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INDIAN MEDICO LEGAL & ETHICS ASSOCIATION

Aims & Objectives

- To promote, support and conduct research related to medico-legal, ethical and quality care issues in the field of medicine.
- To help, guide, co-ordinate, co-operate and provide expert opinion to the government agencies, NGO, any semi-government, voluntary, government agencies, legal bodies / institutions and judiciary in deciding settled or unsettled laws or application of laws / rules related to medico-legal or ethical issues.
- To train the medical professionals in doctor-patient relationship, communication skills, record maintenance and prevention of litigations.
- To promote and support the community members and individuals in amicable settlements of the disputes related to patient care, management and treatment.
- To provide specialized training in related issues during undergraduate or postgraduate education.
- To organize conferences, national meets, CME, updates, symposia etc related to these issues.
- To identify, establish, accreditation and promote organizations, hospitals, institutes, colleges and associations working on the related and allied issues.
- To promote goodwill, better care, quality care, professional conduct, ethical values.
- To establish and maintain educational institutes, hospitals, medical colleges, libraries, research centers, laboratories etc. for the promotion of its objects and to provide scholarships, fellowships, grants, endowments etc. in these fields.
- To print and publish the bulletins, books, official journal / newsletters or periodicals etc on related and allied subjects.
- To co-operate, co-ordinate, affiliate and work with other bodies, agencies or organizations to achieve the objects.

Minimum Legal Points a Doctor should know

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Introduction

Minimum Legal Points a doctor should know is about emergencies, right to practice medicine and crosspathy practice. Same are described below.

Laws related to medical emergencies

The following questions repeatedly confront doctors, patients and social and legal activists:

1. Are doctors and hospitals bound to attend to emergency patients?
2. Is the obligation same for government hospitals and private hospitals?
3. If it is a police case, should the police formalities be first completed before attending to a patient?
4. What if the patient or her relatives do not have money to bear expenses for the treatment?

We read about and hear of many cases where emergency patients are sent from one hospital to another without receiving proper attention. Often private hospitals refuse to admit medico legal emergency cases (like accidents, poisoning and attempted suicide, etc.) and ask them to approach public hospitals.

In India, there is no law that deals specifically with the duties of health facilities and personnel to provide medical treatment in emergency cases. Emergency health care, like public health facilities falls in the shadow of Article 21. In other words, where there is a refusal to treat an emergency case, the patient may approach the court.

In the ordinary course of practice private medical practitioners and private hospitals, have a right to decide whether to undertake a case or not.

If the hospital refuses to treat a patient in emergency cases this can definitely amount to negligence in the performance of its duty towards the patient.

Chapter 2 of the Code of Medical Ethics Regulations 2002 drawn up by the Medical Council of India says:

2.1 Obligations to the sick:

Though a physician is not bound to treat each and every one asking his services except in emergencies for the sake of humanity and the noble traditions of the profession,……..

2.4 The patient must not be neglected:

A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service.

There is still no clarity on certain urgent but non emergency areas of health care. In the absence of a specific law, there is also not likely to be clarity in every area of health care since the law develops depending on the cases which come up before the court and such development is very erratic and uneven.

Obligation to Provide Emergency Health Care

In Paschim Banga Khet Mazdoor Samiti vs. State of W.B. the issue before the Supreme Court was the legal obligation of the Government to provide facilities in government hospitals for treatment of persons who had sustained serious injuries and required immediate medical attention. The petitioner who had suffered brain hemorrhage in a fall from the train was denied treatment at various government hospitals because of non-availability of beds.

The patient was given first aid in a PHC and referred to a specialized state hospital for better treatment. At the specialized hospital, the patient was examined and X-rays of his skull were taken which showed his condition to be serious. Immediate admission for further treatment was recommended. However, he was not admitted in that hospital as there were no vacant beds, and was referred to another specialized hospital. There too, he was refused admission as there were no vacant beds. After doing the rounds of three more state run specialized hospitals, the patient was admitted to a private hospital and the final bill came to much more than he could afford. He had to spend Rs. 17,000 for his treatment. The West Bengal government justified its action on the ground that the petitioner could not have been kept on the floor of a hospital or trolley because such an arrangement of treatment was fraught with grave risks of cross-infection, and moreover there was a lack of facility for proper care after the operation. The government of West Bengal further stated that state hospitals catered to the need of poor and indigent patients, and 90 per cent of the beds maintained by the state government all over the state, were designated as free beds for treatment of such patients. The Court also ordered that the Petitioner be paid Rs. 25,000 as compensation.

Implementation of Case Law on medical emergencies

Labonya Moyee Chandra vs. State of West Bengal case reflected the lack of seriousness of the State in executing its duties and the implementation of the directions and recommendations in Paschim Banga Khet Mazdoor Samiti case. The patient was an old woman residing in a village near the city of Burdwan who was denied admission in SSKM, a state hospital on account of nonavailability of bed even though her condition was recorded as critical. This hospital was also involved in the earlier case of Paschim Banga Khet Mazdoor Samiti. The patient suffered severe chest pain and difficulty in breathing. The local doctor examined her, diagnosed a heart block and recommended immediate hospitalization. She was taken to Burdwan where she was shown to Burdwan Medical College hospital (BMCH) who referred her to cardiology department of Seth Sukhlal Karnanl Medical College (SSKM) in Calcutta or any other State hospital having cardiology department as they didn't have the said facility. At SSKM, RMO referred her to the cardiology department who informed her that there were no vacant beds and referred her back to the RMO. She instead got admitted to a private hospital where she underwent an operation and a permanent pacemaker was implanted. There were two issues before the Supreme Court: First, whether the patient was brought to SSKM hospital in a critical state, and second, whether she was refused admission and 'turned out at night'. The Supreme Court considered the following evidence to conclude that the patient indeed was in a critical state, based on the case notes and prescription of the local doctor, the discharge certificate of the BMCH and the endorsement of the cardiology RMO on the outdoor emergency department ticket of the SSKM hospital:

1. The prescription of the local doctor recorded

that patient was unconscious, suffering from convulsion and frothing at the mouth. He diagnosed a complete heart block condition known as *Stokes-adams*. It is a medical term to designate occasional transient cessation of the pulse and loss of consciousness, especially caused by heart block. *'The condition of such patient must be critical.'* Accordingly the local doctor advised urgent hospitalization, and prescribed oxygen inhalation and medication.

2. Discharge certificate of BMCH described her condition as a 'complete heart block' and referred her to a State hospital with a cardiology department.

3. The endorsement of the cardiology RMO on the outdoor emergency department ticket of SSKM hospital also described her as suffering from a 'complete heart block' with S.A. Attack. This clearly showed that Appellant's condition was not stable as alleged by the State. As regards the second issue, the Supreme Court held that though the SSKM hospital did not turn her out, she could not possibly have been expected to bear with the jostling between the two departments when she was in a critical state. It was the responsibility of the doctor in charge of the cardiology department who examined her, to ensure that a bed was made available in any of the department so that she could be accommodated in the cardiology department as and when a vacancy arose.

The Supreme Court observed that despite the directions issued by it and the State government in Paschim Banga Khet Mazdoor Samiti case there had been no compliance of the same. The Appellant was denied treatment in BMCH on grounds of lack of proper facility. This was despite the specific direction in Mazdoor Samiti case to upgrade facilities and to set up specialist treatment in the district-level hospitals. "Clearly State Government has not taken any follow up action to ensure that recommendations are implemented." There was no 'centralized communication system' set up with the help of which BMCH could have referred the Appellant to a hospital that had vacant beds before setting her off on a long journey in a critical state. The 'admission register' maintained by SSKM hospital was not as per the guidelines set out in the Mazdoor Samiti case. The entries were haphazardly and irresponsibly made. They did not describe the medical condition of the Appellant although such a column had been provided. The inquiry report submitted by SSKM hospital to the Court did not show that a bed could not be arranged for the Appellant. It was silent about the occupancy of beds in other departments.

In the light of above circumstances and lapses on the part of State and the government hospital to implement the recommendations in PaschimBanga Khet Mazdoor Samiti case, the Supreme Court held the state liable to compensate the Appellant for the cost of the pacemaker assessed at Rs. 25,000. Further, the State government was directed to take follow up action on the implementation of the recommendations under the earlier case.

Medico Legal Cases on Right to Emergency Care during Accidents:

Parmanand Katara vs. Union of India was a petition filed by a human rights activist seeking directions against the Union of India that every injured citizen brought for treatment should be instantaneously given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death. The Petition also demanded that in the event of breach of such direction, apart from any action that may be taken for negligence, appropriate compensation should be admissible. The Petitioner had appended to the writ petition

a report titled 'Law helps the injured to die' published by the *Hindustan Times* that told the story of a hit-n-run case where the victim was denied treatment by the nearest hospital and asked to approach another hospital authorized to handle medico-legal cases but situated 20 km away. The victim succumbed to his injury on the way to the other hospital. There were three issues before Supreme Court:

1. Whether there are any legal impediments that hindered timely treatment in medico-legal cases;
2. What is the nature of the duty of the government, the government hospital and the police in medico-legal cases; and
3. Whether private hospitals could refuse to treat medico-legal cases?

The Medical Council of India in its affidavit stated that though doctors are not bound to treat every case they cannot refuse an emergency case on humanitarian grounds and the noble tradition of the profession necessitates this. The affidavit stated that the doctors were reluctant to undertake medico-legal cases because of unnecessary harassment by the police during the course of investigation and trial. The MCI urged that doctors attending medico-legal cases should be indemnified under the law from any action by the government/ police authorities so that it is conducive for doctors to perform their duties. Criminal procedure should be amended so that injured persons may be treated immediately without waiting for a police report or completion of police formalities. The Indian Evidence Act should also be amended so that the diary maintained by doctors in the regular course of their work is admissible as evidence for the purposes of the medico-legal cases in place of their presence during trial to prove the same.

The Supreme Court, agreeing with this, held that- There is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately. The effort to save the person should be the top priority not only of the medical professional but even of the police or any other citizen who happens to be connected with the matter or who happens to notice an incident or a situation.

Preservation of human life is of paramount importance. That is so on account of the fact that once life is lost, the status quo ante cannot be restored as resurrection is beyond the capacity of man. The patient whether he is innocent person or liable to be punished under the laws of the society, it is the obligation of those who are in charge of the health of the community to preserve life so that innocent may be protected and the guilty may be punished. Social laws do not contemplate death due to negligence to tantamount to legal punishment. A doctor at the Government hospital positioned to meet the State obligation is, therefore, duty bound to extend medical assistance for preserving life. Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. Indian courts have held that in emergencies neither government nor even private doctors can insist on payment of money before dealing with the patient. In Pravat Kumar Mukerjee vs. Ruby General Hospital, the National Consumer Commission was concerned with the case of a young student whose motorcycle was dashed by a bus in Calcutta. He was brought to the Respondent hospital but the treatment was not continued as Rs.15, 000 as demanded by the hospital were not immediately paid. The boy died. The National Commission held that though a doctor was not bound to treat each and every patient, in emergencies the doctor was bound to treat the patient and could not insist on delaying treatment until the fees were paid. The Petitioner was awarded a

compensation of Rs. 10 lakh. In conclusion all doctors and hospitals, whether private or government, have to treat emergency patients.

If they do not do so, the patient or immediate kin can approach the court for compensation for violating their right to life (Article 21). The excuse of having no beds does not hold in the case of government hospitals and detailed recommendations are given in this regard. The obligation is the same for government hospitals and private hospitals. The courts have clearly held that no legal procedures can take priority over providing life saving treatment for the patient.

Medical practice and crosspathy

a. What is medical practice?

b. When does a person become entitled to practice medicine?

c. Is cross practice permitted under the law?

d. Are persons who claim to have qualifications such as electropathy, etc. that are not recognized under any law entitled to practice their respective branches?

Medical practice in a given society depends on the quantum of knowledge and also on the extent to which such knowledge is made available to society. In fact, in a welfare state, the medical needs of society accelerate the growth of knowledge in the medical sciences. If medical sciences should be attuned to the aspirations of the Indian people as outlined in the Indian Constitution, medical personnel should be oriented to the practice of the art and science of medicine, in relation to India's social structure. The control of disease must form part of the general alleviation of the social and economic ills caused by the exploitation and deliberate neglect of the Indian villager through the last few centuries. Not every person who has studied medicine has a right to practice medicine. Not every degree or diploma qualifies a person to claim that he has studied medicine. Medical profession is governed by various Central and State Acts that prescribe standard of education and practice in the interest of public and to maintain high standard of the profession. Thus, to be eligible to practice there must be absolute adherence to the provisions of concerned Acts.

Since medical practice is part of the concurrent list of the Constitution, both Central as well as State Governments can pass laws concerning medical practice. Ordinarily if the State law conflicts with the Central law, the Central law will prevail. In respect of all systems of medicine Central as well as State laws have been passed.

- The Medical Council Act, 1956 regulates modern system of medicine;
- The Indian Medicine Central Council Act, 1970 regulates Indian systems of medicine including Ayurveda, Sidha and Unani systems of medicine
- The Homoeopathic Central Council Act, 1973 regulates practice of homoeopathic medicine.

Most State Governments have also passed laws each of these branches of medicines. All these laws have schedules which list the qualifications and degrees and diplomas which would entitle practitioners to practice a particular branch of medicine. Thus, the Medical Council Act, 1956 gives a list of degrees and diplomas which are recognized for practicing allopathic medicine. Similarly, say the Maharashtra Medical Practitioners Act has an additional list of degrees and diploma, available in Maharashtra that would also entitle practitioners to practice allopathic medicine. Medical Councils are set up at both Central and State levels, and these apart from their other functions also set the standards for medical ethics and parameters of medical malpractice.

Cross Practice –

- May a homoeopath prescribe allopathic drugs?

In Poonam Verma vs. Ashwin Patel, the Supreme Court made its famous observation:

A person who does not have the knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill, or to put it differently, a charlatan. The Court went on to observe that no person can practice a system of medicine unless he is registered either under the Central Indian Medical Register or the State Register to practice that system of medicine; and only such persons as are eligible for registration and possess recognized degrees as specified under the concerned Central and State Act may so practice. The mere fact that during the course of study some aspects of other systems of medicine were studied does not qualify such practitioners to indulge in the other systems. In this case, a registered homoeopathy doctor prescribed allopathic medicines to Poonam Verma's husband. His defense was that he had received instructions in modern system of medicine (allopathy), and after the completion of his course, he had worked as Chief Medical Officer at a well known allopathic clinic. The Supreme Court observed that a registered homoeopathic practitioner could only practice homoeopathy. Further the Court opined that, physiology and anatomy is common in all systems of Medicines and the students belonging to different systems may be taught physiology and anatomy together, but so far as the study of drugs is concerned, the pharmacology of all systems is entirely different. Therefore, merely because the anatomy and physiology are similar does not entitle a person who has studied one system of medicine to treat patients under another system. The Court held that the doctor was registered only to practice homoeopathy. He was under a statutory duty not to enter other systems of medicine. He trespassed into a prohibited field and was liable to be prosecuted under Section 15(3) of the Indian Medical Council Act, 1956. His conduct also amounted to an actionable negligence for any injury caused to his patients in prescribing allopathic drugs.

- May an ayurvedic doctor prescribe allopathic drugs?

In Mukhtiar Chand (Dr.) vs. State of Punjab the primary question before the Supreme Court was "who may prescribe allopathic medicines?"

This case raises questions of general importance and practical significance; questions relating not only to the right to practice medical profession but also to the right to life that includes the health and well-being of a person. The controversy in these cases was triggered by the issuance of declarations by the state Governments under clause (iii) of Rule 2(ee) of the Drugs and Cosmetics Rules, 1945 (for short 'the Drugs Rules') which defines "Registered Medical Practitioner". Under such declarations, notified vaids/hakims claim right to prescribe Allopathic drugs covered by the Indian Drugs and Cosmetics Act, 1940 (for short 'the Drugs Act'). Furthermore, vaids/hakims who have obtained degrees in integrated courses claim right to practice allopathic system of medicine. In exercise of the power under clause (iii) of Rule 2(ee) the State of Punjab issued a notice declaring all the Vaids/Hakims who had been registered under various medical acts as persons practicing modern System of Medicine for purposes of the Drugs Act. One Dr. Sarwan Singh Dardi who was a medical practitioner, registered with the Board of Ayurvedic and Unani System of Medicines, Punjab, and who was practicing modern system of medicines was served with an order of the District Drugs inspector, Hoshiarpur, prohibiting him from keeping in his possession any allopathic drug for administration to patients and

further issuing general direction to the chemists not to issue allopathic drugs to any patient on the prescription of the said doctor. Dr. Dardi claimed that he was covered by the said notification and was entitled to prescribe allopathic medicine to his patients and store such drugs for their treatment (hereinafter referred to as Dardi's case). The Court held that the said notification was ultra vires the provisions of sub-clause (iii) of clause (ee) of rule 2 of the Drugs Rules and also contrary to the provisions of Indian Medical Council (IMC) Act, 1956 and accordingly dismissed his writ petition. Now what does the rule 2(ee) say? It defines 'registered medical practitioner' as a person

i) Holding a qualification granted by an authority specified or notified under Section 3 of the Indian Medical Degrees Act, 1916, or specified in the Schedules to the Medical Council Act, 1956; or

(ii) Registered or eligible for registration in a Medical Register of a State meant for the registration of persons practicing the modern scientific system of medicine (excluding the homoeopathic system of medicine); or

(iii) Registered in a Medical Register (other than a register for the registration of homeopathic practitioner) of a State, who although not falling within sub-clause (i) or sub-clause (ii) is declared by a general or special order made by the State Government in this behalf as a person practicing the modern scientific system of medicine for the purposes of the Act. Through this petition, the doctors sought to reinforce their right to prescribe allopathic medicine on the strength of the notification and restrain State authorities from interfering with such a right. Similar issues also arose in various other high courts and finally all the cases reached the Supreme Court. The Apex Court observed that the Rule 2(ee) only defines the expression 'registered medical practitioners' and does not provide as to who can be registered. Therefore, the Court read the notification in consonance with laws regulating and permitting medical practice. As a rule medical practitioner can practice in that system of medicine for which he is registered as a medical practitioner. Under the IMC Act, 1956 there are two types of registration: under 'State Medical Register' and 'Indian Medical Register'.

According to Section 15(2) of the IMC Act only those who are enrolled in any State Medical Register can practice allopathic medicine in the State. Section 15(1) provides that qualifications specified in the Schedules of the Act shall be sufficient for enrolment in the State Medical Register. However, such qualification is not a necessary pre condition for registration. 'State Medical Register' is a contradistinction to 'Indian Medical Register' and is maintained by the State Medical Council constituted under any State law that regulates the registration of medical practitioners. It is thus possible that in a State, the law governing registration may enable a person to be enrolled on the basis of qualifications other than the 'recognized medical qualification'. On the other hand, 'recognized medical qualification' is a perquisite for enrolment in Indian Medical Register. To summarize, persons holding 'recognized medical qualification' cannot be denied registration in any State Medical Register, but the same cannot be insisted upon for registration in a State Medical Register. Further, a person registered in a State Medical Register cannot be enrolled on the Indian Medical Register unless he possesses 'recognized medical qualification'. The Indian Medicine Central Council Act, 1970 has made a similar distinction between 'State Register' and 'Central Register of Indian Medicine'. Section 17 of the Act provides the recognized medical qualification for enrolment in the State Register, and that no person other than those who are

enrolled either on the State register or the Central Register of Indian Medicine can practice Indian medicine. Section 17(3) carves out exceptions to this prohibition and protects, inter alia-

(a) The right of a practitioner of Indian Medicine enrolled on a State Register of Indian Medicine to practice Indian medicine in any State merely on the ground that, on the commencement of this Act, he does not possess a recognized medical qualification.

(b) Privileges including the right to practice any system of medicine which was conferred by or under any State law relating to registration of practitioners of Indian Medicine for the time being in force, on a practitioner of Indian Medicine who was enrolled on a State register of Indian Medicine.

(c) The right of a person to practice Indian medicine in a State in which, on the commencement of this Act, a State Register of Indian Medicine is not maintained if, on such commencement, he has been practicing Indian medicine for not less than five years. Thus, a harmonious reading of Section 15 of the IMC 1956 Act and Section 17 of 1970 Act leads to the conclusion that a medical practitioner of Indian Medicine enrolled on the State Register of Indian Medicine or the Central Register of Indian Medicine can practice modern scientific medicine only if he is also enrolled on a State Medical Register within the meaning of Section 15(2) of the 1956 Act.

The Supreme Court held that benefit of Rule 2(ee) and the notifications issued there under would be available in those States where the privileges to practice any system of medicine is conferred upon by the State law for the time being in force, under which medical practitioners of Indian Medicine are registered in the State. Lastly, doctors urged that integrated courses in ayurvedic medical education includes to an extent the study of modern scientific system of medicine. The right to practice a system of medicine is derived from the Act under which a medical practitioner is registered; whereas the right which the holders of a degree in integrated courses of Indian Medicine are claiming is to have their prescription of allopathic medicine honored by a pharmacist or a chemist under the Pharmacy Act and Drugs Act. The Supreme Court held that the right to prescribe drugs is a concomitant of the right to practice a system of medicine. Appellants cannot claim such a right when they do not possess the requisite qualification for enrolment in the State Medical Register. In Subhashis Bakshi vs. W.B.Medical Council & Ors the Court reiterated that State Governments were at liberty to decide the on qualifications that would permit prescription of allopathic (as also other) medicines in the State. The other issue before the court was whether the right to issue prescriptions or certificates could be treated as a part of right to treat. The court, relying on Mukhtiar Chand's case held that right to prescribe drugs and the right to issue certificates is concomitant to the right to practice medicine. This was a case where the West Bengal Government had allowed certain diploma holders to practice medicine to a limited extent in rural areas. As per the Supreme Court's order this was continued.

- May allopathic doctor prescribe ayuvedic drugs?

The Akhtar Hussain Delvi (Dr.) vs. State of Karnataka case dealt with a situation quite opposite to the earlier cases. Here, a registered allopathic medical practitioner sought the right to prescribe drugs and medicines of ayurvedic origin, which had been accepted by professionals practising allopathic medicine pursuant to clinical and other tests. The high court observed that under the Indian Medicine Central Council Act, 1970 only those who either possess medical qualifications specified in

Second, Third or Fourth Schedule of the Act or are enrolled in the State Register of Indian medicine have right to practice Indian medicine. The Petitioner, neither had acquired such a qualification nor passed qualifying examination under the concerned State Act, nor therefore, was not entitled to prescribe ayurvedic medicine.

Recognition of a medical degree

The Delhi Pradesh Registered Medical Practitioners vs. Director of Health, Delhi Administrative Services was a Petition filed against the decision of the Indian Medicine Central Council constituted under the Indian Medical Central Council Act, 1970 denying recognition to the degree in Indian medicine awarded by Hindi Sahitya Sammelan after 1967. The Appellants' case was that:

1. The Institution in question was very old and reputed, and on the basis of degrees awarded by it, large number of practitioners in the discipline of Ayurveda had been registered in various States including Delhi and have been successfully practicing in the discipline of Ayurveda.
2. In the absence of proper medical facilities available to a large number of poorer sections of society, the ban on practitioners who were providing medical services to the needy and poor people was wholly unjustified. The Supreme Court, however, refused to review the decision of the Indian Medical Central Council merely on the basis of the above submission as it fell within the realm of policy decision of constitutional functionaries who had the requisite knowledge and expertise to take such decisions. Thus, the degrees were not recognized. The courts have by and large left it to the expert bodies such as Medical Councils to decide as to which qualifications should be recognized and which should not be.

Practicing Different Systems of Medicine:

In State of Tamil Nadu vs. M.C. George decided by the Tamil Nadu High Court the Petitioner was a hereditary practitioner of Siddha medicine. He had been practicing Siddha since the mid-1960s after learning it from his father, and was very popular with the villagers. In 1981 the Tamil Nadu Government issued a notification asking people who were practicing Indian system of medicine to register. The Petitioner delayed the matter and was not granted registration. He challenged this in the high court. The Division Bench said that the Petitioner did not have any need to register himself since under the Indian Medicine Central Council Act, if a person had been practicing Indian medicine for a period of five years at the time of the commencement of the Act; he had a right to continue practicing Indian medicine. The Court held that the Petitioner could continue to practice Siddha without registration. It needs to be noted of course, that this right is only for those who were already practicing Indian medicine for five years at the time of commencement of the law and not the subsequent entrants.

The Court also observed: Before dealing with the facts of this case, it may be mentioned that in our country, like in other countries, since ancient times medicine has been practiced and a medical system has been evolved. We had renowned medical practitioners like Sushrut and Charak who are internationally known. In fact, no society can get along without medical practitioners. In every society some people fall sick and get diseases, thus requiring medical treatment. In our country, the Siddha, Ayurveda and Unani systems were evolved, which were traditionally indigenous systems of our country. Medical practitioners of these systems would often pass all their medical knowledge to their children or disciples and often this knowledge were kept secret from others. Thus, this

knowledge was passed on from generation to generation, but it was only given to the children or the devoted disciples and kept secret from others. Many of the treatments in our indigenous medical systems are very effective and there is no reason why we should not utilize the wisdom of our ancestors.

In our opinion, we should encourage indigenous systems of medicines, though with scientific discrimination and after experimentation. However, it is also important that quackery should be suppressed, because it is also true that quackery is widely prevalent in our country, as poor people often cannot afford the fees of qualified doctors. Hence, a balance has to be maintained.

In Private Medical Practitioners Association of A.P. vs. State of Andhra Pradesh, the State Government issued a notification prohibiting all unlicensed practitioners from practicing medicine. The association representing the unlicensed practitioners challenged the notification in the high Court. Its contention was that they were mainly practicing in rural areas and were of great help to the poor villagers. The high court, however, dismissed their Petition holding that unless a person had the qualifications prescribed under one of the medical laws he did not have the right to practice medicine. In the case of Electropathy Medicos of India vs. State of Maharashtra a college was conducting a three year course in electropathy, a branch of medicine contended to be different from homeopathy, ayurveda and allopathy. The State Government had issued a notification directing that such a course was not recognized and no degrees or diplomas could be offered. The Petitioners contended that electropathy was founded in the 19th Century in Italy and provided a sound system of medical practice. The high court, however, rejected this and ordered:

i. The petitioner-society is directed to close down all courses in electropathy/ electrohomoeopathy forthwith.

ii. The petitioner-society is directed not to grant affiliation and/or recognition to any college or institution.

iii. The petitioner-society is hereby directed to refund the fees received from the students admitted by the petitioner-society for its 3 years diploma courses as well as one year diploma course with interest at the rate of 18% p.a. within 3 months.

iv. The State Government is directed to close down all institutions in the State holding the course in electropathy or electrohomoeopathy and to take action against the electropathy practitioners in accordance with the provisions of the Maharashtra Medical Practitioners Act, 1961.

A similar case concerning electropaths and electrohomeopaths in Uttar Pradesh vs. Electro Homeopathic Practitioners Association of India a Division Bench of Allahabad High Court was asked to permit electrohomeopaths to continue to carry on their profession. The court rejected this contention and held that unless a system of medicine was recognized by the legislature it could not be allowed to continue. Upon this, the Association claimed that its members were not practicing medicine. The Court, while rejecting this contention held:

Shri U. K. Shandilya. Learned sr. counsel for the appellants then submitted that the members of the petitioner's Association are not practicing medicine, and hence they cannot be debarred from practice. We cannot agree. Chambers English Dictionary defines medicine to mean “the art or science of prevention and cure of disease.” Thus, medicine is that knowledge which is used for curing the aliment of the human body. Since the petitioners claim that their activities are aimed at curing the ailment of the

human body there can be no doubt that they claim to be practicing medicine. It is of course a different matter that their claim has not been accepted by the expert committee appointed by the Central Government. The Court directed the State to restrain the practice or teaching of electrohomeopathy throughout the State.

Quacks

In the case of D.K. Joshi vs. State of U.P., public interest litigation was filed demanding that the State Government take steps to stop unqualified practitioners from practicing in Agra and the surrounding areas. The Court felt that adequate steps were not taken by the administration and issued directions in respect of the entire state as follows:

In the case of Charan Singh vs. State of U.P., the Allahabad High Court was concerned with practitioners having degrees from unrecognized colleges. This arose as a follow up of the D.K. Joshi case cited above. The court came down heavily on these practitioners and held that they had no right to practice medicine. Similarly, it also ordered the State Government to close down unrecognized institutions. Besides this, the court repeated the directions earlier issued by it meant to ensure that only registered medical practitioners practiced in the State. Towards this the Court directed:

1. All the Hospitals, Nursing Homes, Maternity Homes, Medical Clinics, Private Practitioners, practicing medicine and offering medical and health care services, Pathology Labs, Diagnostic Clinics; whether run privately or by firms, Societies, Trusts, Private limited or Public limited companies, in the State, shall register themselves with Chief Medical Officer of the District where these establishments are situate, giving full details of the medical facilities offered at these establishments, the names of the registered and authorized medical personnel practicing, employed or engaged by them, their qualifications with proof of their registrations, the Para Medical staff employed or engaged and their qualifications, on a form (for each category) prescribed by the Principal Secretary, Medical Health and Family Welfare, Government of U. P. The prescribed pro forma with true and accurate information shall be submitted, supported by an affidavit of the person providing such medical services of the person in charge of such establishment, sworn before Notary Public. The required information shall be submitted for registration, by al these persons, on or before 30-4-2004.
2. The principal Secretary, Medical Health and Family Welfare, U. P. shall publish the information requiring all the persons to obtain registrations, along with the directions given in this order, and the prescribed pro forma, in all leading newspapers of the State, at least three times, in the month of February, 2004.
3. Any change or addition in the particulars submitted shall be notified within thirty days and that the registrations shall be renewed every year before 30th April of the year.
4. On and from 1-5-2004, all those persons who have not furnished the information and obtained registration with the Chief Medical Officers of the District, shall be taken to be practicing unauthorized and that the Chief Medical Officers, shall scrutinize and forthwith report the matter to the Superintendent/Senior Superintendent of Police of the District with information to this Court, to conduct raids and to seal the unauthorized premises/ establishments. All the authorized persons/ establishments, who fail to obtain registration, will have liberty to apply only to this Court to explain the delay

and to seek permission to continue with their medical practice/ profession.

5. All those medical practitioners who desire to offer medical services in the State, in future, shall be required to submit the details in the aforesaid pro forma for registration as above with the Chief Medical Officer of the district before they start medical practice.
6. All the institutions/establishments/ colleges awarding medical degree in the State shall apply and get themselves with the Principal Secretary Medical Health and Family Welfare, U. P. with full particulars of their authorization to confer such degrees/ certificates, on or before 30-4-2004.
7. The news papers and magazines, published in Uttar Pradesh, are restrained from publishing advertisements by and from unauthorized medical practitioners, publishing their claims of quick and magical remedies. They shall require these persons to give proof of their qualifications and registrations. The breach shall be taken to aid and obviate illegal activities violative of Magic Remedies (Objectionable Advertisement) Act, 1954, and other relevant legislations.
8. The Principal Secretary, Medical Health and Family Welfare, it is directed, to ensure that no medical officer in the Government Service is posted beyond three years in any District, and that all para medical staff serving in the Primary Health Centre/Community Health Centre/District Hospitals and other hospitals run by Government of U.P. for more than five years shall be transferred from that centre/ hospital. Any doctor in employment of State Government offering their services to the unauthorized medical practitioners shall face immediate disciplinary action by the State Government, and shall be prosecuted for aiding and abetting such unauthorized practice.

Physiotherapist

In the case of Shri Sarjoo Prasad vs. State of Bihar the Patna High Court was concerned with the right of practice of occupational therapists/ physiotherapists. To begin with, after studying the literature in detail the court held that occupational/ physiotherapy is a recognized form of medical practice. However, the court further observed that unless the concerned qualification finds a place in the schedule to the Medical Council Acts and the holders of the qualifications are registered under that Act, they have no right to practice modern scientific medicine or prescribe allopathic drugs.

Certificate for medical practice

An issue that has been constantly coming up especially in States like Maharashtra concerns registered practitioners of other States. In states like Bihar, the practice of medicine is permitted even without any formal qualifications, if one is able to satisfy certain basic criteria. A number of persons from Maharashtra, for instance, go to Bihar and get these Certificates and start practicing medicine in Maharashtra. Similarly, in a recent case in Maharashtra, the Petitioners were registered in Bihar and Uttar Pradesh but not in Maharashtra. They were not registered under the Central Acts. Their qualifications were recognized under the Bihar and the Uttar Pradesh laws, but not under the Maharashtra or the Central laws. The Maharashtra law entitles only those who are either registered in Maharashtra or under the Central law to practice in Maharashtra. The Court found nothing wrong with this law and held that merely because a person is registered under any other State medical law does not entitle him to practice in Maharashtra unless he is registered in the State (i.e. his qualification is

recognized in Maharashtra) or under the Central law (i.e. his qualification is recognized by the Central Council).

Conclusion

India is a place where various systems of medicine are practiced. The legislature however recognizes five main systems, namely allopathy, ayurvedic, unani, siddha and homeopathy. In order to practice medicine, the practitioner has to have a recognized qualification from a recognized institute. In all other cases, the practice of medicine is prohibited. The law does not recognize an inherent right to practice medicine, but is subject to national and state laws. An interesting issue that has not come up concerns specializations. There is no law that prevents a person who has only an MBBS (and not MD or MS) degree from practicing and even setting up as a specialist in cardiology or ENT, etc. Of course, if a case of negligence is filed against the practitioner, he may be held guilty on account of holding himself out to be an expert in a subject in which he has not acquired such an expertise. But that is only if a case of negligence is filed against him. On the other hand, not having the basic recognized qualification disentitles a person altogether from practicing that branch of medicine and this will not be contingent upon any case being filed against him. In M. Jeeva vs. R. Lalitha, the National Consumer Commission has dealt with the case of a woman running a gynecological hospital for 40 years. The Complainant gave birth to a dead child and her uterus was removed. The person running the hospital and performing procedures and administering treatment was a qualified nurse and midwife but not qualified to practice medicine. The complainant was awarded a compensation of Rs. 2 lakh. The courts have been mainly concerned with cross practice and of certain non recognized systems of medicine. Cross practice has not largely been allowed though there are certain exceptions. Similarly, uniformly the courts have come down heavily against unrecognized degrees or qualifications granted by unrecognized institutions. The courts have also refused to recognize other systems of medicine such as electropathy, etc. Every medical practitioner has a “right to treat” and every patient has a right to say: “treat me, treat me well.” That depends on one's qualification, knowledge, skill and experience. A degree for qualification is no guarantee of knowledge or skill. Justice Suresh feels that it is 'quackery' that is to be taken care of. Quacks are unqualified practitioners who falsely claim to possess a degree in medicine and prescribe drugs, licensed or unlicensed. Hidden quackery occurs in 'doctors' clinics that acquire legitimacy through fake degrees and registration acquired through bribery, etc. and those that claim Tantric powers to cure by miracles. India is otherwise short of registered medical practitioners. According to UNDP Human Development Report, 2003, India has 48 physicians for 1, 00,000 people. This is grossly inadequate. We have to have more people duly qualified to provide medical care with a short term course – may be with an Integrated Medical Course – who can go to villages and small towns, so as to make access to health and health care for all a reality. As part of the strategy to mainstream AYUSH (Ayurveda, Unani, Siddha, and Homeopathy Systems etc.) and reinforce healthcare delivery through the primary health network, the Government has decided to appoint AYUSH doctors in PHCs and Community Health Centers. Initially, AYUSH doctors and medicines would be made available in single doctor PHCs and two doctor Community Health Centers in every district.

Vicarious Responsibility

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Responsibility

Responsible person is defined as being "called to account for the act" in oxford dictionary. In legal parlance responsibility or liability in further defined variously. Some of these defined below.

Direct liability is the legal, moral and ethical responsibility of one's action towards another individual.

The word vicarious literally means indirect, second-hand, secondary, derivative, derived, surrogate or substitute. In legal parlance this essentially means the responsibility of A for the wrongful acts of B against C. This doctrine is held in cases where hospital is held responsible for the negligent acts of its employee like employed doctors including resident doctors, nurses and other staff.

Definition of other terms used

Respondent Superior is the doctrine used to fix this responsibility. Respondent Superior means "let Master be answerable". This is based on the doctrine that it is the master who is deriving the benefits (financial or otherwise) from the actions of B and is responsible for providing facilities and environment for proper functioning and also for selecting the right person for the job.[1-4]

Preceptor is an instructor or teacher who is responsible for teaching the skills to trainees. A preceptor is likely to be held responsible for negligent acts of the trainees e.g a trainee causing perforation during endoscopy or missing a colon cancer during lower GI endoscopy.[1]

Proctor is a physician who monitors another physician usually one seeking certain privileges from the hospital[2]. This concept is almost non-existent in Indian hospitals, although National Accreditation Board is trying to promote it in the hospitals accredited by it. Here the proctor is not responsible for the negligent acts of the physician provided (s)he has not interfered in the process directly, has not suggested the course of action to the observed physician and has reported the matter to the hospital administration correctly. The process of privileging should be honest and should provide the acceptable level of competence to the patients and hospital. It is advisable to document the cases being one during proctoring. Also proctor should not come across as a senior physician to the patient and should not try to introduce himself as if he is the treating physician of the case. Where there is a possibility of him being mistaken as the one by patient, he should clarify his role to the patient.

Employer is easily subject to the most direct form of vicarious responsibilities [2]. Employer in Indian laws is generally accepted a person who has the hiring and firing authority. Therefore it is not necessarily the owner of the organisation who will be considered as vicariously liable. It is also the individuals in the senior management positions who can be held vicariously liable for the acts of employees.

Administrator is a person who is responsible for compliance to legal requirements, framing of

policies and implementation of policies. They are responsible for the credentialing and privileging of the subordinates, infection control and other patient safety practices. To this extent, in Indian context, heads of various clinical departments can be considered as administrators.

Apparent Agency/ Ostensible Agency / Estoppel doctrine [1-3, 5]

This doctrine is brought into consideration where an independent agency e.g. a doctor who is not an employee of the organisation, practices in such a way that gives a perception that the independent agency is working on behalf of the organization (the principal). An example can be a radiology unit established within the campus of a large organisation, receiving all cases from the organisation where fee is being collected on behalf of the radiology unit by the hospital through its own system.

This will also apply to an independent physician, not on salary of the hospital but whose payments are being collected by the hospitals through its system. This liability is based on patient's reliance on hospital for providing good medical service.

Corporate liability is based on the doctrine that the supervisory responsibility to ensure that the patients are examined and treated well in its premises and adequate facilities for such treatment is provided by the hospital.

Proving Vicarious Responsibility

Vicarious liability claims are founded on the notion that hospital have the authority and responsibility to “direct and control” the methods for the treatment of patients by physicians. To prove vicarious responsibility, one has to examine:

- Relationship between hospital and doctor (or other employee- where generally it is more straightforward) and the fact that physician is not an independent contractor.
- That the hospital authorities have the power to select and discharge a physician
- That the hospital provides salary and other benefits like accommodation, provident fund etc to the doctor like all other employees
- Whether the physician practice only at one hospital or at several other places.
- That the health care facility (hospital) handles physician's billing through its system
- That the health care facility (hospital) handles physician's billing in its name
- That the health care facility has control over physician charges
- That the equipments used by physician are supplied by and maintained by it.

Where the health care facility (hospital) does not control the time, the charges and the manner in which physician provides his/her services and does not provide direct compensation, hospital is unlikely to be held vicariously responsible. In such situations, however, the doctrine of ostensible agency may come into picture and may have to be examined.

Court Judgements on Vicarious Responsibility

There have been judgements from Indian courts where the Hon'ble courts have held the hospitals responsible for the negligence of its staff. There are many more judgements from the courts of western countries but in this article, I shall not discuss those judgements.

In case of Mr. M Ramesh Reddy v. State of Andhra Pradesh [2003(1) CLD 81 (AP SCDRC)] where an obstetric patient had fallen in bath room and died, Hon'ble court held hospital authorities responsible for not keeping bathrooms clean (here bathroom was covered with fungus and was slippery) and awarded compensation.

Way back in 1994, in case of Joseph Alias Pappachan and Ors. vs Dr. George Moonjely and anr[6] where a lady died after postpartum sterilisation operation and was found to have intestinal perforation and faecal peritonitis, which was documented at another hospital where she was referred afterwards, concluded that hospital management is vicariously liable for not providing adequate facilities for anaesthesia and clean environment for surgery. The court observed "Persons who run a hospital are in law under the self-same duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves; they have no ears to listen through the stethoscope, and no hands to hold the surgeon's scalpel. They must do it by the staff which they employ; and if their staff is negligent in giving the treatment, they are just as liable for that negligence as in anyone else who employs others to do his duties for him".

In another case Aparna Dutta v. Apollo Hospitals Enterprises Ltd. [2002 ACJ 954, in Madras High Court[7], where a lady underwent hysterectomy and salpingo-oophorectomy and where a abdominal pack was left inside abdomen and was not detected by the treating doctor despite complaints of pain by the patient. This was later removed at a hospital in Saudi Arabia. In her plaint the Apollo hospital as well as the doctors were considered defendants and where hospital stated that it cannot be held liable as hospital does not "employ" the concerned doctor who is an independent Obstetrician, the hon'ble court observed; "These hospitals provide the medical treatment to those patients through doctors employed by them or by doctors who work there on some arrangement. These hospitals raise the bills for the medical treatment provided to those patients. In the circumstances, if the patient suffers injury due to negligence of the doctors, the hospitals would be equally liable for damages, on the principles of vicarious liability or on the principles analogous to vicarious liability. When these hospitals provide these doctors to the patients and when they make the bill and collect the fees for the medical treatment given in those hospitals, these hospitals cannot shove of their responsibility and liability to pay compensation for the damages suffered by the patients due to the negligence to the doctors provided by these very hospitals."

Even in a more recent judgment in Kunal Saha vs AMRI hospital, though the hon'ble Supreme Court has not used the word vicarious responsibility, the judgment clearly reflects the concept of vicarious responsibility while holding the AMRI hospital responsible.[8] This case was discussed in detail in a previous issue of this journal.[9]

What hospitals can do to avoid vicarious responsibility?

With so many judgments, it is very difficult for hospitals to avoid vicarious responsibility or ostensible agency/ apparent agency doctrine in cases of medical negligence. However, some efforts can be made in the following manner [1, 4, 10]

- Hospital should clearly display the relationship with doctors who are not

employee of the hospital.

- Hospitals should encourage writing all institutions where an independent consultant practices on the letterhead so as to make it clear that the doctor is independent agency
- While providing space within the hospital premises, the diagnostic agencies should not be allowed to us hospital name
- Hospital should not collect charges on behalf of independent agencies e.g. diagnostic agencies or independent physicians
- Monitor the performance of physicians and take necessary steps for correction wherever required
- Follow rigorous credentialing process for doctors, including specific competencies of consultants
- Employ trained professionals only including nursing staff and medical technicians and continue to retrain them
- Have documented standard operating procedures for high risk patient management procedures and monitor adherence to clinical protocols.

What seniors can do to avoid vicarious responsibility?

Seniors i.e. consultants should take adequate care and document his/her orders properly in case sheet and review implementation of his orders. They should review the results of investigations and order suitable investigation to define the differential diagnosis of the cases. They should not permit students to handle cases independently, at least during initial part of training. Clinicians should involve themselves in training the support staff including nurses to follow the orders adequately and consistently.

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Are the strikes by the doctors justifiable ?

VIEWPOINT

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There are news galore regarding doctors going on strike from different parts of the country. Doctors go on strike mainly for two reasons (i) because of manhandling of the doctors and staff by relatives of the patients, and/or damage to the property of the hospital or clinic, and (ii) because of some issues regarding service conditions and emoluments. These two issues need to be handled differently.

1. Manhandling and damage to hospital property

Doctors are considered soft targets, because the doctors being educated and sophisticated members of the society are not expected and /not capable to retaliate the rowdy elements. Whatever may be the reasons for dis-satisfaction or anger, taking law in the hands by any person is not acceptable and such people should be brought to the book, ie. complaints should be lodged with the respective police station, and if some photographic evidence is available that should be properly recorded and copies handed over to the police.

Maintenance of law and order is the responsibility of administration, thus ruling party is directly responsible and in case government fails in its duty to maintain law and order and provide protection to law abiding citizens, the opposition party should see to it that justice is done by the administration. But the political parties keep silent on such occasions sending wrong signals to the society that the doctors and hospitals must have been at fault. The authorities should promptly institute proper enquiry of the incidence and publicise the outcome of the enquiry. In case the doctor(s) and/hospital have been found to be at fault the matter should be reported to the State Medical Council and action taken according to the law. People responsible for unlawfull activity in the hospital should be dealt according to the law of the land irrespective of the fact that doctors were at fault or not.

What should be done if no action is taken against the culprits? Doctors should not go on strike, because this would put other innocent people at risk, whereas no direct harm will occur to culprits. Doctors should inform the police of that area, Indian Medical Association and State Medical Council that in future aggrieved doctors as well as other doctors of that area will not atted to culprits in any condition till case is settled by the courts. Such information should be passed on to the media also so that people and doctors of that area are apprised of the facts. Some may consider it as 'khap panchayat farman', that it is against the spirit of medical ethics. Question is: had those people taken any approval or sanction from any appropriate authority before indulging in unlawfull action? It is true that even during war the doctors treat injured enemy soldiers also, but enemy soldiers are fighting on behalf of their country, thus performing their duty. Meanwhile doctors should continue to serve the people.

2. Issues related to service conditions

The doctors should apprise the concerned authorities regarding the issues. In case the decision is not taken or apropriate steps are not taken by the department or authorities the doctors should apprise the political parties, in power as well as those in opposition. Many doctors are members of these political parties. In case no political party takes a stand in favour of the doctors' demands this would suggest that either their demands are not realistic and justified or political parties have no concern for the welfare of the doctors. In case the medical fraternity is of firm conviction that their demands are right, the doctors who are members of different political parties should resign from their respective parties, but doctors should not go on strike to pressurise the authorities even for meeting their reasonable and justified demands. Thus, strike by the doctors is not justifiable under any circumstances.

Risk management: A mantra to prevent litigation

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Introduction: In this era of consumerism, the need of the time is that the physician should explain relevant risks associated with the medical treatment according to the patient in question. There is always certain degree of inherent risk involved with the treatment. Keeping this in mind, the doctor should necessarily take the informed consent to proceed. One may come across risks which though minor, occur frequently and major risks which though serious might occur occasionally.

How to manage risk?

Risk management aims at optimum patient wellbeing and thus prevents health risk to the patient as well as legal risk to the care providing health staff.

The strategy involves following things:

1. Identification of risk: For this detail relevant history with proper clinical examination of the patient helps in the long term. Patients identified as "High risk" can be given special attention & if necessary intensive care management.
2. Risk assessment: Patient to patient risk can be assessed as follows,
   i) Underlying disease in which there are chances of increased risk
   ii) Frequency of risk
   iii) Monetary factor
   iv) Impact on prognosis of the patient
3. Management strategies: The various management strategies can be,
   i) Prevention: Standard guidelines for clinical management in the form of tables, flow charts, modules, ready reckoners should be available in the hospitals that can guide health staff, time to time and thus can prevent disasters with untoward outcome which may lead to litigations.
   ii) Referral to higher centres: A patient diagnosed as "High risk" can be referred to better equipped higher centre for better management if the situation demands.
   iii) Avoidance: A medical practitioner, depending on the facilities and available competent staff, can deny the further treatment after giving first aid. Total refusal is not a good practice even on humanity grounds.
   iv) Defensive practice: Not indulging in high risk cases at all.
   v) Opt for second opinion: In high risk and complicated cases one should be open enough to go for second opinion and manage the patient with team work seeking multi-speciality approach if necessary.
   vi) Minimization of the risk: The risk can be minimized by keeping oneself updated, carrying out necessary investigations and following standard management protocols.
4. Implementation of strategy: It should take in to account the modern medical science, research work (evidence based practice), standard guidelines, various management protocols , their practicability and effectiveness to reach the objectives or the health indicators.
5. Evaluation: Risk management is not a one time job but is a continuous process. Therefore a committee must be formed to study the risk, the strategy applied, to evaluate the success and to point out the lacunae so that there can be a chance for improvement in patient care.
6. Risk financing: Now a days this is a major issue due to the increased number of litigations against doctors. The mental as well as financial burden can be relieved off by taking help of insurance companies which also ensure,
   - Coverage of qualified as well as unqualified staff
   - Medico-legal experts
   - Legal out of court settlement

Thus in short one should not try to run away from the situation but should learn the mantra of risk management and take the help of organizations (FOGSI, AMOGS, IMA, IMLEA, , IAP etc.) medico-legal experts and insurance companies for safe peaceful practice free of litigations.

Landmark Judgement

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Loosened Knee Joint (Tibial) Prosthesis

Mrs. Veera Rohington Kotwal vs PD Hinduja Hospital, Dr. KT Dholakia and Dr. Sanjay Agarwala

Complaint Case No. CC/98/55 (Before the Hon'ble state consumer dispute redressal commission, Maharashtra, Mumbai)

The Case

Mrs Veera Rohington was suffering from Rheumatoid arthritis since 1976. She underwent a knee joint replacement on advice of Dr KT Dholakia at PD Hinduja hospital as medical therapy was not providing relief to her.

Following surgery, she did not get relief, continued to have pain in knee joint, developed swelling of knee joint and later was found to have Staphylococcus infection in knee joint. For this medicines were prescribed and lavage was done. There was no relief. Several antibiotics were changed and supportive care was provided.

As patient continued to have pain and was immobile, they went to Dr A Mullaji for second opinion, who opined that there is loosening of tibial prosthesis which was confirmed on X Ray of the knee joint. She also consulted Dr Amin who is a Rheumatologist. Dr Amin found knee joint to be swollen and tender with some redness and diagnosed it as knee joint infection. He opined that a revision surgery is required for which he referred patient to Dr C Ranawat in USA.

In USA Dr Ranawat confirmed the diagnosis of knee joint infection and loosening of prosthesis and advised two stage revision surgery. In first stage the prosthesis was removed and infection was treated. In second stage implantation was done, following which patient got relief, became pain free and was able to move.

Summary of The Complaints

Patient alleged followings as negligence

1. The service to be rendered by surgeon is not only meant to perform surgery but also treat patient postoperatively. Dr KT Dholakia did not provide post operative care despite frantic efforts. This is a deficiency in service.
2. Staph aureus bacteria entered joint in operation theater either through equipments, cement or failure to provide sterile environment.
3. Posterotibial femoral component were found in varus alignment and loss of bone attributed to gross negligence
4. Failed lavage on two occasions as it did not eradicate bacteria and did not provide relief.
5. Entire fluid was not aspirated during lavage, as a result bacteria continued to grow in the joint.
6. Failure to perform knee joint surgery properly as there was uneven gap in the knee joint.

It was alleged by the complainant that respondent 2 and 3 were not diligent in performing their duties because of which the patient suffered pain and had to undergo a revision surgery.

The complaint against the opponent 1 (hospital) was that they failed to ensure disinfection of operation theatre / hospital room because of which infection entered the joint for which she had to undergo a revision surgery at USA spending a total of Rs.18,08,075/- (at USA and India during subsequent admission).

Summary of Reply of the Opponents

1. The hospital operates on non profit basis and provides with the objective of providing effective medical care to all class of people.

2. Complicated issues raised in the consumer complaint ought not to be adjudged and decided under the provisions of Consumer Protection Act, 1986 as it involves complicated question of the factual, expert, medical and legal issues.
3. Complainant did not approach the patient relations department to resolve the problem
4. Patient got admitted to hospital on her own choice. Dr KT Dholakia operates in several hospitals and his team known as "KTD" unit takes care of the patient in post operative period. This is informed to patients in advance.
5. Postoperative pain is falsified on perusal of nursing records
6. The hospital gave information on sterilization of equipments and methods adopted to keep operation area ultraclean including filter system and air exchanges, controlled temperature and humidity. Periodic use of UV radiation in OT was also mentioned.
7. The hospital also gave details of a functional Infection control committee and internationally accepted protocols being followed by ICC and hospital for prevention of infections
8. Finally opponent 1 (i.e. hospital) prayed for dismissal of complaints.

Reply of opponent no.2 (Dr KT Dholakia)

Dr Dholakia denied all charges. However, as Dr Dholakia expired during the course, complaint against him was dropped with mutual consent.

Reply of opponent no. 3 (Dr Sanjay Agarwala)

Dr Agarwala, like the hospital, contended that the consumer court is not the right forum to decide on such complicated case.

He mentioned in detail, various steps taken for treatment and denied presence of pain during initial days.

He also claimed the adequate investigations and surgical and medical interventions in the form of synovectomy and lavage were carried out at each step as required.

He also informed that the patient was examined by Dr KT Dholakia and the team members and that each team member is well qualified and experienced in handling such cases.

The Defense

The defendants in this case took following defenses

1. That the patient was suffering from Rheumatoid arthritis since 1976 and was receiving treatment including injections of aurothiomalate which are given to only very severe cases.
2. That the patients of Rheumatoid arthritis are at higher risk of infection after TKA (with evidence from journals)
3. That the infection and the wound were treated as per standard protocols.
4. The expert evidence of Dr Laud that infection can occur either from external or endogenous sources as a result it can't be claimed that the source of infection OT of the hospital.
5. The evidence from infection control committee of the hospitals that the proper sterilization activities are in place.
6. That the opponents did not place on record evidence to show that the protocols were not followed in the treatment of the patients.

The Judgment

1. Although patient was seen by Dr KT Dholakia only once after surgery, patient was well looked after by opponent 3 i.e. Dr Sanjjay Agarwala. The hospital records do not show emergency necessitating visit by opponent 2 i.e. Dr K T Dholakia.
2. Opponents no,2 and 3 followed standard protocols for treatment of Staphylococcal infection and once the report showed no growth of Staphylococcal aureus. Thus the allegation of failed lavage could not be established.

3. The allegation of infection from the hospital could also not be established by the complainant. On the contrary, complainant have not placed on records evidence to prove that the claim of hospital regarding sterilization process was not correct. Therefore allegation that infection occurred solely due to hospital sources is not tenable.
4. In absence of authentic material and expert evidence to the contrary led by the complainant, it is impossible to hold that post-operative treatment [to treat wound] was wrong, the allegations of medical negligence on this count against the opponents are not sustainable.
5. Based on the hospital records, whereas Dr Sanjay Agarwala had recorded "Prosthetic components found loose", evidence from the records of Dr Sanjeev Amin and then in USA by Dr Chitaranjan Ranawat, it is clear that loosening of prosthesis was there. While patient continued to be under care of opponent 3 Dr Sanjay Agarwala, from 08/06/1996 to 29/07/1996, There is no record to show that what steps have been taken by the opponents to address 'loosening of prosthetic components'. Opponents have failed to bring on record documentary evidence to show what corrective steps were taken after clinical observations. Opinion of Dr Amin on loosening of prosthesis was vindicated by X Rays. In this respect, there is no reason to disbelieve the statements made on the affidavit, particularly in absence of any documentary evidence to the contrary, brought on record by the opponents. Failure of the opponents to attend the clinically diagnosed problem certainly attributes to the medical negligence leading to deficiency in service. Though the opponents possess skill and knowledge of their subject, but failed to take corrective steps.

The Order

1. Consumer Complaint is partly allowed.
2. Opponent no.1 and 3 are directed jointly and severally to pay an amount of Rs.18,08,000/- to the complainant with interest @9% p.a. from the date of this order within a period of 60 days, failing which rate of interest shall be payable @ 12% p.a. from the date of this order till realization.
3. Opponent no.1 and 3 shall bear their own costs and pay Rs.50,000/- towards costs of this complaint.
4. Certified copies of this order be furnished to the parties.

Learning from the case

Learnings from the case are many. They can be summarized as below

1. Courts feels that the surgeon is responsible for post operative care. However, except for emergency, a competent team of surgeon can take care of the patient and it is acceptable.
2. PD Hinduja hospital was not considered negligent as it could provide the evidence of a functional Infection control committee and evidence of the proper sterilization process according to protocol. It is clear that the hospitals must keep such records and have an infection control committee in place to supervise sterilization and disinfection process.
3. Lack of response to treatment is not considered evidence of negligence as continued pain and low grade fever, despite adequate antibiotic therapy was not considered as evidence of negligence.
4. Second opinion of another specialist and records of treatment at another hospitals form an important evidence.
5. Recognition of a known complication but not acting on it and providing corrective measures is considered as evidence of negligence. This was the only negligence accepted by the court.

Medicolegal News

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Pune doctors protest against one-year jail for incomplete filling of Form F

http://www.indiamedicaltimes.com/2015

In Pune, following a local court's order to punish six doctors with a fine of Rs 10,000 each and one-year imprisonment for the incomplete filling of Form F, which records medical history of pregnant women, over 250 radiologists and sonologists have reportedly decided to refrain from conducting pregnancy-related sonography tests. The Association of Nursing Homes and Clinic Owners of Pune (ANHCOP) and the Indian Medical Association (IMA) Pune chapter feel the punishment is huge. “The court's judgment is insensitive as the punishment is same as conducting a sex determination test,” according to Dr Nitin Bhagali, President, ANHCOP. On February 25, 2015, a court of judicial magistrate (first class) found six doctors of Aditya Birla Memorial Hospital (ABMH) in Pimpri Chinchwad, guilty of violating the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994.The case had been filed against Aditya Birla Hospital, its superintendent, medical director, chief operating officer Rekha Dubey and radiologists under sections 23, 25, 26 and 29 of the PCPNDT Act. While giving its judgement, the court observed that the hospital had been given a chance in 2011 to improve but it failed to do so.

Physician Pleads Guilty to Treating With Misbranded Drugs

http://www.courier-journal.com.30.1.15

A rheumatologist in Louisville, Kentucky,USA pleaded guilty to administering imported drugs to his patients that were not approved by the US Food and Drug Administration (FDA).A federal district judge sentenced the doctor to 1 year's probation and ordered him to pay $177,000 in restitution. Doctor also agreed to pay an additional $338,000 to settle federal civil claims accusing him of Medicare fraud.According to federal prosecutors, Doctor obtained infusion and injectable medications from foreign drug distributors in the United Kingdom to treat patients with cancer, rheumatoid arthritis, osteoarthritis, and osteoporosis. Drug labels were written in foreign languages.The drugs, which included rituximab (Rituxan, Genentech), tocilizumab (Actemra, Genentech), zoledronic acid (Aclasta/Reclast, Novartis), denosumab (Prolia, Amgen), and hylan G-F 20 (Synvisc, Sanofi), were never cleared for use in the United States, even though they might have been identical in composition to FDA-approved versions or come from the same factory. As such, they were deemed misbranded.In the settlement agreement, the government contended that the drugs obtained by Dr Heinicke cost far less than their FDA-approved counterparts. He did not inform his patients that he was treating them with unapproved products, nor did he indicate that on Medicare claims seeking reimbursement for the drugs and their administration, according to the

Department of Justice and the Department of Health and Human Services, which brought the civil claims against Dr Heinicke.

IMA issues directive

Source: Mumbai Mirror | Jan 3, 2015, 12.00 AM IST

The Indian Medical Association (IMA) has issued directions to the 10,000 healthcare facilities and 2.5 lakh doctors it represents that it will initiate action against those physicians and establishments found hiring homoeopaths and ayurveda practitioners to fulfil allopathic functions.According to a senior IMA functionary, the system of employing those qualified to prescribe traditional cures in hospitals and clinics that specialise in allopathic healthcare has resulted in hundreds of medical negligence cases being filed against IMA members.The decision to call for a ban was taken by IMA's central council last week and has been communicated to all its members. The notification stated, "Directions are being given to hospitals and doctors not to appoint Ayush (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy) Doctors as Resident Medical Officers (RMO)/Assistant. Strong action will be taken against those violating the directions". IMA could revoke the membership of a doctor or institution found flouting this directive - outcasts will lose the support of IMA in battling medico-legal and malpractice cases.

Such hiring practices are prevalent primarily in government hospitals in rural areas, which retain the services of Ayush doctors owing to lack of qualified allopathic practitioners.Incidentally, the state government recently passed a bill which allows those practicing ayurveda and homoeopathy to prescribe allopathic cures upon completing a year-long bridge course called 'Certificate Course in Modern Pharmacology', which will be designed by Maharashtra University of Health Sciences (MUHS). "If a homoeopath or an ayurveda practitioner stops practicing his own stream, he is obviously degrading it. Even if they do that course, our stand will remain the same. As far as the issue of shortage of doctors is concerned, the government should increase the number of medical seats instead of allowing this," said Aggarwal, adding that doctors flouting these norms will loose their IMA registration. Many Indian courts have excoriated homeopaths and ayurveda practitioners for prescribing allopathic medicines. In a 1996 case of medical negligence, in which a homoeopath's prescription of allopathic treatment to aman afflicted with typhoid resulted in the patient's death, the Supreme Court, which adjudicated, said: "A doctor must not only be qualified but he must also be registered with the appropriate Medical Council in order to practice as a doctor. A homeopath would not have knowledge about allopathic medicines and its drug reactions. So the mere administration of allopathic treatment by a homeopath would be enough proof to establish negligence."

Research Briefs

Complied by
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Disclosing Genetic Information to Family Members about Inherited Cardiac Arrhythmias: An Obligation or a Choice?

Vavolizza RD, Kalia I, Aaron KE, Silverstein LB, Barlevy D, Wasserman D, Walsh C, Marion RW, Dolan SM.J Genet Couns. 2014 Nov 18.

The familial nature of inherited genetic information raises numerous ethical, legal, and social issues regarding the sharing of genetic information, particularly when an individual found to carry a deleterious mutation refuses to disclose his or her results to at-risk family members who could benefit from life-saving treatments. A study was done in the Department of Obstetrics and Gynecology and Women's Health, Albert Einstein College of Medicine to understand the experiences with genetic testing for 50 individuals with a personal or family history of cardiac events or sudden death.Long QT syndrome and Brugada syndrome are inherited cardiac arrhythmias. Individuals with this familial deleterious mutation are mostly asymptomatic and are diagnosed only after they or their family members suffer from cardiac problems. These cases present clinical as well as ethical, legal, and social challenges.Unstructured in-person focus groups or interviews were conducted for each participant in the study. The recordings of these interviews were transcribed verbatim and subsequently analyzed and coded. Participants' comments regarding sharing of genetic information centered around four main themes, motivation to disclose; extent of disclosure; effect of disclosure on family dynamics; and reasons for not sharing genetic information.Most of individuals believed that affected individuals are obligated to disclose genetic information to family members. In the era of personalized medicine, the disclosure of genetic information provides individuals the opportunities to learn about the genetics, disease characteristics and treatment options in order to reduce morbidity and mortality in themselves and their family members.

Ethical and Professional Challenges Encountered by Laboratory Genetic Counselors.

Groepper D, McCarthy Veach P, LeRoy BS, Bower M.J Genet Couns. 2014 Nov 16.

Laboratory-based genetic counseling is a growing and yet under-researched specialty.A study was conducted at Department of Pediatrics, Southern Illinois University School of Medicine, to conduct an online survey assessing demographics and frequency of encountering 16 domains of ethical and professional challenges encountered by clinical genetic counselors .Laboratory genetic counselors also provided anecdotes of particularly challenging situations and strategies for their resolution. Most respondents had less than 5 years' experience as laboratory counselors (71 %), worked full-time (75 %) in industry-based laboratories (91 %) with a focus on molecular diagnostics (84 %), and had limited patient contact (91 %). Similar to clinical counselors, every ethical and professional challenge was endorsed as occurring frequently by some respondents. It was concluded that laboratory-based genetic counselors generally face similar ethical and professional challenges as clinical genetic counselors but their exact nature and relative frequency differ. These findings contribute to a greater understanding of common and unique experiences of genetic counselors in different professional specialties.

Visitors from Polio Endemic Countries should not be administered OPV on arrival.

Letter to the Editor

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Last case of polio disease caused by wild polio virus was reported on January 13, 2011 from West Bengal. Polio Vaccination in India is being carried out under national immunization program and OPV is administered to every child starting the first dose after birth and more doses are administered during later childhood and sometimes supplemented by Pulse Polio Campaigns. Pakistan, Afghanistan and Nigeria are still reporting polio cases. For sometime now the Government of India has made the policy that every visitor from these polio endemic countries be administered OPV on arrival at air port, railway station or bus terminal. This policy needs reconsideration.

Incubation period for polio disease manifestation in form of flaccid paralysis is 5-35 days[1]. Any person who is un-vaccinated or partially vaccinated if happens to get poliovirus infection and visits India during the incubation is likely to spread polio viruses during his stay in India. For this reason even after India being declared a polio free country on February 11, 2014 by WHO, polio vaccines are being administered. It should be remembered that OPV administered on arrival cannot stop instantly wild polio viruses spread.

The author had raised the issue: "What will be the inter-action between wild polio viruses and vaccine polio viruses, if a child is already infected with polio virus (incubation period) and vaccine polio viruses in the form of OPV are administered[2] ? Sridharan and Abraham stated: "It is primarily a question of which of the virus got access to the host first. If the child is first exposed to the vaccine strains then the vaccine strains would cause gut immunity to develop ..... In a given individual the vaccine virus, if given after the exposure to the wild virus will not replace the former [3].

The visitors from polio endemic countries may be fully immunized or may be un-immunized (or partially immunized). Individuals belonging to latter group may or may not be infected with wild polio viruses at the time of visit to India. In case those infected with wild polio viruses visit India during incubation period can cause spread of wild polio viruses and may develop paralytic disease while in India or on return to their respective countries despite administration of OPV on arrival. In case OPV is administered to these individual who may later develop paralytic disease while in India or after returning to their home countries, OPV administered in India will be blamed for causing the disease in those healthy individuals who develop paralytic disease after administration of OPV in India. This would provide them ammunition for their campaign against polio vaccination. There could also be allegation against India that some special vaccine is being administered to the visitors from these countries to cause polio disease. On the other hand if the visitors were not carrying wild polio viruses and develop VAPP, confirmed on stool cultures this will not only put blame on India for wrong doing but will provide an irrefutable evidence against OPV. Thus, visa be issued to those only who have documentary record regarding proper vaccination againt polio disease.

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Professional Assistance / Welfare Scheme

1. The scheme shall be known as PAS "Professional Assistance Scheme".
2. ONLY the life member of IMLEA shall be the beneficiary of this scheme on yearly basis. The member can renew to remain continuous beneficiary of this scheme by paying renewal fees every year. The scheme shall assist the member ONLY as far as the medical negligence is concerned.
3. This scheme shall be assisting the members by:
   i. Medico-legal guidance in hours of crisis. A committee of subject experts shall be formed which will guide the members in the hours of crisis.
   ii. Expert opinion if there are cases in court of law.
   iii. Guidance of legal experts. A team of Legal & med-legal experts shall be formed which will help in guiding the involved members in the hours of crisis.
   iv. Support of crisis management committee at the city / district level.
   v. Financial assistance as per the terms of agreement.
4. The fund contribution towards the scheme shall be decided in consultation with the indemnity experts. The same will depend on the type & extent of practice, number of bed in case of indoor facilities & depending upon the other liabilities.
5. A trust / committee / company/ society shall look after the management of the collected fund.
6. The Financial assistance will be like Medical Indemnity welfare scheme, where indemnity part shall be covered by government / IRDA approved companies or any other private company. The association shall be responsible only for the financial assistance. Any compensation/cost/ damages awarded by judicial trial shall be looked after by government / IRDA approved insurance companies or any other similar private company.

Admission Fee (One Time, non-refundable)		
1	Physician with Bachelor degree	Rs. 1000
2	Physician with Post graduate diploma	Rs. 2000
3	Physician with Post graduate degree	Rs. 3000
4	Super specialist	Rs. 4000
5	Surgeons, Anesthetist etc	Rs. 5000
6	Surgeons with Super specialist qualification	Rs. 6000

		Annual Fee for Individual	Annual Fee for Hospitals Establishment
1	Physician / doctors with OPD Practice	Rs. 60 / lakh	Rs. 340 / lakh + Re. 1 / OPD Pt + Rs. 5 / IPD Pt + 7.5 % of basic premium + Service Tax 10.3 % on the Total
2	Physician / doctors with Indoor Practice	Rs. 115 / lakh	
3	Physician / doctors with Indoor Practice of Surgeon	Rs. 230 / lakh	
4	Physician / doctors with superspecialty, Anesthetist etc	Rs. 340 / lakh	
5	• Rs/- 1000 (One thousand) per year shall be collected to develop the fund of the IMLEA towards emergency assistance, risk management and conducting trainings, CME, workshops etc. • Physician / doctors visiting other hospitals shall have to pay 5% extra. • For unqualified staff extra charges of 8% shall be collected. • The additional charges 15 % for those working with radioactive treatment. • The additional charges can be included for other benefits like OPD/ indoor attendance, instruments, fire, personnel injuries etc.		

7. Experts will be involved so that we have better vision & outcome of the scheme.

8. The payment to the experts, Legal & med-legal experts shall be done as per the pre-decided remuneration. Payment issues discussed, agreed and processes shall be laid down by the members of these scheme.
9. If legal notice / case are received by member he should forward the necessary documents to the concerned person.
10. Reply to the notice/case should be made only after discussing with the expert committee.
11. A discontinued member if he wants to join the scheme again will be treated as a new member.
12. Most of the negligence litigations related to medical practice EXCEPT the criminal negligence cases shall be covered under this scheme. The scheme will also NOT COVER the damages arising out of fire, malicious intension, natural calamity or similar incidences.
13. All the doctors working in the hospital (Junior, Senior, Temporary, Permanent etc) shall be the members of the IMLEA, if the hospital wants to avail the benefits of this scheme.
14. The scheme can cover untrained hospital staff by paying extra amount as per the decision of expert committee.
15. A district/ State/ Regional level committee can be established for the scheme.
16. There will be involvement of electronic group of IMLEA for electronic data protection.
17. Flow Chart shall be established on what happens when a member approaches with a complaint made against him or her [Doctors in Distress (DnD) processes].
18. Telephone Help Line: setting up and manning will be done.
19. Planning will be done to start the Certificate/ Diploma/ Fellowship Course on med-leg issues to create a pool of experts.
20. Efforts will be made to spread preventive medico-legal aspects with respect to record keeping, consent and patient communication and this shall be integral and continuous process under taken for beneficiary of scheme by suitable medium.

List of Members
Professional Assistance Scheme (PAS)
IMLEA

Name	*Place*	*Speciality*
Dr. Dinesh B Thakare	Amravati	Pathologist
Dr. Satish K Tiwari	Amravati	Pediatrician
Dr. Rajendra W. Baitule	Amravati	Orthopedic
Dr. Usha S Tiwari	Amravati	Hospi/ N Home
Dr. Yogesh R Zanwar	Amravati	Dermatologist
Dr. Ramawatar R. Soni	Amravati	Pathologist
Dr. Rajendra R. Borkar	Wardha	Pediatrician
Dr. Alka V. Kuthe	Amravati	Ob.&Gyn.
Dr. Vijay M Kuthe	Amravati	Orthopedic
Dr. Neelima M Ardak	Amravati	Ob.&Gyn.
Dr. Vinita B Yadav	Gurgaon	Ob.&Gyn.
Dr. Balraj Yadav	Gurgaon	Pediatrician
Dr Kiran Borkar	Wardha	Ob & Gyn
Dr Prabhat Goel	Gurgaon	Physician
Dr Sunil Mahajan	Wardha	Pathologist
Dr Ashish Jain	Gurgaon	Pediatrician
Dr Neetu Jain	Gurgaon	Pulmonologist
Dr V P Goswami	Indore	Pediatrician
Dr Bhupesh Bhond	Amravati	Pediatrician
Dr R K Maheshwari	Barmer	Pediatrician
Dr Jayant Shah	Nandurbar	Pediatrician
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Dr D P Gosavi	Amravati	Pediatrician
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Dr Asit Guin	Jabalpur	Physician
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Dr Anupama Deshmukh	Amravati	Ob & Gyn
Dr Umesh Khanapurkar	Bhusawal	Pediatrician
Dr Mrs Khanapurkar	Bhusawal	Gen Practitioner
Dr Pratibha Kale	Amravati	Pediatrician
Dr Milind Jagtap	Amravati	Pathologist
Dr Varsha Jagtap	Amravati	Pathologist
Dr Rajendra Dhore	Amravati	Physician
Dr Veena Dhore	Amravati	Dentistry
Dr Nilesh Toshniwal	Washim	Orthopedic
Dr Swati Toshniwal	Washim	Dentistry

Indian Medico Legal And Ethics Association
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Photograph

Name of the Applicant _____
Surname *First Name* *Middle Name*

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Address of Correspondence _____

_____

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Mobile _____ *Fax* _____ *e-mail* _____

Name of the Council *(MCI/Dental/Homeopathy/Ayurved /Other)* _____

Registration No. _____ Date of Reg. _____

Medical / Legal Qualification	University	Year of Passing

_____ _____

Name, Membership No. & Signature of Proposer Name, Membership No. & Signature of Seconder

A. Experience in legal field *(if any)* : _____

B. Was / Is there any med-legal case against you /your Hospital *(Yes / No)* : _____ If Yes, Give details

_____

C. Do you have a Professional Indemnity Policy *(Yes / No)* : _____ If Yes, Give details

Name of the Company _____ Amount _____

E. Do you have Risk Management Policy *(Yes / No)* : _____ If Yes, Give details

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F. Is your relative / friend practicing Law *(Yes / No)* : _____ If Yes, Give details

Name _____ Qualification _____ Place of Practice _____

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G. Any other information you would like to share *(Yes / No)* : _____ If Yes, please attach the details

I hereby declare that above information is correct. I shall be responsible for any incorrect / fraudulent declarations.

Place:

Date: (Signature of Applicant)

Enclosures: True Copy of Degree, Council Registration Certificate & photograph.

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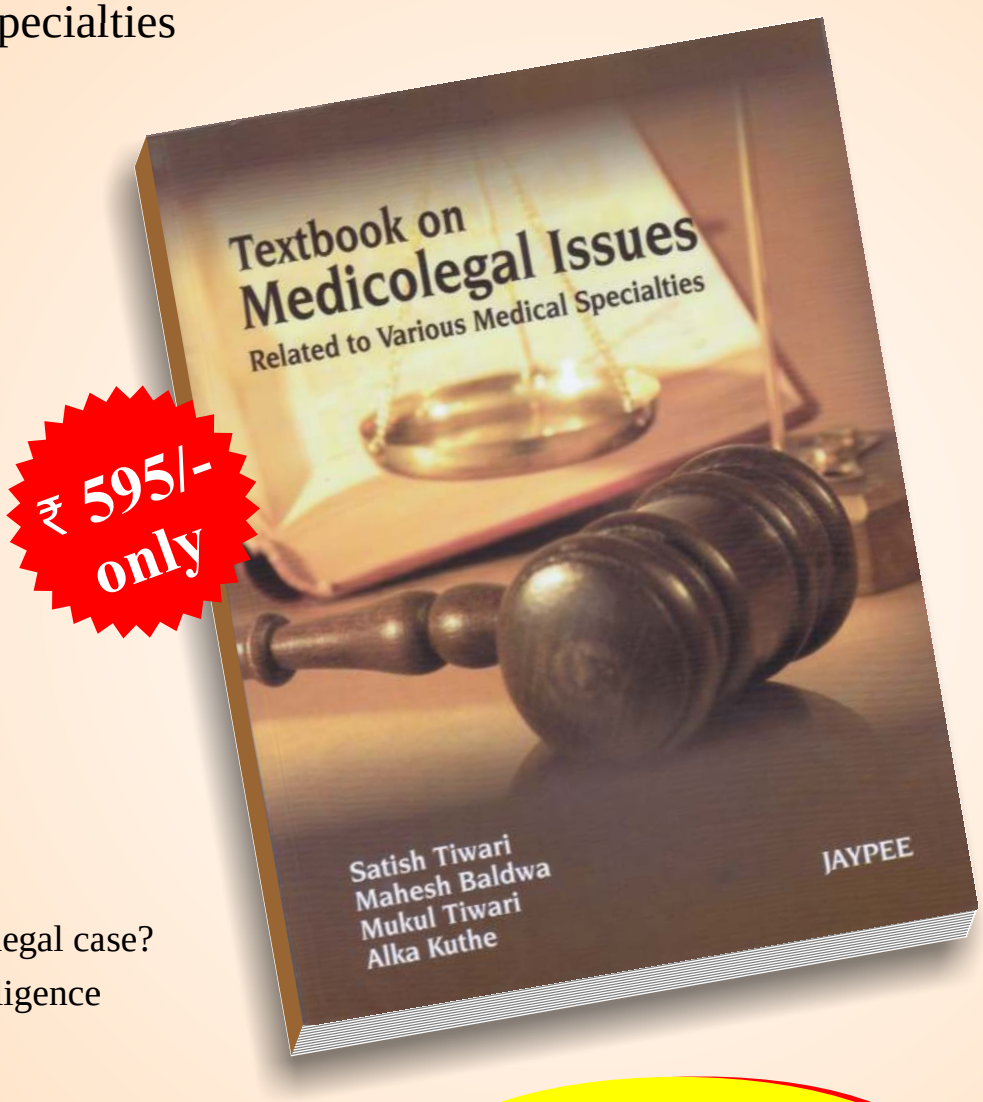

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