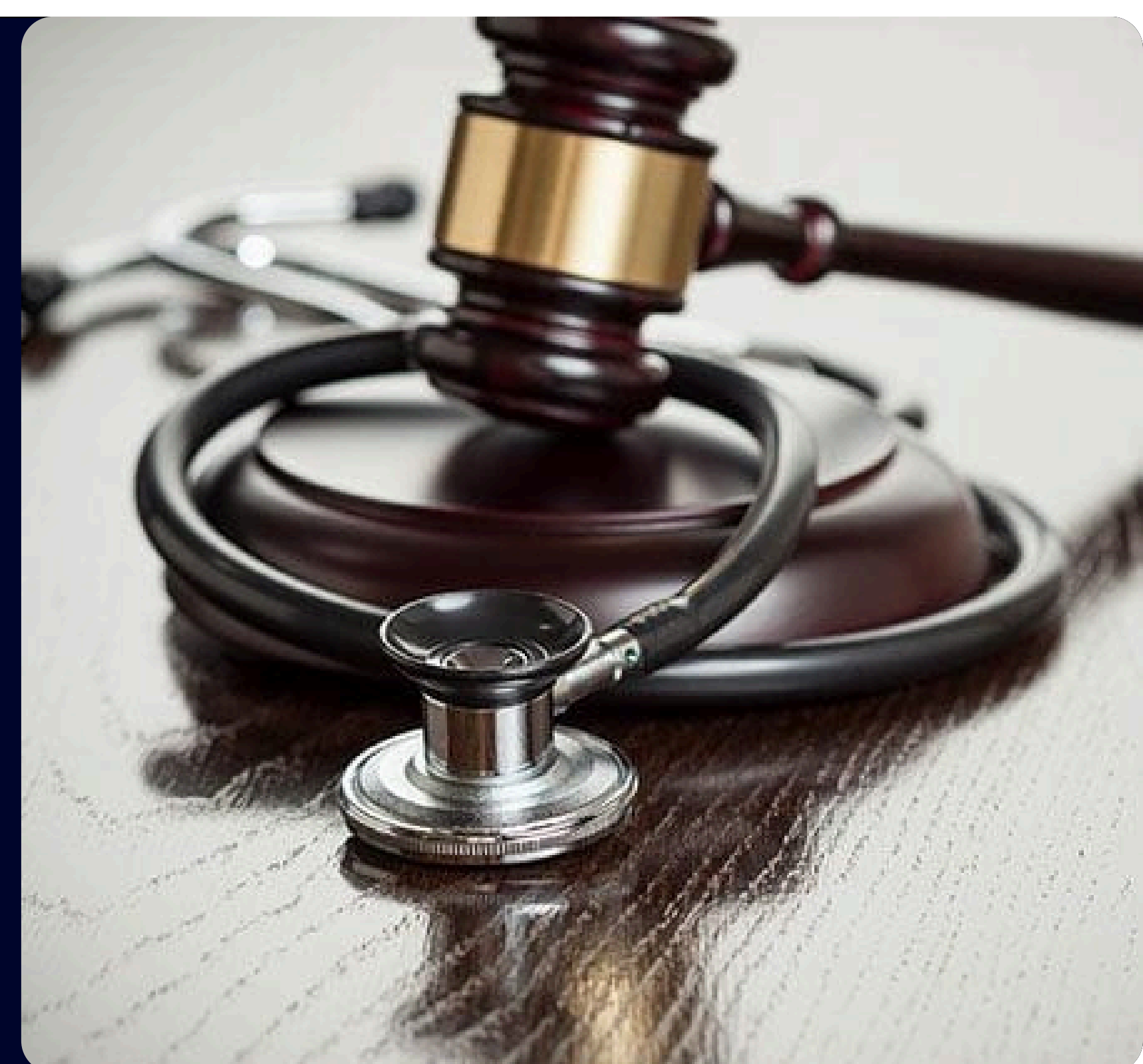
3. Then it is rather mandatory to report this incident to the police immediately. Any settlement or compromise with the patients / attendants must be made only with proper legal advice. (In this case, the patient underwent a TIFFA scan during her sixth month of pregnancy. The scan reported no anomaly, but the child was born without a left arm. The patient filed a medical negligence case against the doctors (OPs). One interesting allegation was that when this matter was raised before the village elders, the doctors (OPs) accepted their negligence and promised compensation but later refused. The court did not comment on this aspect.)

4. Diagnostic tools have limitations; therefore, investigation reports may not always be accurate. The courts recognize these shortcomings and do not hold doctors / facilities negligent for incorrect reports in such cases. Informing the patients / attendants specifically about such shortcomings and providing appropriate disclaimers regarding the accuracy and limitations of the report is all that is expected from the doctor / facility by the courts. (In this case, the patient underwent a TIFFA scan in her sixth month of pregnancy, which reported no anomaly. However, the child was born with a deformity. In defence, it was pointed out that the advanced stage of pregnancy hindered the effective examination of the foetus for any abnormalities. The 26-week-old foetus's flexed position and limited space made it challenging to achieve 100% detection of congenital deformities, even with the available technology. Consequently, the scanning report specifically mentioned “to the extent visualized,” which should be correlated to the clinical findings. On perusing the medical records, the court accepted the defence and held that there was no negligence.)

KEY TAKEAWAY

Advanced investigations have limitations, especially when performed beyond the recommended timeframe.

Clear communication, informed consent, documentation, and honest explanation of limitations are the best legal protection





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1

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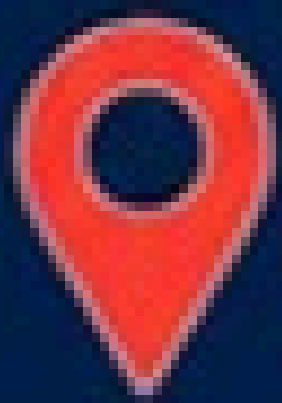
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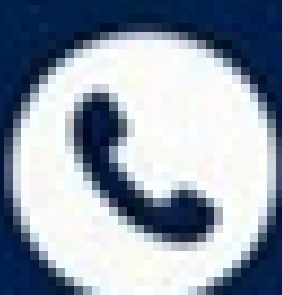
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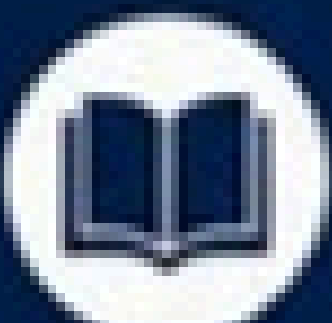
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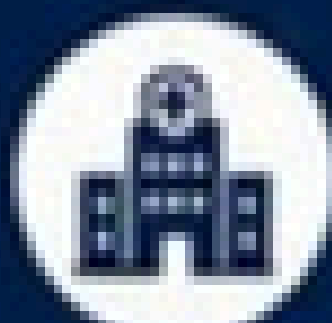
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COUNSELLOR / DOCTOR CAN SHARE PATIENT'S HIV STATUS WITH THEIR PARTNERS / SPOUSE REITERATES COURT CITING NACO GUIDELINES



Dr. Lakshmi Priya N v/s Dr. Sheela Sadashivan

Kerala State Consumer Disputes Redressal Commission,
Thiruvananthapuram

Judgment in favour of: **Doctor**

Facts of the case

1. The patient experienced bleeding and pain after her first intercourse following her marriage and consulted the gynecologist (OP). She was thoroughly assessed and provisionally diagnosed with vaginismus. The patient was advised to undergo various blood tests, including an HIV antibody test, and was managed conservatively.

Patient's allegation/s of medical negligence

1. It was alleged that the patient's husband received the patient's HIV report in her absence, which contributed to their marital discord.
2. Additionally, it was alleged that while the patient was referred for an HIV test, her husband was not referred for the same test, and surgery was unnecessarily recommended to the patient.

Doctor's defense

1. It was stated that a local examination was performed, but the patient did not allow a vaginal examination. Consequently, a provisional diagnosis of vaginismus was made.
2. It was further stated that the patient was informed that a hymenectomy might be needed and was therefore advised to take blood tests, including the HIV antibody test, as part of the treatment. However, the patient did not turn up for follow-up.

Findings of the Court

1. The court, on perusal of medical records, found that the patient's husband had requested complete

medical details from the gynaecologist (OP) for consultations elsewhere. The court, observed that sharing of HIV test results with partners is allowed under the NACO guidelines. Hence, the court held that there was no violation of ethics by the gynaecologist (OP). Moreover, the divorce petition filed by the husband did not refer to the medical certificate issued by the gynaecologist (OP).

2. The court further found that the gynaecologist (OP) had followed standard procedures in the patient's treatment and that the patient's consent for the HIV antibody test was obtained and documented.
3. Hence, the court did not find the gynaecologist (OP) negligent.

Suggested Precautions

1. According to clause 3.6 of the National HIV Counselling and Testing Services Guidelines issued by the National AIDS Control Organisation (NACO), the doctor / counsellor may share a person's HIV test result with that person's partners and provide thorough counselling to them about the implications of the test results. (In this case, the patient who consulted the gynecologist (OP) alleged that the gynecologist (OP) shared the patient's treatment details, including HIV test results, with her husband, which led to their marital discord. The court. Upon reviewing the NACO guidelines, observed that sharing HIV test results with partners is permitted and therefore held that the gynecologist (OP) did not violate ethics by sharing these details with her husband.)

2.Ensure that the patient's attendants are appropriately authorized by the patient to receive the patient's medical records / certificates. Obtain the authorization in writing, especially when issuing sensitive information that may pose a potential threat or breach of privacy to the patient. (In this case, the patient, accompanied by her husband, sought treatment from the gynecologist (OP) and was advised to undergo an HIV test. In one of the allegation, it was pointed out that the gynecologist (OP) had shared the patient's treatment details with her husband, which he later used in divorce proceedings. The gynecologist (OP) clarified that the details were disclosed because the husband indicated that the couple wanted further treatment elsewhere. The court rejected this allegation. Nevertheless, extreme care and caution were expected from the gynecologist (OP) when handing over the medical records to the patient's husband.)

3.The patient's physical examination is integral to the treatment, but it cannot be forced. Clearly explain the necessity of the physical examination to the patient for accurate diagnosis, monitoring or other purposes. If the patient is unwilling to cooperate or feels uncomfortable with certain examinations, then advise and perform alternatives. Record the refusal explicitly in the medical records. (In this case, the patient consulted the gynecologist (OP) after experiencing pain from first intercourse after marriage and later sued the gynecologist (OP) for

negligence. and later sued the gynecologist (OP) for negligence. In one defense, the gynecologist (OP) specifically pointed out that a local examination was conducted, but the patient did not permit a vaginal exam. Thus, a provisional diagnosis of vaginismus was made.)

4.Obtain informed consent from the patient before performing the HIV test. Explain the necessity of this test and maintain a detailed record. (In this case, the patient was advised to undergo the HIV test by the gynecologist (OP) due to her complaints after marriage, which she later questioned in court. The court, after reviewing the medical records, found that consent was obtained from the patient for the HIV test, indicating that she was informed of the reasons, and thus rejected this allegation)

5.Ensure that medical records and certificates are detailed accurately with the date and time. Oversights can sometimes lead to medical and legal issues. (In this case, the patient consulted the gynecologist (OP) with her husband. Later, her husband obtained a medical certificate from the gynecologist (OP) in her absence. The patient alleged that the gynecologist (OP) had intentionally pre-dated the certificate by 3 months to assist her husband in a divorce case. The court, reviewing the medical records, accepted the gynecologist (OP) defense that it was a clerical oversight by the staff and that there was no ulterior motive as alleged.)

4.

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awareness, confidence becomes
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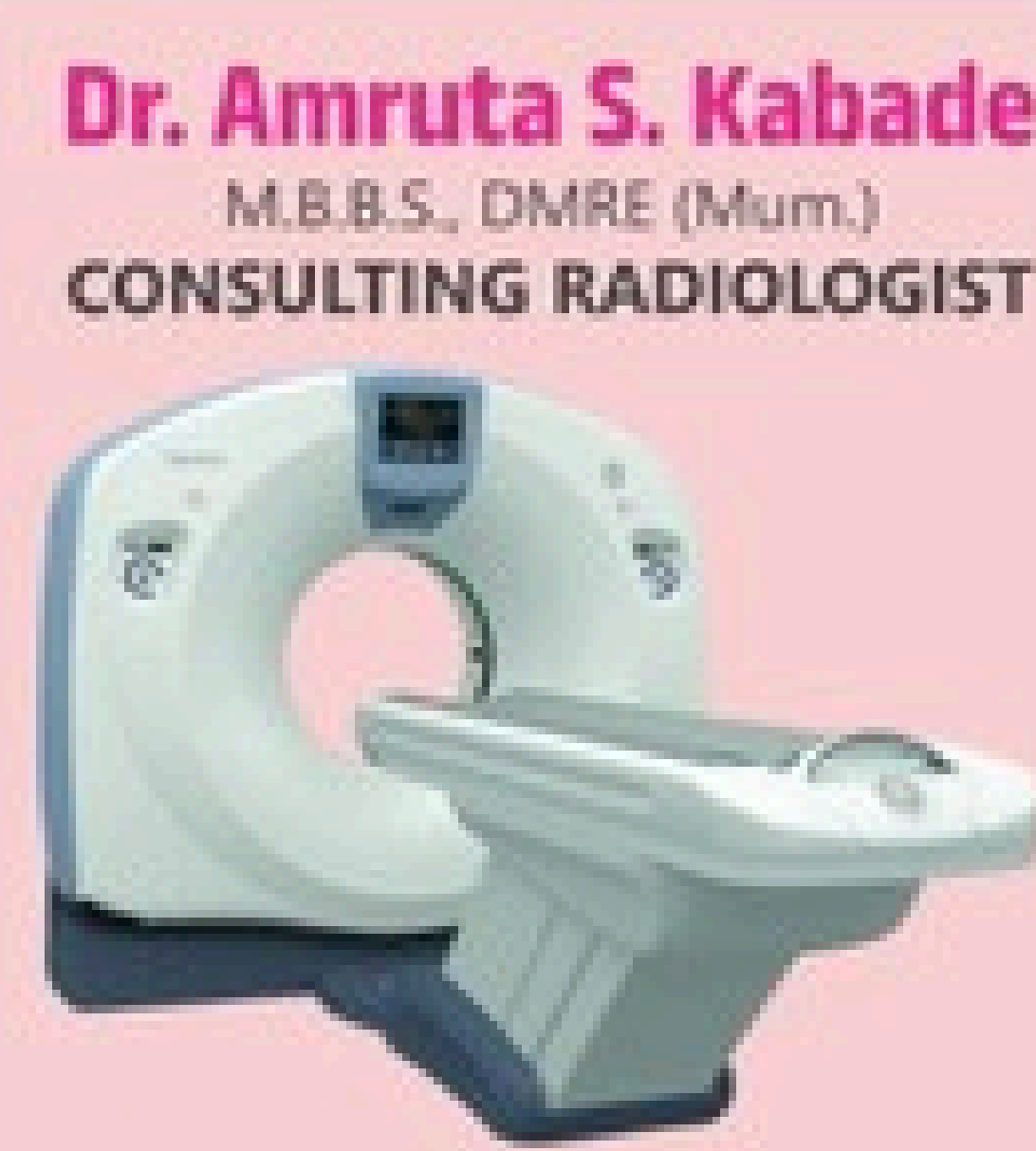


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TELEMEDICINE: MEDICO-LEGAL DO'S & DON'TS FOR DOCTORS

PROFESSIONAL GUIDE FOR SAFE, ETHICAL & LEGALLY COMPLIANT DIGITAL PRACTICE



Telemedicine improves access to healthcare, but remote consultation does not reduce a doctor's duty of care. Follow professional standards, maintain records and protect patient rights.



Legal Reference: Telemedicine Practice Guidelines, Ministry of Health & Family Welfare, Government of India (25 March 2020)-applicable framework in 2026



1. IDENTIFY THE PATIENT

- Take reasonable steps to establish the patient's identity
- Record name, age, contact details and relevant medical history.
- Confirm if the person is the patient or an authorised caregiver.
- Never assume identity based on phone number or message.



2. IDENTIFY YOURSELF AS THE DOCTOR

- Introduce yourself clearly at the start of consultation.
- Display/communicate your name, qualification and medical registration number as applicable
- This builds trust and establishes professional authority.



3. CONSENT MATTERS

- Where patient initiates the consultation, consent is generally implied. Explicit consent is required in specified situations, including when consultation is initiated by the RMP.
- Explain the nature, benefits, limitations and risks of
- telemedicine when appropriate.
- Document consent in the medical record.



4. KNOW THE LIMITS OF REMOTE CONSULTATION

- Telemedicine is not suitable for all conditions.
- Prefer in-person consultation when:
 - Physical examination is essential
 - Diagnosis is uncertain or condition is serious
 - Patient has emergency symptoms
 - Investigations or procedures are required
 - You are not comfortable managing remotely

RED FLAG: If adequate assessment is not possible remotely, refer the patient for in-person evaluation without delay.



5. 3 DOCUMENT EVERY IMPORTANT STEP

- Good documentation is your best protection.
- Record the consultation with: Date & Time, Patient Identity, History & Assessment, advice & Prescription, Investigations/ Referral, Follow-up Plan

DO'S & DON'TS IN TELEMEDICINE PRACTICE

✓ DO'S



DO verify patient identity

Take reasonable steps to confirm identity before consultation.



DO identify yourself professionally

Communicate your qualification and medical registration details as applicable.



DO obtain appropriate consent

Follow applicable consent requirements and document it.



DO maintain confidentiality

Protect patient information, reports, images and conversations from unauthorised access



DO maintain proper records

Document every consultation, advice, prescription and follow-up



DO use clinical judgment

Decide whether telemedicine is suitable for the patient and conditions



DO refer when necessary

Refer to specialist, diagnostic centre or hospital whenever clinically appropriate

✗ DON'TS



DON'T treat every WhatsApp message as a consultation.

A casual message may not provide adequate clinical information.



DON'T ignore emergency symptoms.

Patients with potential emergencies should be referred for immediate care



DON'T prescribe without adequate assessment.

Prescribe only after proper clinical assessment and in accordance with guidelines.



DON'T share patient information casually.

Never forward photos, reports, prescriptions or conversations without authorisation.



DON'T promise guaranteed results.

Avoid statements like "100% cure" or "guaranteed treatment"



DON'T continue when information is insufficient.

If you cannot reach a reliable conclusion, advise an in-person evaluation.



DON'T forget documentation

Poor documentation can make it difficult to justify your clinical decisions.



WHEN TO STOP THE ONLINE CONSULTATION?

If the patient has emergency symptoms, severe deterioration, significant diagnostic uncertainty or needs a physical examination, **DO NOT DELAY – REFER FOR IN-PERSON / EMERGENCY CARE.**



KEY MESSAGE

"Telemedicine changes the method of consultation, not the doctor's duty of care."

Safe Telemedicine = Appropriate Assessment + Consent + Confidentiality + Documentation + Timely Referral



SURGEON VENTURES TO PERFORM ELECTIVE **HIGH-RISK ANGIOPLASTY** ASSUMING PATIENT / DAUGHTER BOTH DOCTORS KNEW THE RISKS – COURT HOLDS SURGEON CANNOT **“SHIRK”** THIS RESPONSIBILITY



Dr. Manju Dadu v/s Fortis Escort Heart Institute & Research Centre & Ors.

National Consumer Disputes Redressal Commission, New Delhi

Judgment in favour of: **Patient**

Facts of the case

1. A 62-year-old patient, a doctor by profession, was diagnosed with 2 blocked arteries and a potentially blocked third artery. He underwent angioplasty on the two blocked arteries, performed by the cardiologist (OP2). After a few months, the patient experienced pain in his cheek and consulted the cardiologist (OP2), who advised angiography. The reports revealed a 60–70% blockage in the third artery, while the stented arteries appeared fine. The patient underwent angioplasty for the third artery. Post-procedure, he was placed on a ventilator due to breathing difficulties. Later, he was transferred to the ICU, where he received heparin to maintain his blood pressure. A CT scan confirmed that he had suffered a brain hemorrhage. A neurosurgeon (OP3) from the second hospital was called, and he performed a ventriculostomy. A repeat CT scan revealed a hematoma requiring surgery. Consequently, the patient was transferred to a second hospital, where the surgery was carried out. Later, he slipped into a coma for nearly a month. When he emerged from the coma, he was paralyzed on the left side and had lost his ability to speak, hear, or understand others. The patient was then transferred to a third hospital, where he stayed for almost three months. Upon discharge, he could barely walk without assistance.

Patient's allegation/s of medical negligence

1. It was alleged that angiography revealed a 60–70% blockage in the third artery. (i.e., the right coronary artery) hence there was no need for angioplasty; nevertheless, it was performed unnecessarily.

2. It was also alleged that although the patient was a known diabetic for the last 20 years, the cardiologist (OP2) administered heparin, causing a brain haemorrhage and informed the cardiologist (OP2), but he ignored this information. It took 72 hours to diagnose the brain haemorrhage, which was the most critical period to save the patient, and this delay resulted in irreparable harm.
3. It was pointed out that the cardiologist (OP2) contacted the neurosurgeon (OP3) from another hospital, located 15 km away, to perform a ventriculostomy since the hospital (OP1) lacked the necessary neurosurgery facilities. However, the hospital's (OP1) board displayed that they had a “team of neurosurgeons”.

Doctor's defense

1. In defence, it was stated that the hospital (OP1) is renowned for offering world-class cardiac facilities and relied on one of its associate hospitals for non-cardiac specialities, particularly neurosurgical services.
2. Furthermore, it was stated that angiography revealed 70% stenosis in the right coronary artery. The cardiologist (OP2) advised elective angioplasty of the third artery in light of positive stress tests and recent symptoms of angina, which was discussed with the family. Further, the patient and his daughter, both doctors, were aware of the risks, benefits, and repercussions, and they consented to the angioplasty, insisting that it be performed on the same day.



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3. It was pointed out that after the repeat CT scan revealed a large haematoma, and after due deliberation with the neurologist (OP3), it was deemed proper and in the patient's best interest to transfer him to the second hospital; accordingly, he was shifted.
4. It was stated that an Intra-Aortic Balloon Pump (IABP) was inserted to support blood pressure, and a small dose of anticoagulation (heparin) was necessary and mandatory to prevent clots. Moreover, no potent anticoagulant was ever given to the patient, and he was already on antiplatelet therapy. Spontaneous bleeding could occur in such patients.

Findings of the Court

1. The court specifically commented that the cardiologist (OP2) cannot shirk his responsibility by claiming that the patient and his daughter were doctors who had given their informed consent, knowing the risks and benefits.
2. Upon reviewing the medical records, the court observed that the patient's radiology report for the chest indicated "congested lung fields." Despite these findings and the patient's diabetic status, the cardiologist (OP2) overlooked and performed angioplasty which was elective at the time. This led to severe pulmonary oedema within half an hour of starting the procedure. Consequently, the court drew an adverse inference against the cardiologist (OP2).
3. The court found from the medical records that a CT scan was performed the day after the convulsions were noted. Furthermore, a ventriculostomy was conducted after more than 14 hours of convulsions, a repeat CT scan of the brain was done 20 hours later, and the patient was transferred for surgery 6 hours later. The court held that this delay constituted gross negligence.
4. Hence, the court held the cardiologist, neurologist and the hospital (OPs) negligent.

Suggested Precautions

1. Informed consent is a critical component of medical procedures, ensuring that patients and their families fully know the risks and benefits of a treatment. When patients and family members are doctors themselves, they possess a unique understanding of the medical intricacies involved.)

However, the doctor's duty remains to keep them informed about the surgery's pros and cons and ensure that consent is truly informed. (In this case, the patient developed a brain haematoma post-angioplasty and subsequently slipped into a coma. It was alleged that the cardiologist (OP2) had not informed the patient about the risks. The cardiologist (OP2) pointed out in defence that the patient and his elder daughter were doctors, and as such they were aware of the risks, benefits and repercussions and had consented to the angioplasty. The court outrightly rejected the defence commenting that the cardiologist (OP2) "cannot shirk their responsibility by saying that the patient and his daughter were doctors and they had given their informed consent, knowing well the risks and benefits."

2. In the current healthcare environment, hospitals generally collaborate with one another to offer a broad and advanced range of specialized treatments that meet patients' medical needs. However, it is crucial to keep patients / attendants adequately informed. Ensure that accurate information is displayed on signboards and in printed materials shared with patients and the public, and there is no misrepresentation. (In this case, the patient developed a brain haemorrhage post-angioplasty. Later, the patient was transferred to the second hospital for surgery, where he subsequently slipped into a coma. It was alleged that the hospital (OP1) did not have the necessary neurosurgery facilities, although its display boards listed a "team of neurosurgeons." In defence, it was stated that the hospital (OP1) relies on the second hospital, one of its associates, for non-cardiac specialties, particularly neurosurgical backup. The court did not comment on this aspect.)

3. Your decisions and actions must not only adhere to accepted standards but also be prompt and timely, especially when managing critical or emergency patients. This involves identifying complications, recommending investigations, making a confirmed diagnosis, and taking necessary measures swiftly, where time is of the essence. Document the details in the medical records. (In this case, the patient suffered a brain haemorrhage after angioplasty and was attended by a neurosurgery team. Ultimately, his condition worsened, and he was transferred to a second hospital, where he slipped into a coma following surgery. The court opined that the patient was managed according to standard guidelines, but specifically noted from medical records a considerable delay of one day in performing a CT scan despite the patient exhibiting convulsions; a repeat CT scan of the brain was conducted after 20

hours: and it took 6 hours to shift the patient for surgery. Almost 72 hours were lost. Therefore, the court held that the hospital and the doctors (OPs) committed gross negligence, which caused permanent brain injury to the patient, leading to coma and paralysis. Even the Medical Council of India commented that “the patient leading to coma and paralysis. Even the Medical Council of India commented that “the patient did not receive timely treatment,” although treatment was administered according to the guidelines.

4. Prescribe and administer the drugs with due diligence and as per medical science, considering the patient’s medical condition, age, complaints, and other relevant factors. Monitor the patient’s vital parameters at regular intervals and take appropriate actions in case of any complications. (In this case, the patient underwent angioplasty, suffered a brain haemorrhage, and later slipped into a coma. One allegation pointed out that the patient was a known diabetic for the last 20 years, but was administered heparin, which caused the brain haemorrhage. In defence, the cardiologist (OP2) stated that an Intra-Aortic Balloon Pump (IABP) was inserted to support blood pressure. Therefore, a small dose of heparin was necessary to prevent limb

arteries from forming clots. The court rejected this defence upon reviewing the medical records and finding that heparin was continued even post-surgery, although the patient from various vital organs with falling platelet levels.)

5. Consider all existing comorbidities of the patient, weigh the risk-reward ratio, and only then proceed with interventions, particularly elective ones. Emergencies are exceptions. (In this case, the patient underwent angioplasty at the hospital (OP1), after which he slipped into a coma due to brain haemorrhage. The court, upon reviewing the medical records, found that the 62 years old patient, was a known case of type 2 diabetes mellitus for the past 20 years, hypertension, coronary artery disease, multiple tuberculomas with tubercular meningitis for the last 1.5 years, had been on ATT for one year, and “congested lung fields” was reported during a routine medical check-up. The court held the cardiologist (OP2) negligent for overlooking the patient’s lung condition and comorbidities while performing angioplasty, even though it was elective, resulting in adverse outcomes.)



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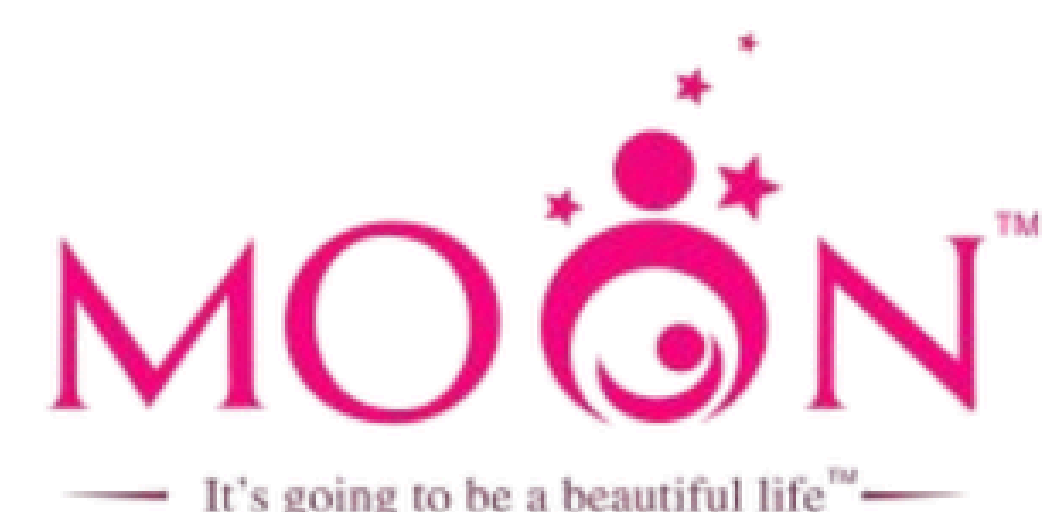
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GENUINE DIFFERENCES OF OPINION OR DIFFERING DIAGNOSES AMONG DOCTORS DO NOT NECESSARILY INDICATE NEGLIGENCE NATIONAL CONSUMER COMMISSION



Dr. K. Rajesh Reddy v/s Yashoda Hospital & Ors

National Consumer Disputes Redressal Commission, New Delhi

Judgment in favour of: **Dector**

Facts of the case

1. The patient's neurological issues began with constipation, followed by difficulty in walking and weakness in the lower limbs within a year. He also experienced urinary problems. The patient consulted the neurologist (OP1) at the hospital (OP2), who diagnosed him with Multiple Sclerosis (MS). The patient was admitted and discharged on the same day, and medications were prescribed. The discharge summary recorded doubts about the diagnosis, suggesting possibilities of Acute Transverse Myelitis or other demyelinating conditions.

Patient's allegation/s of medical negligence

1. It was alleged that the incorrect diagnosis led to the administration of unnecessary medicines, and an inappropriate line of treatment was followed by the neurologist (OP1).
2. It was also alleged that the neurologist (OP1) began treatment despite the test reports being negative for MS and further disregarded the expert opinion from the higher institute, resulting in the patient's deteriorated condition and non-functional lower limb.
3. Furthermore, the neurologist (OP1) reduced the dosage of the medication without explanation, leading to increased spasticity.
4. It was also alleged that the patient's condition did not improve, and he continued to walk with a stick even after the installation of a Baclofen pump.

Doctor's defense

1. It was stated that the patient had been receiving conservative treatment even before consulting the neurologist (OP1). Furthermore, all the indicated tests were promptly carried out after admission. The patient showed immediate improvement but was discharged on the same day.
2. It was further stated that the cerebrospinal fluid test confirmed normal protein and sugar levels, ruling out nervous system infection or active vasculitis, but not completely ruling out MS.
3. It was also stated that the Intrathecal Baclofen injection was administered after a thorough explanation and consent from the patient.
4. It was pointed out that the neurologist (OP1) referred the patient to the higher institute. However, even their team of doctors could not reach a definitive diagnosis, and the possibility of MS remained uncertain. Furthermore, the higher institute suggested a biopsy, which was not advisable due to the procedure's risks and potential damage.

Findings of the Court

1. After perusing the medical records, the court found that the MRI scan and pathological test reports did not conclusively diagnose the disease and did not support the patient's allegation of vasculitis. The court observed that the report from the higher institute, which the patient relied upon, indicated a diagnosis of MS by one of the resident doctors, but there was no firm opinion about vasculitis.

2. The court also noted specifically that the patient did not return to the higher institute after undergoing Ayurvedic treatment.
3. After reviewing the medical records, the court observed that pathological reports, radiological analysis, and clinical examination supported the neurologist's (OP1) treatment. The diagnosis of MS was consistent with norms, especially considering the rarity of spinal cord vasculitis. Moreover, the treatment for vasculitis is similar to that for MS and did not result in any adverse effects. and a higher institute was consulted by the neurologist (OP1).
4. Hence, the court did not hold the neurologist (OP1) negligent.

Suggested Precautions

1. Differences of opinion regarding diagnosis or the course of treatment are acceptable in both medicine and law. A genuine difference of opinion or conclusion among medical professionals does not indicate medical negligence. In cases where there is no firm opinion or uncertainty about a condition or its diagnosis, it is advisable to consult other doctors and perform appropriate investigations. Monitor continuously and keep reevaluating, especially when treatment is not yielding results. This minimizes the risk of misdiagnosis or inappropriate treatment. This case illustrates this point. The patient alleged that he was misdiagnosed and treated for MS instead of vasculitis.

The neurologist (OP1) pointed out that there was no definitive diagnosis, and the reports did not rule out MS. Furthermore, the patient was referred to a higher institute, where this dilemma persisted. Upon reviewing the medical records, the court found that the opinion of the higher institute referred to by the neurologist (OP1) was also not a conclusive diagnosis. The court found that the neurologist (OP1) followed the standard protocol in managing the patient and observed that "genuine difference of opinion and a mere difference of conclusion cannot give rise to a presumption about gross medical negligence". The court rejected the allegations regarding misdiagnosis.

2. Use standard words, abbreviations, and symbols when writing medical records. This reduces misunderstanding and miscommunication among healthcare providers and helps in legal proceedings. (In this case, the patient alleged that he was given the wrong treatment based on the incorrect diagnosis of the neurologist (OP1), who diagnosed him with Multiple Sclerosis (MS) instead of vasculitis. The court found that in the discharge summary, "a doubt was expressed in the diagnosis about Acute transverse myelosis (?) infective (?) and demyelinating." The court also perused another report by a higher institute consulted by the patient. The court observed that "the word vascular has been used with a question mark, meaning thereby that there was no firm opinion about vasculitis as well. This was suspected but not finally diagnosed." The court, referring to these medical records, held that the diagnosis was not definitive and only presumptive and rejected this allegation.)





DISCHARGE AGAINST MEDICAL ADVICE (DAMA/LAMA):

LEGAL PRECAUTIONS FOR DOCTORS



**DAMA/LAMA
DOCUMENTED**

Patients have the right to refuse treatment and leave the hospital. However, when they leave against medical advice, it may lead to serious risk to their health or life. Proper documentation, clear communication and adherence to legal protocols are essential to protect both the patient's autonomy and the doctor's professional integrity.

WHAT IS DAMA/LAMA?

DAMA (Discharge Against Medical Advice) or LAMA (Leave Against Medical Advice) refers to a situation where a patient, after being advised to continue treatment or stay in hospital, chooses to leave against the doctor's medical advice.

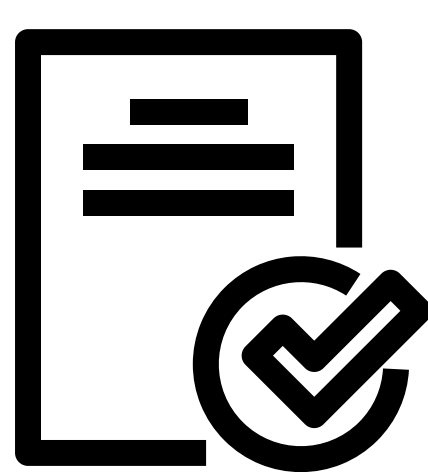
WHY DO PATIENTS LEAVE AGAINST MEDICAL ADVICE?



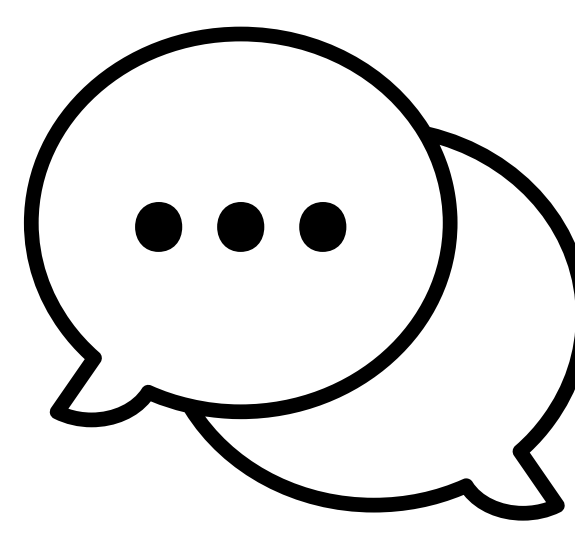
Financial
constraints



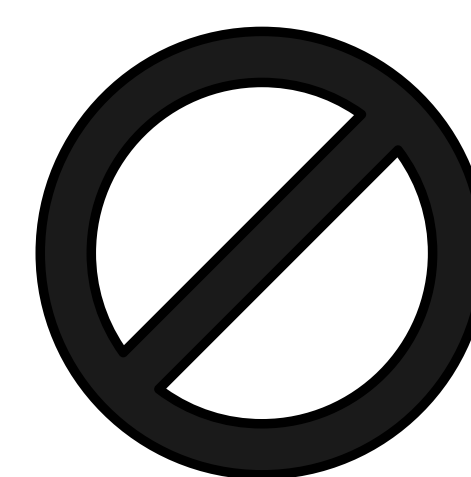
Personal or
family reasons



Fear or lack of
understanding



Lack of trust or
communication



Against medical
recommendation

RISKS/COMPLICATIONS OF DAMA/LAMA

- Condition may worsen, leading to disability or death
- Patient or family may allege negligence or inadequate care
- Legal action/Consumer complaints/Criminal cases
- Reputational damage to doctor and hospital.



8 ESSENTIAL LEGAL PRECAUTIONS FOR DOCTORS (2026)

- 1. **EXPLAIN THE CONDITION & RISKS** – Clearly explain the patient’s diagnosis, seriousness of illness, need for treatment and risks of leaving against advice.
- 2. **ADVICE IN SIMPLE LANGUAGE** – Use understandable language. Ensure the patient (and attendant) understands the consequences.
- 3. **ADVICE & TREATMENT RECORS** – Document in detail: history, examination findings, treatment given, investigations advised and your medical advice.
- 4. **TAKE WRITTEN DAMA/LAMA FORM** – Use hospital’s standard DAMA/LAMA form. Get signature/thumb impression of patient and attendant/witness.
- 5. **INFORM CONSEQUENCES** – Clearly mention possible risks, complications, disability or death in the form. Get acknowledgement.
- 6. **INFORM FOLLOW-UP ADVICE** – Advise to return immediately if condition worsens. Mention warning signs and when to seek urgent care.
- 7. **INFORM ABOUT ALTERNATIVES** – If patient refuses treatment here, advise alternative options (referral to another centre).
- 8. **MAINTAIN RECORDS SAFELY** – Keep all records, forms, investigation reports, nursing notes, IPD papers safely for minimum 8 years.

DAMA / LAMA FORM

(Discharge Against Medical Advice)

Patient Name : _____

Age / Sex : _____

UHID / IP No. : _____

Diagnosis : _____

Advice Given : _____

Advice Given : _____

Patient’s Decision : _____

I have been explained my condition and risks. I will return if condition worsens and medical advice. I take full responsibility for my decision.

Patient Signature / Thumb Impression : _____

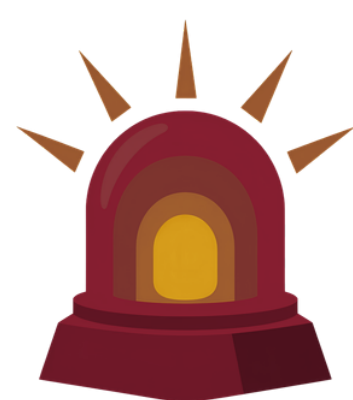
Date / Time : _____

Attendant / Witness Name : _____

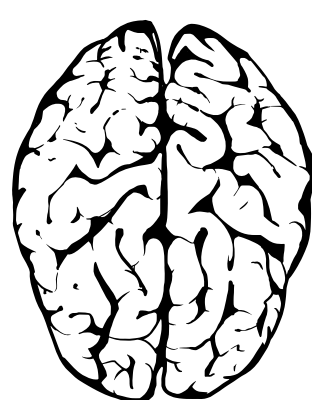
Signature : _____

Doctor’s Name & Signature : _____

Date / Time : _____



EMERGENCY CASES
Stabilize the patient to the best possible extent (as per EMTALA principle & Indian law). Document all efforts.



PSYCHIATRIC PATIENTS
Assess mental capacity. If patient lacks capacity, act in best interest as per Mental Healthcare Act, 2017.



MINORS
Consent of parent/guardian is essential. Explain risks to guardian and take written DAMA.



MLC / POLICE CASES
Inform police as per law. If patient leaves against advice, note it in MLC and inform police in writing if required.

“Good documentation today is your best protection tomorrow.”

LEGAL POSITION IN INDIA (2026)

- Every competent adult has the right to refuse treatment under Article 21 of the Constitution (Right to Life & Personal Liberty).
- The Supreme Court in *Samira Kohli vs. Dr. Prabha Manchanda & Ors.* (2008) 2 SCC 1 held that every patient has the right to refuse treatment. Doctor must respect the patient's autonomy.
- *Common Cause vs. Union of India* (2018) – Right to Die with Dignity recognizes patient autonomy and advance medical directives.
- Doctors are not liable for negligence if proper precautions are taken, risks explained and patient leaves against advice after understanding.



KEY JUDGEMENTS (IMPORTANT REFERENCE)

- ✓ **Samira Kohli vs. Dr. Prabha Manchanda & Ors. (2008) 2 SCC 1**
Right to refuse treatment is part of right to life and personal liberty.
- ✓ **Aruna Shanbaug Case (2011) 4 SCC 454**
Court emphasized dignity of patient and informed decision.
- ✓ **Common Cause vs. Union of India (2018) – Right to Die with Dignity case**
Recognized patient autonomy and advance medical directives.
- ✓ **Various State Consumer Commission Orders (2023–2025)**
Held hospitals/doctors not liable when proper documentation and DAMA procedure followed.

SAMPLE WORDING TO BE EXPLAINED TO PATIENT

“You have been advised admission/treatment for your condition. If you leave the hospital against medical advice, your condition may worsen and it may lead to serious complications, permanent disability or even death. You will be responsible for any consequences.”

WHAT DOCTORS SHOULD NOT DO

- ✗ Do not force or threaten the patient.
- ✗ Do not discharge without explaining risks.
- ✗ Do not skip documentation or written form.
- ✗ Do not ignore if patient is confused, intoxicated or lacks capacity.
- ✗ Do not delay informing police in MLC cases.

**NO
DOCUMENTATION
= NO PROTECTION**

DOCUMENTATION CHECKLIST (BEFORE DISCHARGE AGAINST ADVICE)

- ✓ Diagnosis and current condition noted
- ✓ Treatment advised and reasons explained
- ✓ Risks / complications / consequences explained
- ✓ Patient (and attendant) understood – documented
- ✓ DAMA/LAMA form filled, signed & dated
- ✓ Witness/attendant signature taken
- ✓ Advice for follow-up and warning signs given
- ✓ All entries with date & time in medical records
- ✓ Copy of form placed in medical record



FOLLOW-UP ADVICE & WARNING SIGNS (EXPLAIN TO PATIENT)

Advise patient to return immediately or visit nearest hospital if any of the following occurs:

- Breathlessness
- Chest pain
- Increased fever
- Decreased urination
- Bleeding
- Severe pain
- Drowsiness / confusion
- Any other worsening symptom

DISCLAIMER

This article is for educational purposes only and does not constitute legal advice. Doctors should use their professional judgment and follow institutional protocols and applicable laws





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Sub District Hospital (I.D. Hospital)

St Cruz Tisk Ponda, Mardangad, Ponda,
Goa 403401

KAKODKAR Hospital

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Goa 403401
Phone: 0832 231 2054

PRIOLKAR Nursing home

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Goa 403401

CONSENT: MORE THAN JUST A SIGNATURE

Informed consent is a process, not a form. It is the foundation of ethical practice and patient trust.

“ A well-informed patient is a partner in care, not just a recipient. ”



WHY CONSENT MATTERS

- 1. Respects Patient Autonomy**
It upholds the right of patients to make decisions about their own health.
- 2. Legal Protection**
Proper consent reduces the risk of disputes and strengthens your legal defense.
- 3. Builds Trust**
Transparency fosters confidence and strengthens the doctor–patient relationship.
- 4. Better Compliance**
Informed patients are more likely to follow treatment and instructions.
- 5. Ethical Obligation**
It reflects professionalism, humanity, and respect for patient dignity.

GOOD CONSENT PROTECTS

THE DOCTOR By ensuring clarity and documentation.	THE PATIENT By ensuring awareness and choice.	THE INSTITUTION By reducing avoidable disputes.	THE JUSTICE SYSTEM By ensuring fairness and transparency.

ELEMENTS OF VALID CONSENT

- i Information**
Diagnosis, nature of the treatment, procedures, benefits, risks, and alternatives.
- Understanding**
Information should be in simple, clear language the patient can understand.
- Voluntariness**
Consent should be given freely without pressure or coercion.
- Capacity**
Patient must be mentally and legally competent to decide.
- Documentation**
Properly recorded, dated, and signed (or thumb impression).

REMEMBER



A signature or left-hand thumb impression on paper is not enough; true consent comes from understanding, willingness, and informed choice.

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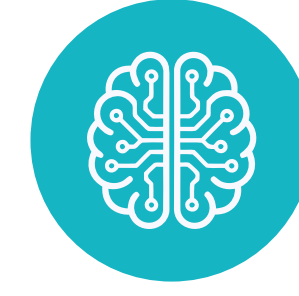


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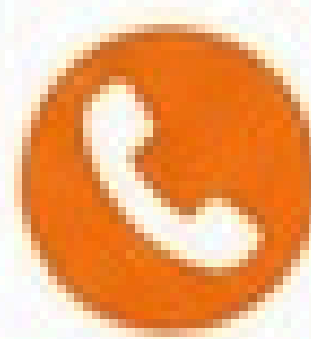
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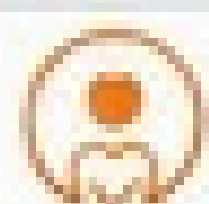


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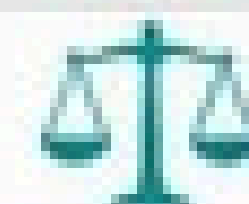
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