No.MCI-5(3)/2009-Med./

MEDICAL COUNCIL OF INDIA

EXECUTIVE COMMITTEE
(Adjourned Meeting)

Minutes of the adjourned meeting of the Executive Committee held on 13th October, 2009 at 2.00 p.m. in the Council office at Sector 8, Pocket 14, Dwarka, New Delhi considering the remaining Item Nos. 6 -25, 33-34 and 48.

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Present:

Dr. P.C. Kesavankutty Nayar	Vice-President, Medical Council of India, Former Dean, Govt. Medical College, **Thiruvananthapuram (Kerala)**
Dr. K.P. Mathur	Former Medical Superintendent, Ram Manohar Lohia Hospital, New Delhi, 77, Chitra Vihar, **Delhi-110092**
Dr. Ved Prakash Mishra	Vice Chancellor, Datta Meghe Instt. of Medical Sciences University, **Nagpur (Maharashtra)**
Dr. Muzaffar Ahmad	Director, Health Services, Govt. of Jammu & Kashmir, **Srinagar (J&K)**
Dr. Nirbhay Srivastav	Officiating Dean and Professor & Head, Orthopedics Department, Gandhi Medical College, **Bhopal –462001(MP)**
Dr. G.K. Thakur	Prof. & HOD cum Superintendent Dept. of Radiology S.K. Medical College, **Muzaffarpur-842004 (Bihar)**
Dr. V.N. Jindal	Dean, Goa Medical College, Bombolim-403202, **Goa**

Lt.Col.(Retd.) Dr. A.R.N. Setalvad -- Secretary

The meeting was chaired by Vice-President as the President of the Council could not attend the meeting.

Apologies for absence were received from Dr. Ketan Desai, Dr. D.J. Borah and Dr. P.K. Das.

6. Matter with regards to Dr. Madhao G. Raje for working at more than one Medical College, simultaneously – Action taken in view of Code of Medical Ethics – Appeal/Representation by Dr. Madhao G. Raje for re-consideration of the earlier decision of General Body.

Read: The matter with regards to Dr. Madhao G. Raje for working at more than one Medical College, simultaneously – Action taken in view of Code of Medical Ethics –

Appeal/Representation by Dr. Madhao G. Raje for re-consideration of the earlier decision of General Body along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 21st and 22nd May, 2009 as under:-

"The Ethics Committee considered the matter of representation/appeal dated 27.02.2008 by Dr. Madhao G. Raje against the decision of the General Body taken at its meeting held on 16.11.2007 and noted –

i) the earlier decision of the General Body taken at its meeting held on 16.11.2007 which is as under:

"The Council approved the following recommendations of the Executive Committee:-

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council noted the following recommendation of the Ethics Committee:-

"……….The Ethics Committee is of the opinion that the Act of Commission in the part of Dr. Madhao G. Raje constitutes PROFESSIONAL MISCONDUCT, which render him liable for disciplinary action.

Under the above mentioned circumstances, the Ethics Committee unanimously recommended that his name may be erased from IMR temporarily for a period of 2 years, as per Section 8.1 of the PROFESSIONAL CONDUCT, ETIQUETTE AND ETHICS REGULATIONS, 2002 ………"

ii) The above decision was communicated to Dr. Madhao G. Raje vide Council letter dated 08.02.2008 with the copy to the concerned institution, State Medical Council as well as DME. Dr. Madhao G. Raje had sent a representation dated 27.02.2008 and requested the Council to consider his request for reconsideration. The whole matter was placed before the Chairman, Ethics Committee and it was directed to place it before the Ethics Committee, the same was endorsed by Secretary.

iii) As per direction, Dr. Madhao G. Raje was requested to appear before the Ethics Committee on 12.08.2008 at 11.00 a.m. vide Council's letter dated 30.07.2008. The matter was considered by the Ethics Committee at its meeting held on 11th & 12th August, 2008 where Dr. Raje appeared before the Ethics Committee & the decision of Ethics Committee was as under:

"The Ethics Committee considered the matter and noted that Dr. Madhao G. Raje who was punished by the General Body of Medical Council of India on 16.11.2007 with eraser of the name from the Indian Medical Register temporarily for a period of two years has made an appeal to the Medical Council of India for re-consideration of the decision. He has requested to review the order to erase his name from the Indian Medical Register because of his instant representation and the additional documents now placed on record and further that during the pendency of the present representation, the effect, implementation and operation of the order dated 08.02.2008 may kindly be suspended.

The Ethics Committee noted that after receipt of this appeal; the Secretary, Medical Council of India has referred the case to the Chairman, Ethics Committee. The Chairman, Ethics Committee has on 16.04.2008 marked the file to Additional Secretary, Medical Council of India with advise as under:-

"In view of the appeal to MCI by a medical teacher we may give him one chance to place his view point before the Ethics Committee. He may be called before the Ethics Committee in second next meeting.

Same action to be taken in similarly placed cases."

It may also be noted that above view expressed by the Chairman, Ethics Committee, was also endorsed by the Secretary, Medical Council of India on file.

The Ethics Committee also noted that Dr. Madhao G. Raje was invited to appear before the Ethics Committee on 12th August, 2008 regarding his appeal and he has appeared today. Dr. Madhao G. Raje has given the statement, which is as under:-

STATEMENT OF DR.MADHAO G. RAJE

I, Dr. Madhao G. Raje did my MBBS from Indira Gandhi Medical College, Nagpur in the year 1983 and I have done my M.D. in FMT from Indira Gandhi Medical College, Nagpur in the year 1987. My registration No. is 54178 with Maharashtra Medical Council and my date of birth is 17.2.1961.

I want to restate the same statement which I have submitted earlier and my stand remains same as stated in my writ petitions and counter affidavit submitted in the High Court.

As per the discussion and directions from the Ethics Committee, I am submitting fax copy received today i.e. 12th August, 2008 here in MCI office of monthly attendance record duly signed by the Dean. This certificate and the other certificate stating my physical presence on 25th February, 2005 at NKP Salve is being sent by post.

Lastly I want to emphasize my prayer once again, since I am not at all guilty and all documents state the truth that I had not been simultaneously employed, please relieve me of all charges leveled against me immediately. Hence submitting the prayer once again.

Sd/-
(Dr. Madhao G. Raje)

The Ethics Committee, after going through the written appeal sent by Dr. Madhao G. Raje, gave a patient and sympathetic hearing to his submission. Dr. Madhao G. Raje has stated that he was only present in NKP Salve Instt. on 25.02.2005

The Ethics Committee after due deliberation in this matter have noted that the Indian Medical Council Act, 1956 as amended up to 2001 has laid specific provisions in case of removal of name from the Indian Medical Register under Section 24(1) & 24(2) of the Act, which is reproduced below:-

1. *"If the name of any person enrolled on a State Medical Register is removed there from in pursuance of any power conferred by or under any law relating to medical practitioners for the time being in force in any State, the Council shall direct the removal of the name of such person from the Indian Medical Register.*

2. *Where the name of any person has been removed from a State Medical Register on the ground of professional misconduct or any other ground except that he is not possessed of the requisite medical qualifications or where any application made by the said person for restoration of his name to the State Medical Register has been rejected, he may appeal in the prescribed manner and subject to such conditions including conditions as to the payment of a fee as may be laid down in rules made by the Central Government in this behalf, to the Central Government, whose decision, which shall be given after consulting the Council, shall be binding on the State Government and on the authorities concerned with the preparation of the State Medical Register."*

The Ethics Committee noted that in view of the clear provision in the Section in the above Act, appeal of these cases can only be dealt with Central Govt. after consultation with the Council. The Ethics Committee also noted that possibly it is not sufficient to delete the name from Indian Medical Register alone but also it should be deleted from the State Medical Register as per the provisions of the Act.

The Ethics Committee further noted that in case of such an appeal against the decision of the General Body, the decision of the appeal should possibly be initiated by the Secretary as per the provisions of the above Act.

The Ethics Committee further feels that as per provisions of the Act and regulation, the Ethics Committee does not have the competence to take any decision whatsoever on an appeal against the decision of General Body unless so directed by General Body/Competent Authority.

In view of above, the decision may be communicated to the Secretary, Medical Council of India for necessary action at his end."

iv) *As desired by the Chairman, Ethics Committee and informed to Secretary, the matter was placed before the Ethics Committee alongwith the information as received. The matter was considered by the Ethics Committee at its meeting held on 15.09.2008 and the decision was as under:-*

"After the consideration of the matter by Ethics Committee in August, 2008; since Dr. Madhao G. Raje has supplied documents to the Ethics Committee as a proof that he was not present at the time of inspection in Dr. D.Y. Patil Pratisthan Medical College, Pune, the Ethics Committee decided to review this case.

Dr. Madhao G. Raje, has been accused of being present at MCI inspection at Dr. D.Y.Patil Medical College, Pimpri, Pune on 25.02.2005 two days after joining N.K. P Salve of Medical Sciences, Nagpur. On the basis of information his name was forwarded to the Executive Committee with the recommendations that his name may be removed from the IMR and the Executive Committee and General Body had already approved this recommendation and action has already taken.

Dr. Madhao G. Raje subsequently made an appeal and thereafter appeared and produced 3 documentary proofs in support of his claim of being innocent. These 3 documents are :-

(i) *A document from Coal India, WCL Headquarter, District, Nagpur which has shown that Dr. Madhao G. Raje, who was allowed to see patients after his duty hour in the hospital run by Coal India Ltd. (A Public Sector Undertakings) which states that on 25.02.2005 he examined 5 patients and was physically present there in Nagpur and not at Dr. D.Y.Patil Medical College, Pimpri, Pune*

(ii) *A monthly Master book/attendance register of the department of Forensic Medicine of N.K. P Salve of Medical Sciences, Nagpur wherein his presence was marked on 25.02.2005.*

(iii) *A letter from Sh. P.D. Patil, Trustee & Director of Dr. D.Y. Patil Pratisthan, dt. 28.03.2005, which is an acceptance of resignation wherein it is clearly written that Dr. Madhao G. Raje has been relieved from Dr. D.Y.Patil Medical College, Pimpri, Pune on 15.02.2005 after working hours. Lastly he has produced 2 documents, both from N.K.P. Salve of Medical Sciences, Nagpur (i) experience certificate dt. 13.04.2007 which states that on 23.02.2005 he has joined and continued as a Professor of Forensic Medicine in the said college and the (ii) a letter issued dt. 12.08.2008 by the Dean, Dr. S. Das Gupta of N.K.P. Salve of Medical Sciences, Nagpur which clearly states that Dr. Madhao G. Raje, Professor of Forensic Medicine was present at the college during the working hours from 10.00 a.m. to 4.00 p.m. on 25.02.2005.*

The Ethics Committee decided to enquire about the authenticity of the letter dt. 12.08.2008 and the Dean was asked whether the Dean has actually issued this letter or not? And the Dean vide letter dt. 15.09.2008 has confirmed by fax that the letter dt. 12.08.2008 is genuine.

The Ethics Committee after consideration of these documents is of the opinion that there is real ground to think that Dr. Madhao G. Raje was not present simultaneously in 2 medical colleges and that his case needs reconsideration. Therefore the Ethics Committee decided that the Secretary, Medical Council of India should be apprised of this fact alongwith the file for taking necessary and appropriate action at his end. This may be placed before the Secretary considering the urgency of the matter even before approval of the minutes."

v) *The whole matter was placed before the Secretary, MCI, who directed to place the matter before Executive Committee. The above recommendation of the Ethics Committee was duly approved by the Executive Committee and members of Adhoc Committee appointed by the Hon'ble Supreme Court at its meeting held on 10th November, 2008.*

vi) *The matter was considered by the General Body of the Council at its meeting held on 13.11.2008 and the decision is as under:-*

"After due deliberations, the members of the Council decided to direct the Ethics Committee to decide in the light of fresh documentary evidence submitted by the candidate, as indicated above".

The Ethics Committee taking into consideration the direction of the General Body taken at its meeting held on 13.11.2008 and perusing the records and evidences, unanimously decided to withdraw the earlier decision as communicated to all vide Council letter dated 08.02.2008."

After due and detailed deliberations and consideration of the above stated submissions, the Executive Committee of the Council decided to recommend to the General Body of the Council to withdraw the decision taken at its meeting held on 16.11.2007 to remove the name of Dr. Madhao G. Raje from IMR temporarily for a period of 2 years, as per Section 8.1 of the Professional Conduct, Etiquette and Ethics Regulations, 2002.

7. Appeal under Section 24(2) of IMC Act, 1956 against the order dated 16.09.2003 passed by the Delhi Medical Council against the Appellant Dr. T.K. Chakraborty - Govt's letter dt. 14/11/2007 regarding.(F.No. 492/2007)

Read: The matter with regard to appeal under Section 24(2) of IMC Act, 1956 against the order dated 16.09.2003 passed by the Delhi Medical Council against the Appellant Dr. T.K. Chakraborty - Govt's letter dt. 14/11/2007 regarding.(F.No. 492/2007) along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 21st and 22nd May, 2009 as under:-

"The Ethics Committee considered the ongoing matter with regards to appeal under Section 24(2) of IMC Act, 1956 against the order dated 16.09.2003 passed by the Delhi Medical Council against the Appellant Dr. T.K. Chakraborty and noted:

i) the following letter dt. 14.11.2007 from Central Govt. forwarding therein a copy of appeal made by Dr. T.K. Chakraborty under Section 24(2) of IMC Act, 1956 against the order dated 16.09.2003 passed by Delhi Medical Council:

"The Central Govt. had invited the attention of the Council towards the Hon'ble Delhi High Court's order dated 11.10.2007 in the CWP No. 6246/2007 in the case of Dr. T.K. Chakraborty Vs. Delhi Medical Council and others wherein the Hon'ble Delhi High Court pronounced that –

"In view of the above, the petitioner shall approach the respondent No.2, Ministry of Health through its Secretary within 3 weeks from today with an appeal under Section 24(2). The Central Government shall take steps to hear the appeal and dispose off the same as expeditiously as possible in accordance with Section 24(2) after consulting the views of the Medical Council of India and giving suitable hearing to the petitioner as well as considering the views of the complainant who is a respondent in these proceedings. This shall be done by giving reasonable notice all the parties. A decision shall be communicated to the petitioner within four months from today."

The Central Govt., Ministry of Health & F.W., had requested the Council to send views/comments on the appeal within 3 weeks i.e. before 23rd November, 2007 so that the Hon'ble Delhi High Court's order can be complied with."

ii) the following decision of the Ethics Committee taken at its meeting held on 21st & 22nd January, 2008:

"The Ethics Committee considered the matter with regard to appeal under Section 24(2) of IMC Act, 1956 against the order dated 16.09.2003 passed by the Delhi Medical Council against the Appellant Dr. T.K. Chakraborty and noted that the Ethics Scrutiny Committee considered this case at its meeting held on 14.01.2008. It has been seen that Dr. T.K. Chakraborty has filed an appeal under Section 24(2) of the IMC Act to the Ministry of Health on 31.10.2007. The appeal was against an order of Delhi Medical Council dated 16.09.2003. After receipt of this, it was submitted pursuant to the decision of the Hon'ble High Court of Delhi in its order dated 11.10.2007 in the CWP No. 6246/2003 filed by Dr. T.K. Chakraborty. The Ministry has sent this case to Medical Council of India for comments on the appeal within three weeks.

It has been seen that MCI office on 09.01.2008 has written to the Ministry that the appeal have been placed before the Ethics Committee scheduled to be held on 21st & 22nd January, 2008 and the decision communicated to them in due course of time.

It is clear from the document that the Hon'ble High Court has asked the Ministry to dispose off the appeal u/s 24(2) of IMC Act.

The Ethics Committee of the MCI can take up an appeal against the decision of the State Medical Council u/s 8.8 only within 60 days or at the most within 120 days. The appellant has not approached the MCI under this clause as the time of the decision of the State Medical Council u/s 8.7 and 8.8 were not in existence at that time. So the appeal is not being heard by the Ethics Committee under this Section. Further, this fact may be recorded. It has already been communicated to the Ministry.

It is apparent that the Ministry only asked for comments of the MCI and has not asked MCI to take up this case. Without investigating this case the Ethics Committee is not in a position to give comments towards the merit or other aspects of this case. Further under directions of the Hon'ble High Court in the above cited case the Ministry may be pleased to take this case u/s 24(2) as there is not time limit for such appeals. This may be placed before the Ethics Committee meeting on 21st & 22nd January, 2008 if approved it may be forwarded to the Ministry.

The Ethics Committee while endorsing the above recommendations of the Ethics Scrutiny Committee decided that since the Hon'ble High Court of Delhi has ordered that " The Central Government shall take steps to hear the appeal and dispose off the same as expeditiously as possible in accordance with Section 24(2) after consulting the views of the Medical Council of India and giving suitable hearing to the petitioner as well as considering the views of the complainant who is a respondent in these proceedings. This shall be done by giving reasonable notice to all the parties. A decision shall be communicated to the petitioner within four months today", the Ethics Committee can offer their comments only after investigation of the case. Therefore, the Ethics Committee decided to call for the documents and other details from Delhi Medical Council, pertaining to this case. The Ethics Committee further decided to call Dr. T.K. Chakraborty to appear before the Ethics Committee on 29.02.2008 at 12.30.p.m and also to call Sh. Basant Patra, who was complainant in this case against DR. T.K. Chakraborty, on 29.02.2008 at 3.30.pm".

iii) the following decision of the Ethics Committee taken at its meeting held on 28th & 29th February, 2008:

"The Ethics Committee noted that the Central Govt. has invited the attention of the Council towards the Hon'ble Delhi High Court's order dated 11.10.2007 in the CWP No. 6246/2007 in the case of Dr. T.K. Chakraborty Vs. Delhi Medical Council and others. The Committee further noted that the Central Govt., Ministry of Health & F.W., has requested the Council to send views/comments on the appeal within 3 weeks i.e. before 23.11.2007 so that the Hon'ble Delhi High Court's order can be complied with.

The Ethics Committee has started the process of enquiry in the above mentioned matter.

The Ethics Committee considered the appeal under Section 24(2) of IMC Act, 1956 against the order dated 16.09.2003 passed by the Delhi Medical Council against the appellant Dr. T.K. Chakraborty and noted that Dr. T.K. Chakraborty was requested to appear before the Ethics Committee & Dr. T.K. Chakraborty has appeared before the Committee and the Committee heard him and he has submitted an oral deposition alongwith a written statement, which is as under:-

Statement of Dr. T.K. Chakraborty

I Dr. T.K. Chakraborty passed my MBBS from UCMS, Delhi in the year 1976 and did my DA from Delhi University in 1981. My registration no. is 18769 of Punjab Medical Council and 19132 of Delhi Medical Council. My date of birth is 01.08.1955.

The patient came to my chamber as a OPD patient on 03.01.2003 with a complaint of pain and swelling in his Left Knee. On visual examination and touching I could find the portion of the knee was firm and tender. The patient was febrile and I on the same very day in the prescription expressed my lurking suspicion that it could be Osteosarcoma and put my question of

interrogation but the initial symptoms of Osteosarcoma as well as the tuberculosis being the same I adopting the "differential diagnosis" wanted to determine the cause. I immediately suggested for the x-ray of knee as well as mantoux test and routine blood haemogram. After seeing his x-ray report which was non-specific suggesting? Tubercular or ?Osteosarcoma. The Mantoux test was found positive after two days and routine ESR having been high suggested the ailment heavily towards tuberculosis. I started him on antitubercular treatment and asked him to come after two to three days in my OPD.

That the patient again turned up on 6th of January and on examining him I categorically advised him to go for "Biopsy" as he was still febrile I prescribed him some antipyretic and antibiotic alongwith ATT. Again on his next visit on 09.01.2003 my clinic when he visited I asked him whether he had gone for Biopsy and hearing that he did not go I suggested to stop ATT and he should immediately go for Biopsy. The seriousness was categorically explained to the mother and her son (patient). Again on 16.01.2003 patient came to my OPD clinic and on enquiry it was found that he did not undergo Biopsy as impressed upon him to do so. The patient and his mother insisted that due to some time constraint and ensuing examination the boy could not go for Biopsy and requested me to continue my treatment till the examinations are over. Thus the ATT was started with the categorical advise that the Biopsy must be done immediately. On 20.02.2003 the patient again came to the OPD till then he did not go for the Biopsy against such categorical medical advise and impressed upon me so that I give him further treatment. Under such compelling circumstances I had to perform the core needle Biopsy with the hope that some liquid and tissue so that some conclusion could be drawn.

Unfortunately the needle biopsy report was non-conclusive after that without prescribing any further medicine I categorically asked him to go for open biopsy and referred him to Orthopaedic Surgeon.

Thus from the above it is crystal clear that from the very first day i.e. on 03.01.2003 I had lurking suspicion that the patient could be suffering from Osteosarcoma and by differential diagnosis wanted to eliminate my suspicion. Since after 3 days when he had come as a OPD patient again and mentioned in the prescription "advised" biopsy and as well explained to the patient and his mother. If my advise had been adhered to on 06.01.2003 by that OPD patient and undertaken the necessary steps – of undergoing biopsy the disease could have been detected then and there. Against my medical advise due to apathy the patient neglected on his own volition and sweet will by one pretext or the other. Thus the main complaint of the complainant that my treatment of ATT has resulted into development of Osteosarcoma which has been categorically negated by the Delhi Medical Council with this "…..eventhough anti tubercular treatment did not contribute to the malignancy…" but still holding me negligent struck off my name from the Delhi Medical Council Register as well as debarred me from medical practice for a period of 6 weeks which is harsh and contrary to the facts and findings as well as the complaint.

Contrary to the fact that I had only undertaken the core needle biopsy and not muscle biopsy but surprisingly in the order dated 16.09.2003 it has been mentioned that I had undertaken the muscle biopsy instead of bone biopsy which is beyond my skill and competence. I could do only core needle biopsy in my clinic which was acceptable and genuine tool of primary medical investigation.

It could be also mentioned that the patient was OPD patient and I charged only Rs. 30/- for visit and being OPD patient he was at liberty to go to some other doctor. Despite repeated advise he did not go for biopsy, this categorically disproves all the allegations as I had advise him to go for biopsy on the very third day which shows my deep concern for the patient and right mythology for the patient. I have seen him only 4 times to have charges Rs. 180/- total during the period

It can also be mentioned that the disciplinary committee of Delhi Medical Council was improperly constituted as could be seen from the Delhi Medical Council Act, 1997 Section 21 says "The council shall have a Disciplinary committee comprising of

(i) a Chairman to be nominated by the Council.
(ii) a Member of Legislative Assembly of the National Capital Territory of Delhi, nominated by the Speaker.
(iii) a Legal Expert to be nominated by the Council.
(iv) an eminent public man nominated by the Government.

(v) an eminent medical specialist in the relevant speciality to which the complaint pertains, to be nominated by the Council and
(vi) a member nominated by Medical Association of Delhi with minimum ten years standing.

That it could be seen that there are three independent members such as 21 (ii), (iii) & (iv) members were not in the Committee who were outsiders and independent members and had they been present the improper order probably would not have been passed. It is also to be mentioned that in the said committee meeting I was not allowed to produce my defence and was not afforded patient hearing substantiating with medical documents pertaining to differential diagnosis initial symptoms of tuberculosis and tumor being similar and also pertaining to the compelling circumstances for a needle biopsy.

The complainant emboldened with Delhi Medical Council findings tarnished my image and reputation by going to various people and press complaints against me.

The complainant has been forum hunting as he has not only gone for the consumer forum claiming 25 lacs against me but also lodged criminal complaint shows that the complainant without appreciating that there is not fault on my part trying to make monitory gain by filing such false and fabricated claims.

The Hon'ble Members of the Ethics Committee put some questions to Dr. Chakraborty and obtained his answers to them.

Q.: Whether you continued to work during the period of suspension from Delhi Medical Council.
Ans.: I am law abiding citizen and being a medical graduate and educated person have tremendous regards and respect for the system have never flouted the order of the Delhi Medical council dated 16.09.2003 clearly shows that I had knock the door of Delhi High Court and obtain stay against such order on 29.09.2003. Prior to the grant of stay I had not practiced at all. Any allegations that I had practiced during that period is baseless and figments of imagination. Had there been any such act by me as alleged the same would have been brought to the knowledge of all the forums. This is clearly an afterthought and raised for the first time to bias the mind of this Hon'ble Forum

Q.: Whether your clinic is registered with the Department of Health or any other authority.

Ans.: Clinic does not require any registration. X-ray and Pathology Laboratory also not required any registration because there are registered Radiologist and Pathologist.

References: Differential diagnosis and Preliminary symptoms of Osteomytitics and Osteosarcoma: International seminar in Surgical Oncology, 2005 2:10 .(copy enclosed)

Core Needle Biopsy : http"//www.caring4cancer.com/go/osteosarcomo/diagnosis
www.cancer.org/docroot/CRI/content/CRI on how is Osteosarcoma diagnosed.(copy enclosed)

sd/-
(Dr. T.K. Chakraborty)
29.02.2008

The Ethics Committee further noted that the complainant Mr. Basant Patra was requested to appear before the Ethics Committee on 29.02.2008 at 3.30 p.m. and he did so. The Ethics Committee heard him and discussed the various aspects of the case with him and has also recorded his statement. He has submitted an oral deposition alongwith a written statement, which is as under:-

"Statement of Mr. Basant Patra

The original complaint in this case Mr. Basant Patra was requested to appear before the Ethics Committee on 29.02.2008. Mr. Basant Patra came and presented himself before the Ethics Committee and he has narrated the whole case showing different papers, prescriptions etc. which were also submitted to Delhi Medical Council. He has said that now he wants justice to be done. His son has left this world and his mother has become mentally imbalance. During his illness when he was taking chemotherapy he has appear in CBSE examination and has passed in the secondary school examination in 2004. I had to sell my house for his treatment. His younger

brother also got imbalanced after his brother's death. My daughter also could not appear in her BA (final) examination due to this tragedy. His mother still thinks that her son is still alive. I have also feel unwell neither I can take treatment nor can work properly. The clinic of the Dr. Chakraborty was open during the 6 weeks. I have this much only to say (the above statement was given by Mr. Basant Patra in Hindi language which has been translated into English).

Sd/-
(Mr. Basant Patra)
29.02.2008"

The Ethics Committee after due deliberation has unanimously decided that this required further inquiry and therefore it had decided to conduct further enquiry. Dr. T.K. Chakraborty may also be called on these occasions.

The Ethics Committee further noted that the Directorate of Health Services, Govt. of NCT of Delhi be requested to inform the office whether registration of clinic with or without facilities of x-ray and laboratory facilities are required under law and whether any clinic/centre with the facilities of x -ray/laboratory can function without registration in NCR of Delhi. A letter in this regard may be sent to the Directorate of Health Services, New Delhi for the same within a period of 15 days."

iv) the following decision of the Ethics Committee taken at its meeting held on 7th & 8th July, 2008:

"The Ethics Committee noted that the Medical Superintendent (Nursing Homes), Directorate of Health Services, Govt. of NCT of Delhi had sent letter dated 30.05.2008, which is reproduced below:-

"I am directed to inform that only such centers that have round the clock inpatient and/or operative procedure with nursing care activities are registered under the provision of Delhi Nursing Home Registration Act, 1953 and the rules framed there-under. The clinics providing outdoor facilities only, are not required to be registered under the aforesaid act. Regarding the issue whether any clinic with facility of x-ray/lab can function without registration may be clarified that the clinics not providing inpatient activities can function without registration, since they are not registered."

The Ethics Committee decided that a reminder for the required documents not found enclosed with the said letter be sent to Directorate of Health Services, Govt. of NCT of Delhi."

v) the following decision of Ethics Committee taken at its meeting held on 11th & 12th August, 2008:

The Ethics Committee considered the matter and noted that the required documents have been received vide DGHS Delhi's letter dated 21.07.2008.

The Ethics Committee decided that opinion from two specialists of Orthopaedics – namely HOD's, Medical College, Rohtak and MAMC, Delhi be obtained with regards to this case and after receipt of opinion, Dr. T.K. Chakraborty may be called to appear before the Ethics Committee at one of its next meetings."

vi) the following decision of the Ethics Committee taken at its meeting held on 11th & 12th December, 2008:

"The Ethics Committee discussed all the relevant details of the present case and also has taken note of the opinion received from Dr.R.C.Siwach, Sr. Prof. & Head Orthopaedics, Pt. Bhagwat Dayal Sharma Postgraduate Institute of Medical Sciences, Rohtak and Prof. Anil Dhal, HOD of Orthopaedics, MAMC, Delhi. After consideration of all these records, the Ethics Committee is of the unanimous opinion that Dr.T.K. Chakraborty should be called once again before the Ethics Committee to defend himself in view of the specific observations received from Dr.Siwach & Dr.Dhal. He may be called in one of the next meeting of the Ethics Committee."

vii) The Ethics Committee at its meeting on 19th January, 2009 after noting the above and while deliberating the matter considered the following opinions received from Dr. R.C. Siwach and Dr. Anil Dhal:

<u>Opinion dated 07.10.2008 of Dr. R.C. Siwach</u>

"On metriculous & through examination of treatment record, court order, complaint, reply of Dr. T.K. Chakraborty, order of the Delhi Medical Council and other relevant literature forwarded by Medical Council of India for expert opinion. In my opinion Dr. T.K. Chakraborty, has possessed only MBBS degree and diploma in Anaesthesiology. He is not specialized to treat bone and joint diseases ethically as the Orthopaedics Onco-surgery comes under specialized services. He is not specialized in the field either to start Anti Tuberculosis treatment or Anti Cancer Drugs. He is also not specialized for taking core biopsy of the bones. Therefore, his course of treatment indulging in the field of orthopedics oncology is not in accordance with accepted practice where a petitioner must bring to his task a reasonable degree of skill knowledge and must exercise a reasonable degree of care. This is also incorrect that Anti tuber-culosis treatment leads to osteo-sarcoma which is absolutely baseless allegation.

In bone tumors whether core biopsy or open biopsy should be taken is decided by the treating orthopedic surgeon because it is a technically demanding procedure as from which area the biopsy should be taken is very important. Hence on this front also Dr. Chakraborty is not competent to take proper core biopsy for the bone under local anaesthesia. Dr. T.K. Chakraborty put the patient on the ATT from very beginning i.e. 03.01.2003 and stopped after six days i.e. on 09.01.2003, where the accepted norms of ATT is, once a trial course is started even for diagnostic purposes should not be stopped less than three weeks unless the diagnose is confirmed. I am unable to understand that how he decided to discontinue the ATT treatment and then again starting is not scientific.

Therefore, in my opinion:

1. Dr. T.K. Chakraborty is not competent to diagnose and treat either osteosarcoma or bone joint tuberculosis as he is not in the specialized field of Orthopedics. He is only MBBS & DA.
2. The procedure to take core biopsy from the tumor is also unethical as it needs specialization to take the core biopsy in a suspected case of osteosarcoma.
3. His method of giving ATT and then stopping within few days and again restarting is also not based on any scientific reasoning.
4. Lastly I am of the opinion that when Dr. T.K. Chakraborty on first visit of the patient suspected osteosarcoma of the femur even lurching doubts rather than lingering on with treatment he should have state forward referred him to a higher centre for its further diagnosis and management.

In the light of the above if any doctor works in the field in which he is not competent or specialized, comes under medical negligence as the person is not in possession of skill, knowledge and experience in that particular field as is the case of Dr. T.K. Chakraborty.

<u>Opinion dated 10.12.2008 of Dr. Anil Dhal</u>

"I have gone through the documents submitted alongwith your letter. The following are my observation on the matter:

1. It seems reasonable to entertain a differential diagnosis of Tuberculosis & Osteosarcoma in this case.
2. Trial of Antitubercular drugs on clinical suspician is in order.
3. As per records patient was referred to Orthopaedic surgeon on 09.01.03 by the treating doctor. It seems the patient visited an Ortho Surgeon only on 09.03.03.
4. The treating physician performed a biopsy on 21.02.03 which seems a logical step since the lesion seemed not responding to anti-tubercular drugs."

The Ethics Committee also noted that Dr. T.K. Chakraborty, as per the earlier decision has again been requested to appear before the Ethics Committee; and Dr. Chakraborty has appeared before the Ethics Committee on 19.01.2009 and his statement is as under.

Statement of Dr. T. K. Chakraborty

Dr. T. K. Chakraborty appeared before the Ethics Committee of the Council today i.e. 19.01.2009 and he has answered the questions put to him as under:-

Q. Dr. T. K. Chakraborty your qualification is MBBS?
A. Yes.
Q. Do you think that you are competent to diagnose and treat Osteaosarcoma?
A. No.
Q. Do you think that you are competent to diagnose and treat Tuberculosis?
A. Yes.
Q. Are you competent by virtue of your training and degree to perform a Core Needle Biopsy from the tumor in the suspected case of Osteaosarcoma?
A. Yes, I can do a Core/Thick Needle aspiration of soft tissue swelling under the supervision of pathologist and under aseptic precaution.
Q. In this case, you did a Needle Biopsy or a Core Biopsy?
A. I did a Core /Thick Needle aspiration from soft tissue swelling in this case.
Q. Can you tell us what is this Core Needle Biopsy and what instruments are used?
A. A Core/Thick Needle Biopsy is done by Needle of 18-20 gauze under local anaesthesia under aseptic condition with sterlie dressing material and autoclave.

Q. How, this is different from FNAC?
A. FNAC is done for aspiration of small firm or cystic swelling by a needle of size 22-24 gauze.
Q. In this case, you have done a Core Needle Biopsy by your admission and you have used a simple needle of 18-20 gauze?
A. Yes, I have done thick needle aspiration of soft tissue swelling under aseptic condition and under local anaesthesia.
Q. When did you suspected this case to be a case of Osteaosarcoma?
A. On his first visit, I had a lurking suspicion of Osteaosarcoma based on differential diagnosis and clinical knowledge.
Q. Where do you perform Core Needle Biopsy on this patient?
A. In my clinic under aseptic condition and under supervision of pathologist.
Q. It is your clinic and proper OT for performing such procedures?
A. Yes, I have an aseptic space where I can perform small procedures.
Q. What was the Radiological Report?
A. Radiological Report was first Tubercular Ostriomylitis and second Osteaosarcoma.
Q. What was the level of ESR?
A. ESR level was around 30 mm in the first hour.
Q. Do you think that 30 mm of ESR is suggestive to Tuberculosis?
A. Yes, it is enough to suggest Tuberculosis for a boy of 14-15 years.
Q. Montoux Test was done in this patient?
A. Yes, it was positive after 48 hours.
Q. Whether positive Montoux test is suggestive of Tuberculosis or not?
A. Yes, It is an important preliminary tool for diagnosis tuberculosis.
Q. Any more test you had done to suggest Tuberculosis?
A. No.
Q. Where was the location of the swelling/site of the leisons?
A. Lower end of Thigh
Q. Whether the lower end of the Thigh is common site of Tubercular leisons or not?
A. Yes, sometimes.
Q. Do you think that will all the parameters mentioned above the leisons could be of Tuberculosis?
A. It was only a provision of diagnosis.

I have explained elaborately and submitted each and every details relating to these questions to the Hon'ble High Court, and I stand by my all submissions to High Court in respect of my diagnosis, lurcking suspicion, treatment of the patient.

My answer of every question is being supported by text-book reference attached alongwith.

Thanking you,

Sd/-
(Dr. T. K. Chakraborty)
19.01.2009

The Ethics Committee decided to take the final decision in the next meeting."

viii) The decision of Ethics Committee taken at its meeting held on 31st March & 01st April, 2009 to defer the consideration of the matter for its next meeting.

The Ethics Committee noting the above and deliberating the matter in length alongwith the opinion rendered by the experts Orthopaedic Surgeons, observed that Dr. T.K. Chakraborty is not competent to diagnose and treat either Osteosarcoma or bone and joint tuberculosis and further that the action of administration of A.T.T (Anti-tubercular treatment) and thereafter stopping the same within few days is not based on scientific reasoning. The Ethics Committee in view of the fact that Dr. T.K. Chakraborty is not in possession of skill, knowledge and experience in this particular field which he was dealing with; decided that this is a clear cut case of medical negligence by Dr. T.K. Chakraborty.

This Ethics Committee, therefore, decided to uphold the order dated 16.09.2003 of Delhi Medical Council that Dr. T.K. Chakraborty be debarred from medical practice for a period of six weeks."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee to uphold the order dated 16.09.2003 of Delhi Medical Council that Dr. T.K. Chakraborty be debarred from medical practice for a period of six weeks.

8. The decision of the Ethics Committee vide its meeting dated 06.10.2008 in the case relating to the Appeal by Dr. R.P. Arora against the order dated 31.01.2007 of Delhi Medical Council - Representations dated 11.12.2008 and 24.04.2009 by Sh. Suman Barthwal husband of Mrs. Munni Devi regarding (F.No. 204/2007).

Read: The matter with regard to the decision of the Ethics Committee vide its meeting dated 06.10.2008 in the case relating to the Appeal by Dr. R.P. Arora against the order dated 31.01.2007 of Delhi Medical Council - Representations dated 11.12.2008 and 24.04.2009 by Sh. Suman Barthwal husband of Mrs. Munni Devi regarding (F.No. 204/2007) along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 21st and 22nd May, 2009 as under:-

"The Ethics Committee considered the matter of representations dated 11.12.2008 and 24.04.2009 by Sh. Suman Barthwal husband of Mrs. Munni Devi against the decision of the Ethics Committee vide its meeting dated 06.10.2008 with regards to appeal by Dr.R.P. Arora against the order dated 31.01.2007 of Delhi Medical Council and noted the decision of the Ethics Committee taken at its meeting held on 06.10.2008 which is as under: –

"The Ethics Committee considered the matter with regard to appeal against order dated 31.01.2007 passed by Delhi Medical Council filed by Dr. R.P. Arora and noted:

i) the following decision of the Ethics Committee taken at its meeting held on 9th & 10th July, 2007:

"The Ethics Committee considered the appeal against the order dated 31.1.2007 passed by Delhi Medical Council filed by Dr. R.P. Arora, Chief Administrator, Vidyasagar Institute of Mental Health & Neurosciences, New Delhi and decided to call the appellant Dr.R.P. Arora and Dr.A.K.Banerji alongwith all the relevant documents in its second next meeting and also ask Delhi Medical Council to provide the relevant records pertaining to the order issued by them."

ii) the following decision of the Ethics Committee taken at its meeting held on 10th & 11th September, 2007:

"The Ethics Committee considered the matter with regard to appeal against order dated 31.01.2007 passed by Delhi Medical Council filed by Dr. R.P. Arora and noted the Dr. R.P. Arora, Chief Administrator, Vidyasagar Institute of Mental Health & Neurosciences, Nehru Nagar, Delhi was requested to appear before the Ethics Committee on 11.9.2007 at 12.00 noon. Dr. R.P. Arora has appeared. The Ethics Committee further noted that Hospital record of the case have been received from the Delhi Medical Council and it was observed that these are authentic copies so Vidyasagar Institute of Mental Health & Neurosciences, Nehru Nagar, Delhi need not submit any more copy of the same records. The Ethics Committee also noted the appeal received by it from Dr. R.P. Arora, Chief Administrator, Vidyasagar Institute of Mental Health & Neurosciences, Nehru Nagar, Delhi. Dr. R.P. Arora has made on oral submission before the Ethics Committee, which reads as follows:-

"11.09.2007

Oral Submission of Dr. R.P. Arora

I, Dr. R.P. Arora, Chief Administrator, Vidyasagar Institute of Mental Health & Neurosciences, Nehru Nagar, Delhi states that:-
The patient was treated in the unit of Prof. A.K. Banerji as per existing protocol and subsequently developed Necrotising Fascitis, which was diagnosed and treated promptly. However, a well-known complication of Gangerne fore-arm developed which had to be subsequently amputated. All concerned consultants i.e. Orthopaedics Dermatologist were involved in the management. At no stage there was any negligence in the management of the case.

However, the detailed management will be given by Prof. A.K. Banerji and his team.

Thanking you,

Sd/-
(Dr. R.P. Arora)"

A Joint written statement of Dr. A.K. Banerji and Dr. R.P. Arora was submitted to the Ethics Committee The statement is as under :-

"The Delhi Medical Council examined a complaint of Shri Suman Barthwal, 2/3, Queen Lines, Lansdowne, PO Lansdowne, Distt Pauri Garhwal, Uttaranchal, referred by Police Station, Sriniwaspuri, New Delhi alleging medical negligence on the part of VIMHANS Hospital, New Delhi in the treatment administered to complainant's wife Smt. Munni Devi Barthwal which resulted in amputation of her right hand on 20.12.2004. The Delhi Medical Council held a hearing on 19.04.2005 in which both the parties were heard in person and questioned by the board set up by the DMC. An order was issued by the DMC on 31st January, 2007 observing that "VIMHANS failed to exercise reasonable degree of care in the treatment administered to the patient, as a consequence of which the right hand of the patient had to be amputated."

We wish to appeal against this order of the Delhi Medical Council to the Medical Council of India. We feel that the Delhi Medical Council has not fully or correctly appreciated the facts and hence we feel the need to file this appeal to your goodself.

Briefly stated the facts of the case are that the patient was admitted to VIMHANS with the diagnosis of dorsal myelitis on 30.11.2004. She was administered I.V. Methyl prednisolone on the same day. She developed swelling of the right forearm- thrombophlebitis on 4.12.2004 and was managed conservatively with removal of I.V. line. Thrombophob ointment & Sumag dressing locally along with elevation of hand and oral antibiotics. The swelling did not subside and IV antibiotics and Fraziparine was started. She developed some blebs on the forearm on 7.12.2004 and was seen by the dermatologist who considered the possibility of contact dermatitis. On 8.12.2004 the patient developed increase in swelling and blisters in the right forearm with discoloration of fingers of right hand and numbness below mid forearm. She was diagnosed as having developed compartment syndrome and necrotizing fascitis and an emergency fasciotomy was done. Postoperatively the limb showed partial neurovascular stabilization. Later septicemia and worsening neurovascular compromise of the forearm set in, which necessitated amputation on the forearm on 20.12.2004 as a life saving measure.

The Delhi Medical Council's observation "that as a complication of intravenous administration of drugs, thrombophlebitis and extravagation occurred. The rapidly spreading inflammation progressed to compartment syndrome in the right forearm which necessitated amputation of right hand ", is erroneous since thrombophlebitis can occur in any individual in which an IV cannula is fixed, despite the best of care. At no point of time was extravasation of fluid deemed to have resulted because IV fluid and methylprednisolone was administered on 30.11.04 and swelling was observed in forearm on 4.12.04, i.e 4 days after fluid administration. It is easy to understand that if extravasation of fluid occurs which presses on vital structures and causes a compartment syndrome it would occurs immediately and not after 4 days as resulted in this case. That the swelling came after 4 days is accepted even by the complainant. The patient was treated as per the standard protocol for thrombophlebitis in consultation with the physician, dermatologist etc.

The DMC contention that "only on appearance of blisters, discoloration on 8.11.2004 she was diagnosed to have compartment syndrome with septicaemia for which Fasciotomy was done, which did not help the patient at all" is not based on correct appreciation of the facts because the patient was being treated for thrombophlebitis from 4th to 8th December. Only on the 8th of December she rapidly developed necrotizing
fascitis and compartment syndrome as evidenced by the discoloration and sensory loss in the forearm and fingers. It is a known fact that compartment syndrome develops suddenly and can manifest as a rapidly fulminant presentation in a span of less than 6 hours (pg 686 of Orthopedics by SamuelL. Turek, fourth edition- enclosed). It has to be appreciated that compartment syndrome develops in a few hours and not few days as contented in the said order. The patient was taken up for fasciotomy within 30 minutes of evaluation by an orthopedician. No one can and no one will do fasciotomy for thrombophlebitis alone which the patient had from 4.12.04 to 8.12.04.

The potential role of steroids in contributing partly to the patient's problems cannot be denied. She had received three injections of methyl prednisolone and subsequently also received dexamethasone for her spinal problem. The steroids could have masked early signs of necrotizing fascitis as well as made the course of the infection much more fulminant than usual despite the use of antibiotics. However we would like to emphasize that we had no option but to give steroids because of her serious neurological illness for which this was the only treatment.

It is again stressed that

- *Patient has thrombophlebitis and no extravasation occurred.*
- *She was appropriately treated for thrombophlebitis from 4th Dec to 8th Dec*
- *Acute necrotizing fascitis and compartment syndrome occurred rapidly on 8th Dec and was treated by timely fasciotomy. However the limb could not be saved because of septicemia and local edema and amputation was done as a life saving measure.*
- *Steroids given for her neurological illness could have made her infection more fulminant and rapidly progressive and masked the early symptoms.*

It is unfortunate that a relatively small and very frequent problem IV therapy- thrombophlebitis- progressed in this patient to necrotizing fascitis and compartment syndrome resulting in amputation. It happened inspite of use of standard management protocols. The complications were diagnosed in time and managed appropriately in consultation with various specialists.
The family was kept fully informed of the progress and all decisions were taken with their full concurrence. On several occasions the family took the clinical summary and MRI scans for getting a second opinion and these were given freely.
The treatment was carried out by experienced clinicians of repute and patient was observed closely and frequently. The unfortunate loss to limb in this patient occurred not because of us but despite our best efforts.
The Delhi Medical Council order observing that we 'failed to exercise reasonable degree of care in the treatment administered to the patient" greatly disturbs and pains us. We have treated this patient to the best of our ability-based on our knowledge and nearly 50 years of experience in the medical profession. The order is extremely disturbing because even today we do not know what more we could have done to save this patient's limb. If we get another such patient today-we would probably treat him/her in the same manner. We fail to understand what further "reasonable degree of care' we could have exercised in the situation. We appeal to the Medical Council of India to reverse this order and give us justice."

The Ethics Committee further noted Dr. A.K. Banerji was requested to appear before the Ethics Committee on 11.9.2007 at 12.00 noon. and Dr. A.K. Banerji has appeared. He has submitted his deposition as under:-

"11.09.2007

Statement of Dr. A.K. Banerji

I, Dr.A.K. Banerji, did my MBBS from K.G. Medical College, Lucknow in the year 1957 & I did my postgraduation in M.S.(General Surgery) from the same institute in the year 1961 and also did M.S.(Neuro-Surgery) in the year 1964. I am registered with the Delhi Medical Council, bearing Registration No.4765. My Date of Birth is 11.09.1935.

I have already submitted a written statement jointly with Dr. R.P. Arora & I have nothing to add in this regard.
Thanking you,

Sd/-
(Dr. A.K. Banerji)"

The Ethics Committee further decided to request (i) Dr. P.R. Patan, Director, K.M. School of P.G. Studies, Ahmedabad (ii) Dr. Tamal Choudhary, Prof. & Head of General Surgery, Medical College, Calcutta to assist the Ethics Committee by giving their detailed opinion and advise regarding this case."

iii) the following decision of the Ethics Committee taken at its meeting held on 11th & 12th August, 2008:

"The Ethics Committee considered the appeal against the order dated 31.01.2007 passed by Delhi Medical Council and noting that opinion from Dr. Pankaj R. Patel has been received therefore, the Ethics Committee decided that a reminder may be sent to other specialist Dr. M. Mukherjee for his opinion."

iv) the following decision of the Ethics Committee taken at its meeting held on 15.09.2008:

"The Ethics Committee considered the matter and noted that an opinion from third expert – Dr. P.K. Dave – has been requested recently and the Ethics Committee decided to wait for the receipt of opinion from Dr. Dave and to consider the matter thereafter."

The Ethics Committee at its meeting today i.e. 06.10.2008 after noting the above considered the matter and went through the proceedings of Delhi Medical Council thoroughly. The Committee also went through the oral submission of Dr. R.P. Arora, Chief Administrator, Vidyasagar Institute of mental Health & Neurosciences, Nehru Nagar, Delhi and the Committee further perused the written statement given by Dr. R.P. Arora, which was submitted to the Ethics Committee and the statement of Dr. A.K. Banerji, which was submitted by him on 11.09.2007.

The Ethics Committee noted that Dr. P.R. Patel, Director, K.M. School of P.G. Studies & Dr. M. Mukherjee, Prof. & HOD of Surgery, Calcutta Medical College were requested to assist the Ethics Committee of the Medical Council of India in this case with their opinion. They have sent the following opinion:-

Comments/Opinion of Dr. P.R. Patel

"On verifying data and the case papers submitted by your office, it is observed that the patient was having unfortunately viral infection in spinal cord which has guarded prognosis and patient was also having other medical comorbidities. The patient was diagnosed and related as per the standard protocols and procedures and would have been treated at any other hospitals like this only. Patient was given intravenous Methylprednisolone on 30/11/04 and developed swelling on 4th December and then rapidly progressed for infection in right forearm and also lungs which ultimately drawn into Septicemia. With injectable steroids, infection is a known complication and in few cases in forearm and leg in bedridden patients compartment compression syndrome would also be possible. However, consultants including Neurosurgeon, Orthopaedic Surgeon, Plastic Surgeon, CT Surgeon, Skin Specialist also have examined the patient at appropriate time and also have treated specifically noted as per the standard protocols and procedures. The decision of amputation was also taken with consultation of Orthopaedic Surgeon, CT Surgeon and Plastic Surgeon together, which was essential as a lifesaving procedure for the patient. The patient has

been given due care and also emergency care whenever required which is observed from the case records.

It is unfortunate that Thrombophlobitis progressed to necrotizing fascilitis and subsequently septicaemia which require amputation as a life saving procedure. However, patient receiving Injectable Steroids has always more chances of getting infection because of immunosuppresion. The patient also having other comorbidites made her as high risk patient.

The complications arising in this was diagnosed in time, managed appropriately in consultation with various specialists whenever required. Therefore, it is observed that patient has been given reasonable degree of care and there is no negligence observed in the treatment of patient named Munni Devi by different consultants and staff of the Vidyasagar Institute of Mental Health and Neuro Sciences, New Delhi."

<u>*Remarks/Opinion of Dr. M. Mukherjee*</u>

"It is difficult to accept that a patient under treatment for dorsal myelopathy should lose her limb as an iatrogenic complication. The question is whether the complication was avoidable or not. It is presumed that there was some gap in monitoring of the condition of the limb between 30/11/04 and 4/12/04. However, it cannot be clearly opined whether the limb could be made to survive by earlier fasciotomy or not".

After going through the particulars of this case and submission of the complainant, the Ethics Committee noted that Dr. P.K. Dave, Formal Ex-Director, Prof. & Head of Orthopaedics, All India Institute of Medical Sciences, New Delhi was requested to assist the Ethics Committee of MCI in this case with his opinion. He has sent the following opinion:-

<u>*Opinion/comments/remarks of Dr. P.K. Dave*</u>

"Steroids are the treatment of choice in such case, of viral transverse myelitis. From the perusal of records it is evident that the patient was suffering from viral myelitis which is a serious condition and carries a poor prognosis; more so with hypertension and hypothyroidism. There was a prompt response in diagnosing her condition and initiating the management.

During her management standard treatment modalities were instituted.

The patient had to be given methylpredonisolume which is a standard treatment of transverse myelitis. She developed a swelling on 4th December and which rapidly progressed to infection in the right forearm leading on to septicemia. The administration of the steroids is known cause of complications of infection and in some cases may lead to compartment syndrome.

It is felt that at every stage of treatment the concerned consultants were invited to give their opinions regarding their further management. The Dermatologist, Orthopaedic Surgeons, plastic surgeon, cardiothoracic surgeon and neuro surgeon were part of the team which managed this patient. They examined the patient as and when needed. The decision for amputation was advised by the Orthopaedics surgeon and cardiothoracic surgeon together. It was a life saving procedure and was done as soon as the patient's attendants had given their consent for that.

From the perusal from the records I felt that timely and effective management strategies were instituted and the patient was given due care. It is unfortunate that the patient had to be amputated due to thrombophlebitis leading on to septicemia as a life saving measure and to avoid further morbidity.

The steroids are an immuno suppressive agent and whenever administered carry a grave prognosis particularly in patients who have other medical problems which in this case involved hypertension & hypothyroidism. In my opinion complications in this particular case were managed properly and promptly. And all the consultants required gave their opinions for further management.

It is felt that she was given due care and the perusal of the records shows that there was no negligence in the treatment of condition on the part of Vidyasagar Institute of Mental & Health Sciences".

After going though all the records pertaining to this case as well as the opinion/remarks/comments of the three mentioned specialists, the Ethics Committee discussed this case in detail and came to the unanimous opinion that no case of medical negligence could be substantiated against the treating surgeon in this case.

In view of the above; order passed by the Delhi Medical Council is hereby set aside. This may be informed to the Secretary, Medical Council of India and the involved parties accordingly."

The above decision vide council's letter dated 24/10/2008 was communicated to Dr. R.P. Arora with a copy to the Registrar, Delhi Medical Council, Shri Suman Barthwal, the Chief Adminstrator, VIMHANS Hospital, SHO, Police Station Srinivas Puri, New Delhi, the Medical Superintendent, Directorate of Health Servies, Govt. of NCT of Delhi, New Delhi. Necessary amendments in the Council's letter dated 24/10/2008 were communicated vide Council's letter dated 27/10/2008. Further amendment in consonance with the modification in the minutes of the Ethics Committee effected at the time of confirmation of minutes on 11th December, 2008 were communicated vide Council's letter dated 31/01/2009.
The representation vide letter dated 11/12/2008 by Sh. Suman Barthwal, husband of Mrs. Munni Devi Barthwal, as quoted below was placed before the Ethics Committee at its meeting held on 31st March & 1st April, 2009 and the Committee decided that the item be deferred for its next meeting.

"Kindly ref your letter Endst. No. MCI – 211(2)(204)/2007 – Ethics/12748 dt. 27.10.2008 addressed to VIMHANS, New Delhi and copy endorsed to undersigned. It is a matter of great displeasure and shameful act of M.C.I. that the order passed by Council is totally baseless and against Medical Ethics () the decision given in favour of VIMHANS seems to be under some personal influence by VIMHANS doctors () The affected parties had neither been called by Council nor any intimation sent to party/Delhi Medical Council in this reference () It is reittered to mention that the affected parties and chronic patient caused under medical negligencies by VIMHANS is in the bad to worse condition and lying in the bed and waiting last decision from the court. The Interim orders passed by M.C.I. in suppression of earlier orders of Delhi Medical Council and without consideration of patient statement/condition is totally a inhuman, unethical and also illegal consiperacy against the complaint and leaving black spot against the image of a reputed Council i.e. M.C.I. In view of above, order passed by MCI is hereby set aside and status Quo may be maintained of order passed by Delhi Medical Council in this reference." The Council office has also received another letter dated nil on 24/04/2009 from Mr. Suman Barthwal

The Ethics Committee after due deliberation of the request by the complainant Mr.Suman Barthwal for review of the decision of the Ethics Committee taken at its meeting held on 06.10.2008 unanimously decided to reiterate its earlier decision taken at its meeting held on 06.10.2008."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee taken at its meeting held on 21st and 22nd May, 2009 reiterating its earlier decision taken at its meeting held on 6.10.2008 that no medical negligence could be substantiated against the treating surgeon Dr. A.K. Banerji and to further set aside the order passed by the Delhi Medical Council dated 31.1.2007 that "*VIMHANS failed to exercise reasonable degree of care in the treatment administered to the patient, as a consequence of which the right hand of the patient had to be amputated*".

9. Complaint against Dr. Yash Nigam, Orthopedic Surgeon as alleged by Mr. Sachin Shah (F.No.358/2007).

Read: The matter with regard to complaint against Dr. Yash Nigam, Orthopedic Surgeon as alleged by Mr. Sachin Shah (F.No.358/2007) along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 21st and 22nd May, 2009 as under:-

"i). the following decision of the Ethics Committee taken at its meeting held on 21/05/2008:

"The Ethics Committee considered the complaint against Dr. Yash Nigam, Orthopedic Surgeon as alleged by Mr. Sachin Shah and noted that this is the fourth complaint in the Medical Council of India received against this particular doctor. Previous complaints have already been disposed off.

The Ethics Committee decided that para-wise comments may be called from Dr. Yash Nigam regarding all the points raised by the complainant within 15 days of receipt of this letter. All the documents may be sent to him. This case should be taken up once these replies are received."

ii). *The following decision of the Ethics Committee taken at its meeting held on 11th & 12.08.2008 :-*

"The Ethics Committee considered the matter of complaint against Dr. Yash Nigam, Orthopedic Surgeon, by Mr. Sachin Shah and noted that Dr. Yash Nigam vide his letter dated 08.07.2008 has requested that he should be supplied the relevant "x-ray and its report" and further that he should be given at least 10 days to submit reply of the complaint.

The Ethics Committee, in view of above, decided that the complainant, Mr. Sachin Shah, should be asked to appear before the Ethics Committee alongwith all the documents including relevant "x-ray and its report". The Ethics Committee further decided that Dr. Yash Nigam should subsequently be called to appear before the Ethics Committee at one of its next meetings."

iii). *The following decision of the Ethics Committee taken at its meeting held on 15/09/2008:-*

"The Ethics Committee considered the matter today and noted Sh. Sachin Shah has come to appear before the Ethics Committee. He made the following submissions:

Statement of Mr.Sachin Shah

I, Mr. Sachin Shah, complainant has narrated all the sequence of events which followed the fracture on the left arm bone which he suffered on 1st May,2006 while coming from Vaishno Devi. I have already submitted my detailed case history paper vide letter dated 13.9.2007 addressed to Medical Council of India.

I am handing over the x-ray report one taken on 6th July, 2006 at MRI centre, Hauz Khas, New Delhi and 4 more x-rays which were taken on the advise of Dr. Pradeep Sharma at Holy Family Hospital, New Delhi. After operation at Holy Family Hospital, 4 months Physiotherapy treatment was given to me.

Now at present I am alright but my earnest request is to take the action against Dr.Yash Nigam.

Sd/-
(Mr. Sachin Shah)

The Ethics Committee further decided that Dr. Yash Nigam may be called at one of its next meetings where only documents including x-rays would be made available to him."

iv). *The following decision of the Ethics Committee taken at its meeting held on 11th & 12th December, 2008:-*

"The Ethics Committee noted that Dr.Yash Nigam who was called to be present today at 11.30 a.m. before the Ethics Committee has failed to appear before the Committee. Also no communication has been received from him. The Ethics Committee, therefore, decided to give him one last and final chance to appear before the Ethics Committee and further decided that in case he fails to appear again, proceedings would be held ex-parte and decision taken accordingly. He may be called in the next meeting of the Ethics Committee."

v). *The following decision of the Ethics Committee taken at its meeting held on 19th & 20th January, 2009:-*

"Dr.Yash Nigam was called before the Ethics Committee on 19.1.2009 and he has presented himself before the Committee. The X-ray report which were submitted by the patient to the Ethics Committee and which were supposed to be shown to Dr.Yash Nigam were made available to him. Dr. Yash Nigam has given a written submission to MCI which he had earlier submitted to Consumer Court. He has said that he shall be submitting the detailed para-wise comments within two weeks from today. His statement is as under:-

Statement of Dr.Yash Nigam

I, Dr.Yash Nigam passed my MBBS from erstwhile USSR in the year 1984 and did my MS(Orthopaedics) from S.N. Medical College, Agra in the year 1989. I have taken a special training in the Institute of Professor Ilizarov at Kurgan, Russia.

I have seeing the x-rays and I shall be submitting my para-wise comments within 15 days to the MCI.

Sd/-
(Dr.Yash Nigam)

The Ethics Committee decided that final decision in this case will be taken after receipt of all the documents which are to be submitted by Dr.Yash Nigam. The Hon'ble members of Ethics Committee have discussed the matter regarding the quality of fixator under laser procedure by Dr.Yash Nigam and further advised him to submit copies of hospital's consent taken from the patient and the attendance before operation alongwith his statement.

The Ethics Committee further decided to take the opinion from reputed Orthopaedics specialist Dr.Kotwal, HOD, AIIMS, New Delhi. Dr.Kotwal may be requested to assist the Ethics Committee with his opinion after going through all the documents and also the X-rays regarding the quality of treatment by fixator in this case.

He be further requested to give an overall view of the patient as to whether there was any lacking or negligence on the part of Dr.Yash Nigam."

vi). *The following opinion dated 14.3.2009 received from Dr. P.P. Kotwal, Prof. & Head, Department of Orthopedics, A.I.I.M.S., New Delhi, which is as under:-*

"…….. regarding the complaint against Dr.Yash Nigam, I am submitting the following comments:-

- *From the records it appears that the patient Mr.Sachin Shah had sustained a fracture shaft of humerus for which Dr.Yash Nigam performed an operation of external fixator (Ilizarov Fixator) on 3.5.2006. It is not clear from the papers whether the patient had a radial nerve palsy immediately after the injury and before the application of the fixator. However, it appears from the papers that somewhere down the line in the post-operative period the patient developed weakness of the hand on the same side as the fracture possibly due to radial nerve paralysis.*
- *Treatment of a fracture by the Ilizarov method is certainly a standard method of treatment although it is generally not used as the method of choice particularly in fracture of the mid shaft of the humerus since better methods of internal fixation are available which cause relatively less mobidity as compared to Ilizarov fixation. The Ilizarov fixator is also not used routinely in fracture of the mid shaft of humerus because there remains a risk of injury to the radial nerve since the nerve lies in close vicinity of the bone in the middle third of the humerus.*
- *The Ilizarov fixator used by Dr.Yash Nigam in this particular case was not biomechanically sound, in my personal opinion. Dr.Nigam had used only two rings which do not provide sound mechanical stability to the fracture. If at all this method of treatment is to be used, more rings or wires are required to provide stability to the fracture which can enhance union of the fracture.*

In my opinion, therefore, there was some error of judgement on the part of Dr.Yash Nigam in choosing the best method of treatment for the type of fracture which Mr.Sachin Shah had sustained since Ilizarov fixator is not the standard first choice of treatment these days, in fresh fractures of the mid shaft of humerus; and also there was perhaps inadequate stability provided to the fracture by the external fixator used."

vii). *The Ethics Committee at its meeting held on 31st March & 01st April, 2009 decided that the item be deferred for its next meeting.*

The Ethics Committee after due deliberations of the documents, comments/statements of the patient and the doctor and the opinion of the expert Orthopaedic Surgeon Dr.P.P.Kotwal, Prof. & HOD, Deptt. of Orthopaedic, AIIMS, New Delhi is of the unanimous opinion that the name of Dr. Yash Nigam be erased from Indian Medical Register for a period of six months and further that during this period he should attend a minimum of six weeks of C.M.E programme in Orthopaedics Department of a recognized medical institution. The Committee further decided that the name of Dr.Yash Nigam would be restored in the Indian Medical Register only after he submits a certificate as proof of attending the C.M.E programme."

The Executive Committee of the Council further observed that it is not clearly evident from the record whether the patient had a radial nerve palsy immediately after the injury and before the application of the fixator or in the post-operative period after the application of the fixator. It is also not clear whether parawise comments have been submitted by Dr. Yash Nigam, as stated by him before the Ethics Committee at its meeting held on 19-20 January, 2009.

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to refer the matter back to the Ethics Committee for reconsideration.

10. Representation by Dr. Jaideep Bansal against MCI's order dated 16th May, 2008 on the appeal by Sh. Rakesh Sharma against order dated 25.10.2006 of Delhi Medical Council (F.No. 481/2008)

Read: The matter with regard to representation by Dr. Jaideep Bansal against MCI's order dated 16th May, 2008 on the appeal by Sh. Rakesh Sharma against order dated 25.10.2006 of Delhi Medical Council (F.No. 481/2008) along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 21st and 22nd May, 2009 as under:-

"i) The decision of the General Body of the Council taken at its meeting held on 15.03.2008 approving the following recommendations of the Executive Committee:-

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council observed that at its earlier meeting dated 24.08.2007, had decided to refer the matter back to the Ethics Committee for re-consideration.

The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council also noted the following recommendation of the Ethics Committee dated 15th & 16th Oct.,2007:-

"The Ethics Committee noted the decision of the Executive Committee wherein it has referred the case back to Ethics Committee for reconsideration. The Ethics Committee went through all the documents pertaining to this case, discussed about the reasons of its decision in this case and decided to review its recommendation. After all deliberation the Ethics Committee decided unanimously to recommend that the name of Dr. Jaideep Bansal who was found to have committed an act of professional misconduct amounting to negligence in the treatment of patient be removed from the IMR for a period of 1 week. The fact may be recorded in IMR and the recommendation be sent to Executive Committee and General Body for necessary action at their end. "

After due deliberation on the matter, the members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council decided that Dr. Jaideep Bansal be issued strict warning to be more careful in treatment of patient in future and the facts of the warning be recorded in the IMR against his name and the recommendation be placed before the General Body of the Council."

The said decision was communicated to Dr. Jaideep Bansal with copy to the complainant as well as the Registrar, Delhi Medical Council and IMR Section, MCI vide Council's letter dated 16/05/2008.

ii) the representation vide letter dt. 18.06.08 from Dr. Jaideep Bansal which was considered by the Ethics Committee at its meeting held on 7th & 8th July, 2008 and the decision is as under:

"The Ethics Committee noted that this case was originally taken up on 23.11.2006 as an appeal case by the complainant u/s 8.7 & 8.8 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 against the order of Delhi Medical Council vide order no. DMC/14/2/Comp.295/2006/25844 dated 25.10.2006.

The Ethics Committee discussed the appeal/review/representation of Dr. Jaideep Bansal and has observed that as per recommendations of the Executive Committee, the General Body has approved the punishment of warning to Dr. Jaideep Bansal. The appeal/review/representation is against the decision of General Body.

The Ethics Committee noted that as per provisions of the Act and Regulations there is no scope for Ethics Committee for taking up an appeal/review/representation against the decision of General Body unless so directed by the General Body/Competent Authority.

The Ethics Committee further noted that i) u/s 24(1) & 24(2) of IMC Act, 1956; there is a provision of appeal to the Central Govt. in case of decision of removal of name from Indian Medical Register only and ii) u/s 8.7 & 8.8 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 which have been inserted under the direction of the Hon'ble Supreme Court whereby Medical Council of India has been made the supreme appellate authority in cases of appeal against the decision of said Medical Councils or inordinate delay by such Medical Councils to take the decision. However, it is not clear whether there is any scope for any appeal/review/representation under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 once the decision has been taken by the General Body of the Council.

In view of above, this decision alongwith the relevant file may be referred to Council Advocate for his considered opinion in this case. The Council Advocate may be requested to kindly specify whether under Rules and Regulations there is any scope of entertaining an appeal made to the Council once the decision is taken by the General Body of the Council."

iii) MCI vide letter dt.25.07.2008 to Dr.Jaideep Bansal conveyed that his representation is under consideration of the Council. A copy of the said letter was also communicated to the Police authorities vide MCI letter dt. 30.07.2008.

iv) the following decision of the Ethics Committee taken at its meeting held on 6th October, 2008:

"The Ethics Committee considered the matter with regard to representation by Dr. Jaideep Bansal against MCI's order dated 16th May, 2008 on the appeal by Sh. Rakesh Sharma against order dated 25.10.2006 of Delhi Medical Council and noted that Sh. Maninder Singh, Council advocate has sent his opinion. The summary of the opinion can be formed in para 31, 32 & 33 which are as under:-

"31. Now, coming back to the query raised by the querist and in the light of the above, I am of the view that under these circumstances, Regulation 8.8 would not permit any appeal by the medical practitioner to the MCI itself, against the order which is passed by the MCI in exercise of its appellate jurisdiction.

32. However, in the light of the latest judgment of the Hon'ble Delhi High Curt in the case of Anis Qureshi Vs. Commissioner of Police & Ors., I am of the opinion that if the competent authority of the MCI, on prima facie consideration of the representation, is of the view that it deserves a closer look so as to eliminate the possibility of any miscarriage of justice and where professional honour and dignity of a medical professional is also involved alongwide the grievances of the complaint's family, it would not be prohibited for the MCI to place this representation before the competent authority, i.e., General Body of the Council in the present case, for having a fresh look on the matter so as to eliminate any possibility of miscarriage of justice.

33. Thus in the present case the representation of the registered medical practitioner be looked into by the Ethics Committee and with its comments and observations, place it before the

General Body of the Council, who would then consider the representation and in the event it finds substance in the representation and / or the representation reflecting any miscarriage of justice, it may consider the representation on its own and / or require the Ethics Committee to do so and thereafter place the matter before the General Body of the Council".

In view of above important nature of this case and the opinion given by Sh. Maninder Singh, Council's advocate, the Ethics Committee decided this has to be studied and discussed in detailed before arriving in a final decision. In the meantime, the Ethics Committee decided the Additional Secretary of the Council to prepare a note in this particular case and the same to be placed before the next meeting of the Ethics Committee."

v) The following decision of the Ethics Committee taken at its meeting held on 11th/12th December, 2008:-

> *"The Ethics Committee at its present meeting discussed the various aspects of this particular case and it has taken into consideration the opinion expressed by the Council Advocate Sh.Maninder Singh and also considered the report prepared by the Addl. Secretary, which is as under:*

"Note by Dr. Prem Kumar, Additional Secretary, Medical Council of India in terms of the decision of the Ethics Committee taken at its meeting held on 06.10.2008

The matter pertains to representation dt. 18.06.2008 by Dr. Jaideep Bansal against MCI's order dated 16th May, 2008 on the appeal by Sh. Rakesh Sharma against order order no. DMC/14/2/Comp.295/2006/25844 dated 25.10.2006 of Delhi Medical Council. Though the very item of the agenda gives a graphic picture of the events in relation to any matter including this one; the note as requested, in brief is as under:

- The General Body of the Council at its meeting held on 15.03.2008 considered the appeal of Mr. Rakesh Sharma against the order dt. 25.10.2006 of Delhi Medical Council and duly approved the following decision of the Executive Committee taken at its meeting held on 29.12.2007:

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council observed that at its earlier meeting dated 24.08.2007, had decided to refer the matter back to the Ethics Committee for re-consideration.

The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council also noted the following recommendation of the Ethics Committee dated 15th & 16th Oct.,2007:-

"The Ethics Committee noted the decision of the Executive Committee wherein it has referred the case back to Ethics Committee for reconsideration. The Ethics Committee went through all the documents pertaining to this case, discussed about the reasons of its decision in this case and decided to review its recommendation. After all deliberation the Ethics Committee decided unanimously to recommend that the name of Dr. Jaideep Bansal who was found to have committed an act of professional misconduct amounting to negligence in the treatment of patient be removed from the IMR for a period of 1 week. The fact may be recorded in IMR and the recommendation be sent to Executive Committee and General Body for necessary action at their end. "

After due deliberation on the matter, the members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council decided that Dr. Jaideep Bansal be issued strict warning to be more careful in treatment of patient in future and the facts of the warning be recorded in the IMR against his name and the recommendation be placed before the General Body of the Council."

The said decision of the General Body of the Council was communicated to all concerned vide Council's letter dt. 16.05.2008.

- Subsequently the Council received a representation dt. 18.06.2008 from Dr. Jaideep Bansal against the MCI's note dt. 16.05.08.

- The matter was considered by the Ethics Committee at its meeting held on 7th & 8th July, 2008 and the decision was as under:

"The Ethics Committee noted that this case was originally taken up on 23.11.2006 as an appeal case by the complainant u/s 8.7 & 8.8 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 against the order of Delhi Medical Council vide order no. DMC/14/2/Comp.295/2006/25844 dated 25.10.2006.

The Ethics Committee discussed the appeal/review/representation of Dr. Jaideep Bansal and has observed that as per recommendations of the Executive Committee, the General Body has approved the punishment of warning to Dr. Jaideep Bansal. The appeal/review/representation is against the decision of General Body.

The Ethics Committee noted that as per provisions of the Act and Regulations there is no scope for Ethics Committee for taking up an appeal/review/representation against the decision of General Body unless so directed by the General Body/Competent Authority.

The Ethics Committee further noted that i) u/s 24(1) & 24(2) of IMC Act, 1956; there is a provision of appeal to the Central Govt. in case of decision of removal of name from Indian Medical Register only and ii) u/s 8.7 & 8.8 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 which have been inserted under the direction of the Hon'ble Supreme Court whereby Medical Council of India has been made the supreme appellate authority in cases of appeal against the decision of said Medical Councils or inordinate delay by such Medical Councils to take the decision. However, it is not clear whether there is any scope for any appeal/review/representation under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 once the decision has been taken by the General Body of the Council.

In view of above, this decision alongwith the relevant file may be referred to Council Advocate for his considered opinion in this case. The Council Advocate may be requested to kindly specify whether under Rules and Regulations there is any scope of entertaining an appeal made to the Council once the decision is taken by the General Body of the Council."

- Meanwhile MCI vide letter dt. 25.07.08 to Dr. Jaideep Bansal conveyed that his representation is under consideration of the Council. A copy of the said letter was also communicated to the Police authorities vide MCI letter dt. 30.07.08.

- The Ethics Committee at its meeting held on 6.10.2008 again considered the matter upon receipt of opinion from the Council's Advocate (vide his letter dt. 12.09.2008 received in the Ethics Section on 30.09.2008) and the decision is as under:

"The Ethics Committee considered the matter with regard to representation by Dr. Jaideep Bansal against MCI's order dated 16th May, 2008 on the appeal by Sh. Rakesh Sharma against order dated 25.10.2006 of Delhi Medical Council and noted that Sh. Maninder Singh, Council advocate has sent his opinion. The summary of the opinion can be formed in para 31, 32 & 33 which are as under:-

"31. Now, coming back to the query raised by the querist and in the light of the above, I am of the view that under these circumstances, Regulation 8.8 would not permit any appeal by the medical practitioner to the MCI itself, against the order which is passed by the MCI in exercise of its appellate jurisdiction.

32. However, in the light of the latest judgment of the Hon'ble Delhi High Curt in the case of Anis Qureshi Vs. Commissioner of Police & Ors., I am of the opinion that if the competent authority of the MCI, on prima facie consideration of the representation, is of the view that it deserves a closer look so as to eliminate the possibility of any miscarriage of justice and where professional honour and dignity of a medical professional is also involved alongwide the grievances of the complaint's family, it would not be prohibited for the MCI to place this representation before the competent authority, i.e., General Body of the Council in the present case, for having a fresh look on the matter so as to eliminate any possibility of miscarriage of justice.

33. Thus in the present case the representation of the registered medical practitioner be looked into by the Ethics Committee and with its comments and observations, place it before the General Body of the Council, who would then consider the representation and in the event it finds substance in the representation and / or the representation reflecting any miscarriage of justice, it may consider the representation on its own and / or require the Ethics Committee to do so and thereafter place the matter before the General Body of the Council".

In view of above important nature of this case and the opinion given by Sh. Maninder Singh, Council's advocate, the Ethics Committee decided this has to be studied and discussed in detailed before arriving in a final decision. In the meantime, the Ethics Committee decided the Additional Secretary of the Council to prepare a note in this particular case and the same to be placed before the next meeting of the Ethics Committee."

Considering the above opinion by the Council Advocate, it is worthwhile to note that; (i) the matter has been considered twice by the Ethics Committee; and further that the Executive Committee where members of the Adhoc Committee appointed by the Hon'ble Supreme Court of India were also present twice considered and decided in the matter & (ii) the decision of Ethics Committee taken at is meeting held on 7th & 8th July, 2008, the relevant portion of which is as under:

"……The Ethics Committee noted that as per provisions of the Act and Regulations there is no scope for Ethics Committee for taking up an appeal/review/representation against the decision of General Body unless so directed by the General Body/competent authority."

However, considering the matter in totality, the undersigned feels that the whole exercise seems futile in the light of MCI's letter dt. 25.07.08 to Dr. Jaideep Bansal conveying therein that his representation for review is under consideration of the council. The said letter also has been communicated to the police authorities. The matter thus admittedly is under consideration of the Council and it would be difficult to treat it otherwise."

Sd/-
(Dr. P. Kumar)
Additional Secretary
26.11.2008

"The Ethics Committee has taken note of the report and observed that an application under the RTI Act has also been sent by Mr. Rakesh Sharma, the complainant in this case. The Committee also noted and discussed the two opinions that have already been received from Dr.S. Prabhakaran who is Professor and HOD, Deptt. of Neurology, PGI, Chandigarh and Dr.U.K. Mishra, Prof. & HOD of Neurology, SGPGIMS, Lucknow which have already been recorded.

The Ethics Committee feels that a third opinion from a senior neurologist may be sought and for this Dr. Ashok Pangariya, Principal & Head of Deptt. of Neurology in SMS Medical College, Jaipur may be requested to assist the Ethics Committee with a detailed report to help the Ethics Committee in arriving at a final decision in this case.

Dr. Ashok Pangariya may therefore be requested to go through all the documents of this case and give his detailed views regarding the case, the short-comings or the negligence by any/all the treating doctor(s) and fixing the responsibility thereof if needed to assist the Ethics Committee."

vi) Dr. Ashok Pangariya, Principal & Head of Deptt. of Neurology in SMS Medical College, Jaipur vide his letter dated 16/02/2009 conveyed as under:

"This has reference to your letter No. MCI – 211(2)(481)/2008-Ethics./16817 dated 13/01/2009, which I received a few days back. While going through the record I realized that Dr. Jaideep Bansal whose case is under consideration of Ethics Committee, Medical Council of India has been a student of this Medical College and has done M.D. (Medicine) from this institution when the undersigned had been in the teaching faculty and now the Controller of the Medical College. It would be therefore be in the fitness of things that my services for this purpose be withdrawn since it may not look fair on my part to opine when opinion may be perceived as biased. In all such situations, not only the man should be honest but should also appear to be honest. Following

the same policy, I would like myself to keep away from this particular case for the reasons already mentioned."

vii) Mr. Rakesh Sharma vide his letter dated 05.03.2009 under RTI Act, 2005 has requested to be informed as to how other doctors have been spared.

viii) The following decision of the Ethics Committee taken at its meeting held on 31st March & 01st April, 2009:

"The Ethics Committee considered the matter with regards to representation dated 18.06.2008 by Dr. Jaideep Bansal against MCI's order dated 16th May, 2008 on the appeal by Sh. Rakesh Sharma against order dated 25.10.2006 of Delhi Medical Council. The Ethics Committee noted that the earlier appointed expert by the Ethics Committee, Dr. Ashok Pangariya Principal & HOD, Neurology in SMS Medical College, Jaipur has conveyed his reluctance to provide opinion in this case and therefore decided to take opinion in the matter from Dr. V.N. Jindal, Dean, Goa Medical College."

ix) Dr. V.N. Jindal, Dean, Goa Medical College vide letter dated 04/05/2009 has opined as under:

"I have gone through the papers sent to me with reference to the above mentioned subject as requested by ethics committee. I have to submit as follows:-

1. *The patient Anirudh Sharma when admitted to Saroj Hospital had symptoms and signs of Meningism this can happen both in SAH as well as in TBM.*
2. *CECT was advised for the patient as investigations. This has misled the radiologists well as the clinician to interpret the SAH as basal exudates. Incase a plain CT had been done SAH would have been diagnosed.*
3. *Inspite of suspecting SAH a CT Angio or Four vessel Angiography by DSA was delayed because MRI Angio was normal.*
4. *The patient detetoriated because of the vaso spasm that he developed as a consequence of SAH.*
5. *CT Angiography done subsequently revealed internal carotid bifurcation Aneurysm.*

In case the aneurysm had been detected at an early stage by way of DSA before the development of vasospasm and subsequently brain infract the aneurysm could have been clipped or dealt with by interventional neuroradiology. This probably could have saved the child from brain infract and this might have saved his life."

The Ethics Committee deliberated in the matter in the light of the Hon'ble Supreme Court's judgement (2005) 6 SCC in the criminal appeals Nos.144-45 of 2004 decided on 05.08.2005 in the matter of Jacob Mathew –vs- State of Punjab & others, and noted the following relevant conclusions :-

"………….

(3) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.
…………………….

(7) To prosecute a medical professional for negligence under criminal law it must be shown that the accused did domething or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was mostlikely imminent."

The Ethics Committee perusing all the documents/records, the representations received through the Govt. vide its letter dated 05.05.2009 and the opinion from Dr.V.N. Jindal, Dean, Goa Medical College, Goa; and unanimously decided to agree that no negligence can be attributed on the part of Dr.Jaideep Bansal as all the required battery of modern investigations were found normal and it's only the assumption of the expert that some other investigations would have detected aneurysm before the development of vasospasm. Therefore, the Ethics Committee unanimously was of the opinion to recommend that the earlier decision of the General Body taken at its meeting held on 15.03.2008 and communicated to all concerned vide the MCI's letter dated 16th May, 2008 be withdrawn and further decided to recommend that Dr.Jaideep Bansal be exonerated as no attributable negligence could be established against him."

After due and detailed deliberations and consideration of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee to recommend to the General Body of the Council that earlier decision taken at its meeting held on 15.3.2008 be withdrawn and further decided to recommend that Dr. Jaideep Bansal be exonerated as no attributable negligence could be established against him.

11. Fee as prescribed by the General Body for complaint & appeal cases received u/s 8.7 & 8.8 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 – Govt. letter dated 09.03.2009 regarding.

Read: The matter with regard to Fee as prescribed by the General Body for complaint & appeal cases received u/s 8.7 & 8.8 of Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 – Govt. letter dated 09.03.2009.

The Executive Committee of the Council observed that the General Body of the Council at its meeting held on 15.3.2008 had approved the following recommendations of the Executive Committee :-

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council noted the following recommendation of the Ethics Committee:-

"……………………………………………

ANNEXURE – I

Instructions for complaint cases

- *The Application Form should be properly and neatly filled in.*
- *Incomplete applications shall not be entertained by the Council.*
- *A Bank draft of Rs.2000/- (Rupees two thousand only) in favour of Secretary, Medical Council of India payable at New Delhi should be sent alongwith the application as fees (cheques are not acceptable).*
- *If the person/complainant/appellant is a person of BPL (Below Poverty Line) category the fees is not required to be paid but acceptable proof of being BPL category must be provided. The photo copy of proof must be attested by a Gazetted Officer.*

ANNEXURE – II

Instructions for Appeal cases

- *The Application Form should be properly and neatly filled in.*
- *Incomplete appeals shall not be entertained by the Council.*
- *A Bank draft of Rs.5000/- (Rupees five thousand only) in favour of Secretary, Medical Council of India payable at New Delhi should be sent alongwith the application as fees (cheques are not acceptable).*
- *If the person/complainant/appellant is a person of BPL (Below Poverty Line) category the fees is not required to be paid but acceptable proof of being BPL category must be provided. The photo copy of proof must be attested by a Gazetted Officer.*

The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council decided to approve the above recommendation of the Ethics Committee with following modifications:-

The fee for original complaint filed before MCI shall be Rs.5,000/-.

(B) Fee for appeal under section 8.7 and 8.8 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 shall be Rs.10,000/-.

(C) Persons Below Poverty Line (BPL) would have to pay only 10% of the prescribed fee for the original complains or the appeals as the case may be provided that a certificate issued by a Government Authority is attached with the complaint/appeal."

II) It may be stated that the Council received an earlier letter dated 03.09.2008 from the Central Govt., Ministry of Health & F.W. regarding fee to be charged for appeal under Section 8.7 and 8.8 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which was considered by the Executive Committee of the Council at its meeting held on 15.09.2008 and it was decided to constitute a Sub-Committee comprising of Dr. D.J. Borah, Chairman, Ethics Committee and Dr. Ved Prakash Mishra, Chairman, Finance Committee to look into the matter and submit its report.

In this context, a Sub-Committee of the above two members met on 03.11.2008 and submitted a report. The said report was considered by the Executive Committee as well as General Body of the Council and approved the following recommendations. The relative part of the recommendations is as under:

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council considered the matter alongwith the report of the Sub-Committee and decided to approve the following report of the Sub-Committee:-

After due deliberation the Sub-Committee decided to recommend to the Executive Committee and General Body of the Council that even this 10% fee for persons of Below Poverty Line (BPL) in both original complaint and appeal should be dispensed with to make the redressal mechanism for the common man easy and free. Therefore, clause (C) of the decision of the Executive Committee/General Body may accordingly be modified as under:-

Persons Below Poverty Line (BPL) shall not have to pay any fees for the original complaints or the appeals as the case may be provided that a certificate issued by a Government Authority/attested copy of the BPL Card issued by the Competent Authority is attached with the complaint/appeal."

The above decision was communicated to the Central Govt. vide Council's letter dated 02.02.2009 in response to their letter dated 03.09.2008.

III) In this context, the Central Govt., Ministry of Health & F.W. has sent a D.O letter dated 09.03.2009 in which it is stated as under:

"Please refer to Council's letter No. MCI-211(2)(Gen.)/2008-Ethics/18734 dated 02/02/2009 exempting Persons Below Poverty Line (BPL) from depositing fee for filing original complaints or appeals under Regulations 8.7 and 8.8 of the Indian Medical Council (Professionnal, Conduct, Etiquette and Ethics) Regulations, 2002.

2. I would like to draw your attention towards this Ministry's letter of even number dated 03/09/2008 directing MCI not to charge any fee from anybody for grievance redressal as it would act as deterrent for a common man willing to file appeal, and will ultimately benefit the delinquent doctors.

3. In view of the above and the concept of "Welfare State" enshrined in the Constitution of India, I again request you consider the matter and not to charge any kind of fee from any person for filing appeal under Regulations 8.7 & 8.8 of the Indian Medical Council (Professional, Conduct, Etiquette and Ethics) Regulations, 2002 as it is meant for redressal of grievances. It is also requested to kindly intimate the action in the matter."

The matter was considered by the Executive Committee at its meeting held on 27/04/2009 and the decision was as under:

"The Executive Committee of the Council considered the Central Government DO letter dated 09.03.2009 and decided to refer to the matter to the Finance Committee of the Council for examination."

The matter was considered by the Finance Committee at its meeting held on 29/05/2009 and the decision was as under:

"The Finance Committee decided to recommend to the Executive Committee of the Council to reiterate its earlier decision, which was also approved by the General Body of the Council. The relative part of the recommendations is as under:

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council considered the matter along with the report of the Sub-Committee and decided to approve the following report of the Sub-Committee:-

After due deliberation the Sub-Committee decided to recommend to the Executive Committee and General Boyd of the Council that even this 10% fee for persons of Below Poverty Line (BPL) in both original complaint and appeal should be dispensed with to make the redressal mechanism for the common man easy and free. Therefore, Clause (C) of the decision of the Executive Committee/General Body may accordingly be modified as under:-

(C) Persons Below Poverty Line (BPL) shall not have to pay any fee for the original complaints or the appeals as the case may be provided that a certificate issued by a Government Authority/attested copy of the BPL Card issued by the competent authority is attached with the complaint/appeal."

After due and detailed deliberations, the Executive Committee of the Council decided to approve the recommendations of the Ethics Committee that clause (C) of the "Instructions for complaint cases" as shown in Annexure I and "Instructions for Appeal cases" as shown in Annexure II be modified as under:-

"(C) Persons Below Poverty Line (BPL) shall not have to pay any fee for the original complaints or the appeals as the case may be provided that a certificate issued by a Government Authority/attested copy of the BPL Card issued by the competent authority is attached with the complaint/appeal."

12. Payment of honorarium to the senior consultants for the expert opinions solicited by the Ethics Committee – Proposal regarding.

Read: The matter with regard to Payment of honorarium to the senior consultants for the expert opinions solicited by the Ethics Committee – Proposal regarding along with the recommendations of the Ethics Committee.

The Executive Committee of the Council approved the following recommendations of the Ethics Committee as under:-

"The Ethics Committee considered the proposal for payment of honorarium to the senior consultants for the expert opinions which they are requested to render time to time by the Ethics Committee. The Committee deliberated in matter in totality and decided to recommend that an amount upto Rs.1,500/- (One thousand and five hundred only) may be considered for payment as honorarium."

13. Matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. K. Padma, Medical teacher.

Read: The matter with regard to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. K. Padma, Medical teacher along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

i) "The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council were, therefore, were clearly of the view that the Council should take steps for referring these cases to the Police authorities for registration of FIRs and conducting investigations in all such cases. It was also observed that in the complaint to be sent to the Police authorities, it should also be clearly requested that all those cases where there is a collusion and conspiracy of such persons with the management of the colleges, the necessary action should also be taken against the management of those colleges."

ii) FIR had been recommended to the Police authorities vide Council's letter dated 03/07/2006 & the following office observations recommended in FIR:

"In his declaration form, he has claimed that he has worked at Kasturba Medical College, Manipal from 1989 to 1991 as Tutor. In its letter, Kasturba Medical College, Manipal has stated that he has not worked at all in the institution. Thus, he has submitted a false and forged experience certificate and therefore cannot be accepted as a teacher."

iii) Dr. K. Padma vide her letter dt. 05/05/2009 has sent her explanation

The decision of the Ethics Committee is as under:

"The Ethics Committee considered the matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. K. Padma, Medical teacher and noted the clarification submitted by her vide letter dated 05.05.09 wherein she has conveyed that her maiden name Dr.Lingamaneni (L.Padma) was changed to Koneru padma (K.Padma) after her marriage and further that her PG qualification and the experience – all from Kasturba Medical College, Manipal are correct and genuine.

The Ethics Committee, in view of the above, decided to drop the proceedings against her and close the matter with regards to Ethical consideration of the case."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee to drop the proceedings and close the matter with regard to the ethical consideration of the case.

14. Matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Deepakala N., Medical teacher.

Read: The matter with regard to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Deepakala N., Medical teacher along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

"i) the following operational part of the decision by the members of Adhoc Committee appointed by the Hon'ble Supreme Court of India and of the Executive Committee:

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council were, therefore, were clearly of the view that the Council should take steps for referring these cases to the Police authorities for registration of FIRs and conducting investigations in all such cases. It was also observed that in the complaint to be sent to the Police authorities, it should also be clearly requested that all those cases where there is a collusion and conspiracy of such persons with the management of the colleges, the necessary action should also be taken against the management of those colleges."

ii) FIR had been recommended to the Police authorities vide Council's letter dated 03/07/2006 & the following office observations recommended in FIR:

"In her declaration form, she has claimed that she has worked at JJM Medical College, Davangere from January, 1995 to Jan. 1997 as Tutor In its letter, JJM Medical College, Davangere has stated that she has not worked at all in the institution. Thus, she has submitted a false and forged experience certificate and therefore cannot be accepted as a teacher."

iii) Dr. Deepakala N. vide her letter dt. 07/05/2009 has sent her explanation.

The decision of the Ethics Committee is as under:

"The Ethics Committee considered the matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Deepakala N, Medical teacher and noted the clarification submitted by her vide letter dated 07.05.09 clarifying her concept of working simultaneously as Tutor in the department while undergoing her postgraduation in the subject of Pathology.

The Ethics Committee, in view of the above, decided to drop the proceedings against her and close the matter with regards to Ethical consideration of the case."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee to drop the proceedings and close the matter with regard to the ethical consideration of the case.

15. Matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Bhavna Chavda, Medical Teacher.

Read: The matter with regard to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Bhavna Chavda, Medical Teacher along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

"i) the following operational part of the decision by the members of Adhoc Committee appointed by the Hon'ble Supreme Court of India and of the Executive Committee:

"The members of the Ado Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council were, therefore, were clearly of the view that the Council should take steps for referring these cases to the Police authorities for registration of FIRs and conducting investigations in all such cases. It was also observed that in the complaint to be sent to the Police authorities, it should also be clearly requested that all those cases where there is a collusion and conspiracy of such persons with the management of the colleges, the necessary action should also be taken against the management of those colleges."

ii) FIR had been recommended to the Police authorities vide Council's letter dated 24/02/2009 & the following office observations recommended in FIR:

"Signatures are forged and No Dean's Signature."

iii) Dr. Bhavna Chavda vide her letter dt. 20/05/2009 has sent her explanation.

The decision of the Ethics Committee is as under:

"The Ethics Committee considered the matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Bhavna Chavda and noted the clarification submitted by Dr. Bhavna Chavda, a holder of BDS qualification and the then tutor in Dental department of the institution vide her letter dated 20.05.09 has conveyed that her signatures are genuine and true and further that she cannot comment with regards to absence of the genuinety of the signature of the Dean of the institution in the declaration form.

The Ethics Committee, in view of the above, decided to drop the proceedings against her and close the matter with regards to Ethical consideration of the case."

The Executive Committee of the Council further observed that while Dr. Bhavna Chavda has been exonerated by the Ethics Committee, no cognizance has been taken by it with regard to counter signature of the Declaration Forms by the Dean of the institute i.e. Kesar Sal Medical College.

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to refer the matter back to the Ethics Committee for reconsideration.

16. Matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Yogesh Rathi, Medical Teacher.

Read: The matter with regard to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Yogesh Rathi, Medical Teacher along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

i) the following operational part of the decision by the members of Adhoc Committee appointed by the Hon'ble Supreme Court of India and of the Executive Committee:

"The members of the Ado Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council were, therefore, were clearly of the view that the Council should take steps for referring these cases to the Police authorities for registration of FIRs and conducting investigations in all such cases. It was also observed that in the complaint to be sent to the Police authorities, it should also be clearly requested that all those cases where there is a collusion and conspiracy of such persons with the management of the colleges, the necessary action should also be taken against the management of those colleges."

ii) FIR had been recommended to the Police authorities vide Council's letter dated 24/02/2009 & the following office observations recommended in FIR:

"Signatures are forged and No Dean's Signature."

iii) Dr. Yogesh Rathi vide his letter dt. 05/06/2009 has sent his explanation.

The decision of the Ethics Committee is as under:

"The Ethics Committee considered the matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Yogesh Rathi, Medical teacher and noted the clarification submitted by him vide letter dated 05.06.09 conveying that he neither ever joined the institution nor attended any inspection in the college after initially filling up the declaration form and further that he believes that either the institution or some person has misused his documents for their personal interest.

The Ethics Committee, in view of the above, decided to drop the proceedings against her and close the matter with regards to Ethical consideration of the case."

The Executive Committee of the Council further observed that while Dr. Yogesh Rathi has been exonerated by the Ethics Committee, no cognizance has been taken by it with regard to counter signature of the Declaration Forms by the Dean of the institute i.e. Kesar Sal Medical College.

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to refer the matter back to the Ethics Committee for reconsideration.

17. Matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Bijay Kumar Pathnaik, Medical teacher.

Read: The matter with regard to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Bijay Kumar Pathnaik, Medical teacher along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

i) the following operational part of the decision by the members of Adhoc Committee appointed by the Hon'ble Supreme Court of India and of the Executive Committee:

"The members of the Ado Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council were, therefore, were clearly of the view that the Council should take steps for referring these cases to the Police authorities for registration of FIRs and conducting investigations in all such cases. It was also observed that in the complaint to be sent to the Police authorities, it should also be clearly requested that all those cases where there is a collusion and conspiracy of such persons with the management of the colleges, the necessary action should also be taken against the management of those colleges."

ii) FIR had been recommended to the Police authorities vide Council's letter dated 28/06/2006 & the following office observations recommended in FIR:

"In his declaration form, he has claimed that he has worked at Mamata Medical College, Khammam from 11.12.2004 to 31.7.2005 as Professor. In its letter, Mamata Medical College, Khammam has stated that he has not worked at all in the institution. Thus, he has submitted a false and forged experience certificate and therefore cannot be accepted as a teacher."

iii) Dr. Bijay Kumar Pathnaik vide his letter dt. 22/05/2009 has sent his explanation.

The decision of the Ethics Committee is as under:

"The Ethics Committee considered the matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Bijay Kumar Pathnaik, Medical teacher and noted the clarification submitted by him vide letter dated 22.05.09 conveying therein that there has been slight mistake on the part of Medical Council while soliciting the confirmation of my experience from the concerned college since my name was mentioned as Pathak & not Pathnaik in the MCI communications to the concerned institution and therefore the misunderstanding.

The Ethics Committee, in view of the above, decided to drop the proceedings against him and close the matter with regards to Ethical consideration of the case."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee to drop the proceedings and close the matter with regard to the ethical consideration of the case.

18. Matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Anita Chhibba, Medical teacher.

Read: The matter with regard to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Anita Chhibba, Medical teacher along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

"i) the following operational part of the decision by the members of Adhoc Committee appointed by the Hon'ble Supreme Court of India and of the Executive Committee:

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council were, therefore, were clearly of the view that the Council should take steps for referring these cases to the Police authorities for registration of FIRs and conducting investigations in all such cases. It was also observed that in the complaint to be sent to the Police authorities, it should also be clearly requested that all those cases where there is a collusion and conspiracy of such persons with the management of the colleges, the necessary action should also be taken against the management of those colleges."

ii) FIR had been recommended to the Police authorities vide Council's letter dated 12/05/2008 & the following office observations recommended in FIR:

"In his declaration form, she has claimed that he has worked at Govt. Medical College, Auranagabad 14.09.1994 to 31.12.1994, 14.02.1995 to 21.12.1995, 15.01.1996 to 06.01.1997 as Asstt. Prof. In its letters, Govt. Medical College, Aurangabad has stated that she has worked in the institution from 14.02.1995 to 14.3.1995, 31.03.1996 to 31.12.1996.Thus, she has submitted a false and forged experience certificate and therefore cannot be accepted as a teacher."

iii) Dr. Anita Chhibba vide his letter dt. 12/06/2009 has sent his explanation.

The decision of the Ethics Committee is as under:

"The Ethics Committee considered the matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. Anita Chhibba, Medical teacher and noted the clarification submitted by her vide letter dated 12.06.09 providing with satisfaction the details with regard to her experience/posting in Govt. Medical College, Aurangabad.

The Ethics Committee, in view of the above, decided to drop the proceedings against her and close the matter with regards to Ethical consideration of the case."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee to drop the proceedings and close the matter with regard to the ethical consideration of the case.

19. Matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. C. Vijayalakshmi, Medical teacher.

Read: The matter with regard to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. C. Vijayalakshmi, Medical teacher along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

i) the following operational part of the decision by the members of Adhoc Committee appointed by the Hon'ble Supreme Court of India and of the Executive Committee:

"The members of the Adhoc Committee appointed by the Hon'ble Supreme Court and of the Executive Committee of the Council were, therefore, were clearly of the view that the Council should take steps for referring these cases to the Police authorities for registration of FIRs and conducting investigations in all such cases. It was also observed that in the complaint to be sent to the Police authorities, it should also be clearly requested that all those cases where there is a collusion and conspiracy of such persons with the management of the colleges, the necessary action should also be taken against the management of those colleges."

ii) FIR had been recommended to the Police authorities vide Council's letter dated 27/04/2009 & the following office observations recommended in FIR:

"Dr. C. Vijayalakshmi in her Declaration Form has mentioned that she has worked in the Department of General Surgery of Cancer Institute as Assistant Professor from September 2001 to August 2002 and as an Associate Professor from February 2003 to March 2003.

While, on verification, the Director Incharge & Dean, Cancer Institute, College of Oncological Sciences vide its letter no. C1:D:361:2008-09 dated 19.01.2009 has confirmed that Dr. C. Vijayalakshmi was not in their service at any time."

iii) Dr. C.Vijayalakshmi vide his letter dt. 29/05/2009 has sent his explanation.

The decision of the Ethics Committee is as under:

"The Ethics Committee considered the matter with regards to supply of alleged forged/fake information/certificate in/with the declaration forms submitted to the MCI by Dr. C.Vijayalakshmi, Medical teacher and noted the clarification submitted by her vide letter dated 29.05.09 with regards to her experience at Govt. Arignar Anna Memorial Cancer Hospital & Institute and her misunderstanding with regards to the affiliation of the said institute with Chengalpattu Medical College, Chengalpattu/Govt. Medical College, Chennai.

In view of the above, the Ethics Committee decided to drop the proceedings against her and close the matter with regards to Ethical consideration of the case."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the decision of the Ethics Committee to drop the proceedings and close the matter with regard to the ethical consideration of the case.

20. Appeal against the order dated 01.11.2007 of Delhi Medical Council made by Sh. Harishchandra Chavan, Hon'ble Member of Parliament (Lok Sabha).

Read: The matter with regard to Appeal against the order dated 01.11.2007 of Delhi Medical Council made by Sh. Harishchandra Chavan, Hon'ble Member of Parliament (Lok Sabha) along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

"The Ethics Committee considered the ongoing matter with regard to appeal against the order dated 01.11.2007 of Delhi Medical Council and noted :-

i). The following decision of the Ethics Committee taken at its meeting held on 21st May, 2008:-

"The Ethics Committee considered the appeal against the Order dated 01/11/2007 of Delhi Medical Council made by Sh. Harish Chandra Chavan, Hon'ble Member of Parliament and decided to take this case as an appeal case against the decision of Delhi Medical Council. The Registrar, Delhi Medical Council may be requested to send copies of documents pertaining to this case. Dr. S.S. Sanyal against whom the complaint is lodged may be called and requested to submit their parawise comments on this case within 15 days of receipt of letter of MCI. The complainant Mr. N.C. Roy may be called in one of the next meetings of Ethics Committee."

ii). The following decision of the Ethics Committee at its meeting held on 7th & 8th July, 2008:

"The Ethics Committee noted that at its meeting held on 21.05.2008, the Committee considered the letter dated 06.02.2008 from the Central Govt., Ministry of Health & F.W. wherein they had forwarded the complaint of certain Members of Parliament against Dr. S.S. Sanyal and requested to re-examine the matter; and decided "to take this case as an appeal case against the decision of Delhi Medical Council. The Ethics Committee further decided that the Registrar, Delhi Medical Council may be requested to send copies of documents pertaining to this case. Dr. S.S. Sanyal against whom the complaint is lodged may be called and requested to submit their

parawise comments on this case within 15 days of receipt of letter of MCI. The complainant Mr. N.C. Roy may be called in one of the next meetings of Ethics Committee."

The Delhi Medical Council vide letter dated 23.06.2008 has sent the documents as requested. Dr. S.S. Sanyal and Mr. N.C. Roy were invited to appear before the Ethics Committee on 8th July, 2008. They appeared on 08.07.2008 before the Ethics Committee and have given the following statement:-

"Statement of Dr. S.S. Sanyal

I Dr. S.S. Sanyal did my MBBS from J.N. Medical College, Aligarh in the year 1976. I did my MS (Ortho.) in 1982 from the same place. My date of birth is 24.06.1953. I am registered with Delhi Medical Council bearing registration no. 14794.

I have already submitted by comments vide my letter dated 18.06.2008 which should be taken as my statement in addition, I will also like to submit a copy of documents from Dr. Pradeep Dutta, Radiologist, MD, DMRD indicating that x-ray and ultrasound were performed on 09.05.2006. Dr. Pradeep Dutta stated that Mr. N.C. Roy had sustained scooter accident on that day. The patient, Mr. N.C. Roy came to me on 10.05.2006 with history of injury at (R) Heel as a result of scooter accident.

Q.: Patient came on 10.05.2006 with what history?
Ans.: With acute pain in right heal as a result of scooter accident.

Q.: Was there any external injury?
Ans.: No, there was not any external injury.

Q.: Will it cause pathological fracture?
Ans.: No.

Q.: What is the proof that he has met with an accident?
Ans.: 1. My OPD register.
2. Copy of the discharge slip of Moolchand Hospital.
3. Copy of the certificate issued by Dr. Pradeep Dutta, Radiologist dated 05.07.2008.

Sd/-
(Dr. S.S. Sanyal)"

"STATEMENT OF SHRI N.C. ROY

I, N.C. Roy son of Late K.P. Roy, Resident of 43, Amritpuri 'A', East of Kailash, New Delhi-110065 would like to bring to the notice of the Ethics Committee that I have submitted an application addressed to Hon'ble Health Minister dated 10.1.2007 which indicates the complete history of my case. I am presenting the copy of the same as my statement.

Further, I would like to state that I have never met with scooter accident or an injury and was never given any treatment for the same by Dr. S.S. Sanyal on 10th May, 2006. Further, I am not satisfied with the investigations/decision of the Delhi Medical Council and solemnly affirm that he wrongly injected me on the ankle while he should have
injected on the sole, that too only after confirming that since I am a diabetic, whether the said injection was advisable in my case or not, that too four times. This treatment resulted in my being tendo Achillis rapture and had to undergo the surgery and long treatment till date by the noted surgeon Dr. R.P. Narayan, HOD, Plastic Surgery, Safdarjung Hospital, New Delhi.

Dr. S.S. Sanyal while injecting me the injection near the ankle joint to put needle inside and then used to rotate it claiming that the drug will spread all around. While his Compounder used to forcefully hold my right leg while I was crying in pain.

I underwent operation for tendo repair at Moolchand Hospital, New Delhi in September, 2006 and presently I am under treatment of Dr. R.P. Narayan, Head of Department of Plastic Surgery, Safdarjung Hospital, New Delhi.

I am saying truthfully and otherwise has no more proof.

Q.　Do you have any history of disease?
Ans.　I am diabetic since 1998 on medication tablets and now I am taking insulin since my operation.

Sd/-
(N.C. Roy)"

The Ethics Committee discussed the matter and decided to request Dr. R.C. Siwatch, Prof. & HOD, Deptt. of Orthopaedics, Medical College, Rohtak to assist the Ethics Committee with his opinion regarding the method of treatment
followed in this case. Whether the course of treatment is the standard treatment or not. Whether, in view of long standing diabetes it was the suitable treatment or not and also regarding any shortcoming or negligence or want of competence on the part of treating doctor in this case or not. Further, the present treating doctor, Dr. R.P. Narayan, HOD, plastic surgery, Safdarjung Hospital may also be requested to give a detailed account of treatment of Mr. N.C. Roy under this case alongwith copy of records. He may be specifically asked as to what may have been the cause of rupture of tendoachilis in this case in view of the past treatment records. He may be requested to give his comments within 15 days."

iii)　Dr. R.C. Siwach, Prof. & HOD, Deptt. of Orthopaedics, Medical College, Rohtak was requested to provide his opinion vide Council's letter dated 26/08/2008. In response to above, Dr. R.C. Siwach sent his opinion vide letter dated 20/09/2008, the same is as under:-

"After going through all the records and complaint of Sh. N.C. Roy, 43, Amrit Puri-A, East of Kailash, New Delhi-110065 forwarded by the Medical Council of India for expert opinion alleging medical negligence on the part of Dr. S.S. Sanyal in the treatment administered to Sh. N.C. Roy at Ramakrishna Orthopaedic and Trauma Centre. On perusal of complaint, record of various hospitals and investigations (X-rays and Ultrasound etc.) I am of the opinion that the complainant was treated for planter fasciitis of right heel by Dr. S.S. Sanyal by administering Injection Depomedrol alongwith 2% Xylocaine on 11.2.06, 20.2.06, 4.3.06 and 23.3.06 alongwith medical therapy in a diabetic patient. Steroid alongwith Xylocaine specially at the interval of 10 days is undesirable as diabetic patients are vey prone for infection and physical therapy like hot formentation, sponge under heel and medicines are first line of treatment.

As far as his rupture of Tendo Achillis is concerned, diabetic patients are prone for spontaneous rupture of Tendo Achillis and record of the patient indicates that there was calcification in Tendo Achillis on the first x-rays done in Oct. 2005 and this type of rupture are well known to occur while climbing stairs, just walking or trivial trauma. It is unlikely that scooter accident has caused this rupture because there has been no evidence of any external injury like abrasion, swelling or eckymosis on the rupture site of tendo achillis.

Hence it is concluded that rupture of Tendo Achillis has not much relevance with the treatment given for planter fibro fasciitis.

In light of above findings, I am of the opinion that 4 Injections of Depomedrol with 2% Xylocaine at interval of 10 days are not recommended specially in diabetic patients but this treatment has no relevance with the Tendo Achillis rupture for which the patient has complained. It may be an act of want of competence or less experience but not negligence.

This is for your information and necessary action, please."

iv)　The following decision of the Ethics Committee taken at its meeting held on 06th October, 2008:

"The Ethics Committee considered the matter with regard to appeal against the order dated 01.11.2007 of Delhi Medical Council made by Sh. Harishchandra Chavan, Hon'ble Member of Parliament (Lok Sabha) and noted Dr. R.P. Narayan, HOD, Plastic Surgery, Safdarjung Hospital, Delhi has been sent all the case records on 23.09.2008. However, the opinion has not received till date. A reminder may be issued to Dr. R.P. Narayan with the request to send his reply within 15 days of receipt of the letter to the Council, so that the Council to proceed further in this case. This may be informed to the complainant."

v)　The following decision of the Ethics Committee taken at its meeting held on 11th & 12th December, 2008:

"The Ethics Committee considered the matter with regards the appeal against order dt. 1.11.07 of Delhi Medical Council and noted that the detailed documents of the treatment to Sh. N.C. Roy by the Deptt. of Plastic & Burn

Surgery have not been forthcoming inspite of request for the same. The Ethics Committee therefore decided that Dr. R.P. Narayan. Prof. & Head, Deptt. of Plastic Surgery & Burn, Safdarjung Hospital, Delhi be called to appear before the Ethics Committee at one of its next meetings with all the relevant documents/record."

vi) The following decision of the Ethics Committee taken at its meeting held on 21st & 22nd May, 2009:

"The Ethics Committee considered the matter with regards to appeal against the order dated 01.11.2007 of Delhi Medical Council made by Sh. Harishchandra Chavan, Hon'ble Member of Parliament (Lok Sabha) and decided to call Dr.R.P. Narayan to appear before the Ethics Committee. His statement is as under:-

STATEMENT OF DR. R.P. NARAYAN

I, Dr. R.P. Narayan passed MBBS from M.L.N. Medical College, Allahabad in the year 1978, MS (General Surgery) in the year 1982 from the same institute and M.Ch. (Plastic Surgery) from Delhi University, Safadarjang Hospital, New Delhi in the year 1985. Presently working as Professor & HOD, Burn, Plastic and Maxillofacial Surgery, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi. I am registered with U.P. Medical Council and Delhi Medical Council.

Mr. N.C. Roy was treated as an OPD patient for in the department for ulcer over Tendo Achilles area. The patient was known diabetic for which he was taking treatment. On examination, the patient had ulcer over Tendo Achilles area measuring approx. 6cm x3 cm in size. Patient had come with a request for surgery which was not done as in my opinion, doing another surgery in a diabetic foot had considerable risk of non-healing of operated area. The wound was managed conservatively which resulted in healing of the wound.

Q. What is your opinion of rupture of Tendo Achilles in following treatment of plantar fascitis with local steroid injection.
Ans. As far as my opinion is concerned, both structures are quite far away and giving injection into plantar fascia region will not result into weaking/rupture of Tendo Achilles.

Sd/-
(Dr. R.P. Narayan)

22nd May, 2009"

The Ethics Committee noting the above and after going through all the documents and the consultant's expert opinion; decided to warn Dr. S.S. Sanyal to be more careful in dealing with his patients in future."

The Executive Committee of the Council further observed that the technical expert Dr. R.C. Siwach in his opinion has stated that "I am of the opinion that 4 Injections of Depomedrol with 2% Xylocaine at interval of 10 days are not recommended specially in diabetic patients but this treatment has no relevance with the Tendo Achillis rupture for which the patient has complained. It may be an act of want of competence or less experience but not negligence.

It was further observed that the present appeal against the order dated 1.11.2007 has been filed by Shri Harishchandra Chavan, Hon'ble M.P., Lok Sabha and not by either the patient or by the concerned doctor.

In view of above, the Executive Committee of the Council decided to refer the matter back to the Ethics Committee for reconsideration.

21. Complaint-cum-Appeal dt.14.12.06 against Medical Mishaps - Representation/ Private Hospitals as alleged by Mr. P. Raju.

Read: The matter with regard to Complaint-cum-Appeal dt.14.12.06 against Medical Mishaps - Representation/ Private Hospitals as alleged by Mr. P. Raju along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

"The Ethics Committee considered the ongoing matter of complaint-cum-Appeal vide letter dated 14.12.2006 from Mr. P. Raju and noted:-

i) The letter dated 14.12.2006 from Mr. P. Raju:-

"I beg to bring the following a few lines before your Honourable presence for necessary action.

Sir, I applied to the Director of Medical Services, Chennai on 25.04.2001 for necessary action due to the sudden demise of my daughter Smt. Sarada, on 4.01.2001 who was admitted for delivery in the Salem Poly Clinic, Salem. The demise occurred due to the negligence and improper treatment in the said Hospital. The same was again brought to the notice of the Director (Mr. C.M.K. Reddy) by name on 25.04.2001, 13.12.2002. Both turned deaf ears to my petition.

Repeatedly I brought to the notice (my incident) to the relevant authorities on 8.03.2003, 28.12.2004, 16.8.2005 and 8.03.2003 (Dr. Reddy, Registrar of Medical Council, Chennai and Delhi and C.E.R.S., etc.) But all brought forth nothing and I received no reply from any authorities. The Tamil Nadu Govt. looked into the grievance and advised the Joint Director, Salem to enquire and submit the report of enquiry. The Joint Director as directed, enquired on 7.12.2001 and sent his report.

I again represented my grievance to the Director of Health and Rural Services, Chennai on 28.12.2004. As per reference cited I, I received an answer that for such medical mishaps, I have to approach, if desired, either to Tamil Nadu Medical Council, Chennai/ Indian Medical Council or Competent Consumer Redressal forum. Accordingly I approached to the Medical Council of India on 5.04.2006 for Justice.

The Honourable Medical Council of India directed the Registrar of Medical Council, Tamil Nadu to make investigation and take necessary action and send the report within a period of Six months under clause 8.4 of the Indian Medical Council (Decision on complaint against delinquent physician shall be taken within a period of six months. The copy of the letter cited in the ref.3 has also been forwarded to me. But so far I received no information about any action in this regard."

I also extend my humble salutations and thanks to the Medical Council of India, New Delhi, which ordered the Registrar of Medical Council to investigate in this regard.

I humbly bring this before the Medical Council of India, that so far no action is being even after the said stipulated six months period. I again request and pray the Honorable benovalent authority, kindly look into the matte for speedy action and favour me at the earliest convenience possible."

ii) The following decision of the Ethics Committee taken at its meeting held on 19.02.2007:-

"The Ethics Committee considered the matter with regard to complaint against medical mishaps – Representation/Private Hospital as alleged by Mr. P. Raju and noted that the matter was referred to Tamil Nadu Medical Council on 11.05.2006 and more than 6 months has lapsed till date the Tamil Nadu Medical Council has not taken any action and the Medical Council India take up this case as an appeal case and the Ethics Committee decided that Mr. P. Raju may be asked to appear before the Ethics Committee in its next meeting at 2.30 p.m. The Ethics Committee decided to ask the Director, Mr. C.M.K. Reddy, Salem Poly Clinic, Salem to give his para-wise comments on the complaint lodged against him by Mr. P. Raju within 15 days of issue

of this letter alongwith copy of the case sheet and treatment records & all the relevant documents relating to this particular case.

The Ethics Committee further decided to write the Tamil Nadu Medical Council that this case has been taken over by the Medical Council India as an appeal case as per the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 as amended on 26th May, 2004.

The Ethics Committee further decided to request Mr. P. Raju to appear before the Ethics Committee at 12.30 p.m. in its second next meeting."

iii) *The following decision of the Ethics Committee taken at its meeting held on 19.03.2007:*

"The Ethics Committee considered the matter with regard to complaint against medical mishaps – Representation/Private Hospital as alleged by Mr. P. Raju and noted that the matter was referred to the Tamil Nadu Medical Council by this Council and the Tamil Nadu Medical Council has not taken any action till date and the complainant Mr. P. Raju has requested to this Council to take up this case as an appeal case under Section 8.8 as per the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 as amended on 26th May, 2004 and the Committee decided to accept this as an appeal case and this may be informed to the Tamil Nadu Medical Council that this case has been taken over by the Medical Council of India as an appeal case as per Regulations. Mr. P. Raju was requested to appear before the Ethics Committee at 12.30 p.m on 19.03.2007 and he has explained & also informed that there is a clear-cut professional misconduct (medical mishaps/negligence) which her daughter died. The baby is certified as female but actually it was a male baby. He also brought to the notice of the Committee that the time of death of her daughter was different about the actual time of death with the hospital records.

In view of the above, the Ethics Committee decided to call the Director, Salem Ploy Clinic & Dr. S. Venketswara to appear before the Ethics Committee in its second next meeting at 3.00 p.m."

iv) *The following Ethics Committee the Ethics Committee taken at its meeting held on 14th & 15th May, 2007:-*

"The Ethics Committee considered the matter and saw the letter given by Salem Polyclinic wherein it was stated that "Mr.C.M.K. Reddy and Dr. Venketwara Rao were never in our employment nor worked in the past or present in our hospital as doctor."

After receiving this letter from Salem Polyclinic, the Ethics Committee decided to write to the Salem Polyclinic the following:-

1. *Who is the owner of Salem Polyclinic whether he is a doctor or non-doctor, if the owners are doctor, their detail i.e. name, postal address, and registration number are to be asked for.*

2. *The Authorities of Salem Polyclinic are to be requested to give the details, of all the doctors who have treated this particular case No.2000/F/9798 of Saradha w/o Panneerselvam, Namagiripettai.*

3. *The name and address alongwith registration number of the Managing Director/Medical Supdt.,/Medical Director/Incharge of Obst. & Gynae. wards at present as well as at the time of the said case, are to be provided..*

4. *The para-wise comments regarding this particular case is to be provided.*

5. *A copy of the hospital record and complaint is being sent to the Salem Polyclinic, Salem with a request to send the above information within 15 days of receipt of this communication.*

Further a copy of the letter addressed to Salem Polyclinic may also be marked to:-

1. *Secretary, Health, Tamil Nadu.*
2. *The Registrar, Tamil Nadu Medical Council, Chennai-26.*
3. *Director of Medical and Rural Health Services, Chennai-6*
4. *The Joint Director of Medical and Rural Health Services, Salem-1.*
5. *District Magistrate, Tamil Nadu*
6. *Superintendent of Police, Tamil Nadu requesting their kind co-operation in obtaining the above information."*

v) *The following decision of the Ethics Committee taken at its meeting held on 10th & 11th August, 2007:-*

"The Ethics Committee considered the matter with regard to complaint against Medical Mishaps-Representation/Private Hospitals as alleged by Mr. P. Raju and noted that Dr. Rashmi Rao, Salem Poly Clinic, Salem has sent a letter dt. 16.7.2007 to the Medical Council of India vide letter dated 28.6.2007 from the reply, it has been seen that Dr. Rashmir Rao, was the doctor who treated Mrs. Saradha W/o Mr. P. Raju the complainant.

The Ethics Committee therefore decided to call Dr. Rashmi Rao to appear before the Ethics Committee in its second next meeting at 11.30 a.m. with the relevant documents, case history and hospital records of the patient. The Ethics Committee further decided to ask the complainant to appear before the Ethics Committee in its next second meeting at 3.00 p.m."

vi) *The following decision of the Ethics Committee taken at its meeting held on 15th & 16th October, 2007:*

"The Ethics Committee considered the matter with regard to complaint against Medical Mishaps-Representation/Private Hospitals as alleged by Mr. P. Raju and noted that Dr. Rashmi Rao was requested to appear before the Ethics Committee on 16.10.2007 at 11.30 a.m. The Ethics Committee further noted that Dr. Rashmi has sent a letter dt. 9.10.2007 informing her regrets to appear before the Ethics Committee on 16.10.2007 due to unavailability of travel tickets.

The Ethics Committee therefore decided to call Dr. Rashmi Rao at its second next meeting at 2.30 p.m. (first day) alongwith all the relevant case records of the patients."

vii) *The following decision of the Ethics Committee taken at its meeting held on 17/12/2007:-*

"The Ethics Committee considered the matter with regard to complaint against Medical Mishaps-Representation/Private Hospitals as alleged by Mr. P. Raju and noted that Dr. Rashmi Rao has been requested to appear before the Ethics Committee on 17/12/2007 but she has failed to do so. The Ethics Committee decided that Dr. Rashmi Rao should be given a last and final chance to appear before the Ethics Committee in its next meeting at 1.00 p.m. failing which the Ethics Committee will be constrained to take ex-parte decision in this case."

viii) *The following decision of the Ethics Committee taken at its meeting held on 12th & 13th February, 2008:*

"The Ethics Committee considered the matter with regard to complaint against Medical Mishaps-Representation/ Private Hospitals as alleged by Mr. P. Raju and noted that Dr. Rashmi Rao was called on 2.30 p.m. on 12.2.2008 but she has failed to appear before the Ethics Committee. The Ethics Committee decided to give her one last chance to appear before the Ethics Committee. She may be called on the second next meeting of the Ethics Committee, failing which the Ethics Committee will be constrained to take an ex-parte decision in this particular case."

ix) *The following decision of the Ethics Committee taken at its meeting held on 21st May, 2008:*

"The Ethics Committee considered the matter with regard to complaint against Medical Mishaps- Representation/ Private Hospitals as alleged by Mr. P. Raju and noted that Dr. Rashmi Rao was requested to appear before the Ethics Committee on 21.05.2008 but she did not turn up. The Ethics Committee further noted a letter dated 14.5.2008 received today i.e. 21.5.2008 addressed to the Addl. Secretary, Medical Council of India, New Delhi where she has written that she requires one month time.

Therefore, the Ethics Committee decided to give her one more chance to appear before the Ethics Committee in its next meeting."

x) *The following decision of the Ethics Committee taken at its meeting held on 7th & 8th July, 2008:*

"The Ethics Committee considered the matter with regard to complaint against Medical Mishaps-Representation/Private Hospital as alleged by Mr. P. Raju and noted that Dr. Rashmi Rao was asked to appear before the Ethics Committee on 16.10.2007, 17.12.2007, 12.02.2008, 21.05.2008 & 07.07.2008 but she did fail to do so.

The Ethics Committee unanimously decided to give her a last and final chance to appear before the Ethics Committee at one of its next meetings."

xi) *The Council received a letter dated 25/07/2008 from the Complainant Mr. P. Raju conveying his inability to come because of his physical problems.*

xii) *The following decision of the Ethics Committee taken at its meeting held on 11th & 12th December, 2008:*

"The Ethics Committee considered the matter with regards to complaint against Medical Mishaps as alleged by Mr. P. Raju and discussed the various aspects of this case and have called Dr. Rashmi Rao who is in-charge of Obst. & Gynea. Deptt. of Salem Polyclinic, Salem and observed that the case was admitted under Dr. Rashmi Rao. However, it is observed that this emergency operation (Caesarean Section) was not done by Dr. Rashmi Rao but one Dr. Venkatesan MS (FRCS) who is not in possession of qualification required for the speciality had performed this operation. The Ethics Committee therefore, decided that Dr. Venkatesan should be called to appear before the Ethics Committee to give his deposition with the original case sheets, operation register, form of consent and other hospital records of this patient. In the meantime statement of Dr. Rashmi Rao has also been recorded which is as under:

"Statement of Dr. Rashmi Rao

I Dr. Rashmi Rao did my MBBS from Bangalore Medical College in the year 1990 and did DGO from the same institute in the year 1994. My registration no. is 29936 of Karnataka Medical Council. My date of birth is 8.5.1967.

This is to certify that Mrs. Sharda age 30 years w/o Mr. Paneer Selvam came to me for four antenatal visits on the forth antenatal visit on 26.12.2000, the patient came with pregnancy of 37 weeks and leeking since 3.00 p.m. The patient came to me at 4.30 p.m and labour was induced but as the labour did not progress satisfactorily She underwent emergency cesarean on 28.12.2000 and delivered a live male baby at 10.49 a.m. The baby cried well post operatively, the patient was normal until the third day. The patient was on Inj. Amoxy-Cloxacillin. On the forth post-operative day she had temperature of 101^0 F. On

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the forth day she was afebrile. On the fifth day she again had temperature of 101^0 F. on 4.1.01 at 4.45 a.m she complaint of mild dyspneoa and abdominal distension for which a suppository was given and the patient passed motion. She was given Inj. Ceftriaxone 1gm and Inj Tiniba at 9.00 a.m. She became breathless and x-ray abdomen and scan was taken which showed dilated bowel loops. Her Hb was 7.4 gms. She was transfused 2 units of blood.

Prophylactic ventilation was explained to the patient's father. At 1.25 pm the patient suddenly collapsed and resuscitation measures were immediately immediately under taken but the patient could not be revived and the patient was declared dead at 2.00 pm.
Suspected casue of death – Pulmonary embolism.

Sd/-
(Dr. Rashmi Rao)
12.12.2008"

The Ethics Committee also noted that the complainant Mr. P. Raju vide his letter dt. 28.07.08 has conveyed his inability to appear before the Ethics Committee because of his physical problems. Dr. Venkatesan may be called to appear before the Ethics Committee in one of its next meetings."

xiii) The following decision of the Ethics Committee taken at its meeting held on 21st & 22nd May, 2009:

"The Ethics Committee considered the matter with regards to complaint against Medical mishaps-Representation/ Private Hospitals as alleged by Mr. P. Raju and noted that the operating surgeon Dr. M. Venkatesan had been asked to appear before the Ethics Committee on 21.05.2009. He has submitted his oral as well as written deposition before the Ethics Committee which is as under:-

STATEMENT OF DR. M. VENKATESAN

I, Dr. M. Venkatesan, passed my MBBS in 1986 and did my MS (General Surgery) in the year 1991 from Stanley Medical College, Chennai. I also finished my FRCS (Ed) and FRCS (Glas) in 1997. My Registration No. is 43296 with the Tamil Nadu Medical Council. My date of birth is 05.04.1964.

I worked in Salem Polyclinic, Salem from 1991 to 1993 and then from 1998 onwards. I had assisted Ceasarian operations and have performed myself under supervision and unsupervised during this period. I have enclosed a letter from the Chief of the Salem Polyclinic, Salem to support this. I also enclosed my training certificates.

On 28.12.2000, I was called by Dr. Rashmi Rao to do an emergency Caesarian Section at Salem Polyclinic, Salem. The indication was foetal distress. Under spinal Anaesthesia with Aseptic precautions, I did a lower segment Caesarian Section and delivered a male baby and the baby cried after two minutes resuscitation. Perfect haemostasis was secured and the wound was sutured. The patient was haemodynamicaly stable and recovered well in the immediate post operative period.

I have done this procedure as an emergency life saving operation to the best of my knowledge and efforts to save the mother and the baby.

Sd/-
Dr. M. VENKATESAN
R/o 41/14, Bajanai Madam Street,
Gugai, Salem – 636 006
Tamil Nadu, India.

He was asked the following and the answers are given against each.

Question: *During your MS training, was there any training on Caesarian Section and OBG Management procedure?*
Answer: *During my house surgeon period, I have worked in OBG Department and during that period I had exposure to Gynaecological surgery and Caesarian Sections. Occasionally, I have assisted emergency gynaecological surgeries like, twisted ovarian cyst and removal of uterine tumours.*

Question: *Whether the course and curriculum for MS (Surgery) during your training period included any chapter or hands on training on OBG patients management?*
Answer: *No.*

Question: *Was the matter referred to the Judiciary Court?*
Answer: *Yes, it was taken to the Judiciary Court also.*

Sd/-
Dr. M. VENKATESAN
R/o 41/14, Bajanai Madam Street,
Gugai, Salem – 636 006
Tamil Nadu, India.

The Ethics Committee while considering the matter noted that Dr.M. Venkatesan, who had conducted the caesarian section of the patient, is a general surgeon and he did not attend to the patient any time after the operation; and moreover the post operative notes of the patient were noted to have been written by the Anaesthetist of the Hospital. The Ethics Committee, therefore, decided that the Dr.M.

Venkatesan, General Surgeon should be issued a show cause notice as to why his name be not erased from the Indian Medical Register and further that he should ensure that the reply to the show cause notice should be sent within one month's period positively from the date of issue of the letter to this effect."

xiv) Dr. Venkatesan has sent letters dated 30/05/2009 & 23/06/2009 in response to the show cause notice issued to him.

The Ethics Committee noting the above and considering all the relevant documents, statements and the reply to the show cause notice and after observing that Dr.M.Venkatesan has been negligent by not caring to write the post operative notes of the patient and thereafter post operatively not attending the patient even once; decided to recommend that the name of Dr.M.Venkatesan be erased temporarily from I.M.R. for a period of three months."

The Executive Committee observed that in view of above, an emergency caesarian operation was done by Dr.M. Venkatesan on 28.12.2000 wherein a male baby was delivered and baby cried after two minutes resuscitation. The patient was haemodynamicaly stable and recovered well in the immediate post operative period and was normal until the third post operative day.

After due and detailed deliberations, the Executive Committee decided to refer the matter back to the Ethics Committee for reconsideration.

22. Appeal against the order dated 21/02/2006 passed by the Delhi Medical Council as per order dated 30/11/2007 passed by NCDRC, New Delhi.

Read: The matter with regard to Appeal against the order dated 21/02/2006 passed by the Delhi Medical Council as per order dated 30/11/2007 passed by NCDRC, New Delhi along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 8th and 9th July, 2009:-

"The Ethics Committee considered the considered the ongoing matter of appeal against the order dated 21/02/2006 passed by the Delhi Medical Council as per order dated 30/11/2007 passed by NCDRC, New Delhi and noted –

i) Order vide letter dated 30/11/2007 from passed by NCDRS, New Delhi which is as under:-

"Learned counsel Mr. J.S. Bhasin appearing on behalf of Medical Council of India (MCI) states that for implementation of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) regulation, 2002 framed by the Medical Council of India, MCI would issue Notification informing all hospitals and medical practioners all over the country to implement the same stating that in any set of circumstances, Hospital/Medical practioners shall handover the medical records of the patient to him/her or his relatives within 72 hors, as contemplated .

MCI is directed to submit compliance report.

With regard to the grievance of the complainant against the order paased by the Delhi Medical Council, it would be open to the complainant to approach the Medical Council of India by filing the proper application within 15 days from today. Limitation period shall be condoned by the MCI and the matter shall be decided on merit.

Learned counsel appearing on behalf of Mool Chand Khairati Ram Hospital & Research Institute states that whatever record was maintained by the Hospital relating to the mother and child, copy of the same has been filed before this Commission and is given to the complainant."

ii) The following decision of the Ethics Committee taken at its meeting held on 21st & 22nd January, 2008:

"The Ethics Committee considered the matter with regard to appeal against the order dated 21/02/2006 passed by the Delhi Medical Council as per order dated 30/11/2007 passed by

NCDRC, New Delhi and noted that the letter sent to the complainant i.e. Mr. Atanu Dutta has returned back in the Council office with the remarks that "House Always Locked". The Committee decided to make one more attempt by sending a reminder to Mr. Atanu Dutta."

iii) The following decision of the Ethics Committee taken at its meeting held on 21st May, 2008:-

"The Ethics Committee considered the matter with regard to appeal against the order dated 21/02/2006 passed by the Delhi Medical Council as per order dated 30/11/2007 passed by NCDRS, New Delhi and discussed in detail and observed that the order on 30/11/2007 passed by NCDRS, New Delhi whereas the Medical Council of India was asked to issued a notification informing all hospitals and medical practitioners all over the country to implement the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 stating that in any set of circumstances, Hospital/Medical practitioners shall handover the medical records of the patient to him/her or his relatives within 72 hours.

From the records, it is apparent that a circular has been issued on 23.01.2008. The Ethics Committee requested the Addl. Secretary to find out whether this order has been carried out in letter and sprit and to kindly submit a report to the Ethics Committee at its next meeting.In this case, various issues have come out which can be stated as follow:-

(a) Whether it was MTP or Pre-term termination?
(b) Whether informed consent was obtained in a proper format from the patient or hospital?
(c) Whether chromosomal abnormality of the patient warranted termination of pregnancy.
(d) Who are the doctors who are party to the decision of termination of pregnancy?
(e) Who administered Anaesthetist? What type anaesthesia has been given? Was it given empty stomach.
(f) Was PAC done?
(g) Was it an attack of bronchial asthma or aspirated pneumonia?

There are many other issues in this case which also needs looking into.

The Ethics Committee is of the opinion that a prima-facie case is for starting a full fledge investigations in this case. It has therefore decided to call all the doctors who were called by the Delhi Medical Council, in addition to Anaesthetist shall also be called and all the treating doctors may also be asked to submit a detailed parawise comment regarding this case.

The Medical Superintendent of the treating hospital should be requested to (i) handover all the copies of the certified medical records pertaining to this case including copies of the Bed Head Ticket. (ii) He may also be requested to provide the full name of doctors, addresses for communication as well as registration particulars of the Anaesthetists and the Paediatrician involved in this case. (iii) He may also be asked to submit a written explanation as to why the hospital records were refused on 17.11.2003 in contravention of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

iv) The matter was placed before the Ethics Committee at its meeting held on 30/06/2008 and decided as under:

"The Ethics Committee considered the matter with regard to appeal against the order dated 21/02/2006 passed by the Delhi Medical Council as per order dated 30/11/2007 passed by NCDRC, New Delhi and noted the action taken so far. The Ethics Committee also noted the following report submitted by the Additional Secretary in terms of the decision of Ethics Committee taken at its meeting on 21.05.2008 with regards to action taken on the orders of NCDRC, New Delhi:-

The report by Addl. Secretary :"The sequences of events, in summary, are :-

(i) The order dated 30.11.2007 from NCDRC reads as under: -

"Learned counsel Mr. J.S. Bhasin appearing on behalf of Medical Council of India (MCI) states that for implementation of the Indian Medical Council (Professional Conduct, Etiquette & Ethics)

Regulations, 2002 framed by the Medical Council of India, MCI would issue Notification informing all the hospitals and Medical practitioners all over the country to implement the same stating that in any set of circumstances, Hospital/Medical practitioners shall handover the Medical records of the patient to him/her or his /her relatives within 72 hours, as contemplated. MCI is directed to submit compliance report.

With regard to the grievance of the complainant against the order passed by the Delhi Medical Council, it would be open to the complainant to approach the Medical Council of India by filing proper application within 15 days from today. Limitation period shall be condoned by the MCI and the matter shall be decided on merit.

Learned counsel appearing on behalf of Mool Chand Kharaiti Ram Hospital & Research Institute states that whatever record was maintained by the hospital relating to the mother and child, copy of the same has been filed before this Commission and is given to the complainant."

(ii) A circular dated 23.01.2008 from MCI to various authorities sent in this regard is as under :-

"It has brought to the notice of the Council that various hospital/institutions are violating the said regulations.

In pursuance of order dated 30/11/2007 passed by the Hon'ble National Consumer Disputes Redressal Commission, New Delhi in original petition No. 47 of 2005 filed by Mr. Atanu Dutta & others Vs. M/s Mool Chand Khairati Ram Hospital & Ayurvedic Research Institute and others directing inter-ailla to issue Notification informing all the hospitals and medical practitioners all over the country to implement the same stating that in any set of circumstances, Hospital/Medical practitioners shall handover the Medical records of the patient to him/her or his/her relatives within 72 hours, as contemplated.

In this context, I draw the attention of clause 1.3.2 under chapter Maintenance of Records of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which is reproduced below:-

"If any request is made for medical records either by the patients/ authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours."

You are requested to implement and strictly adhere to the said regulations and issue Medical records to all the aggrieved within the stipulated period of 72 hours their demand/request."

(iii) It may be stated that the above circular was issued after the same was prepared & vetted by the Ld. Councel retainer once the matter was referred to him by the Section through Secretary. However, though the very nature of directions of NCDRC was to give wide publicity in this regard to the doctors in India, there is found no advice/direction from Council's retainer/ Secretary to the effect that the said decision was to be notified in print media for the knowledge of whole medical fraternity.

However, after the Ethics Committee meeting held on 21.05.2008; the said directions from NCDRC have been given publicity through print media. A copy of the same vide The Indian Express dated 14.06.2008 in this regard is enclosed with this report."

Sd/-
(Dr.P.Kumar)

The Ethics Committee further noted that as per the information supplied by Establishment Section, the notification vide print media has been issued in the following newspapers:-

1. *Andhra Prabha*
2. *Agradoot*
3. *AJ*
4. *Indian Express+New Indian Express*
5. *Sandesh*
6. *Divya Himanchal*

7. Indian Punch | *8. Samyukt Karnataka*
9. Madhyamam | *10. Dainik Bhaskar*
11. Loksatta | *12. Punjab Kesari*
13. Rajasthan Patrika | *14. Thina Bhoomi*
15. Anand Bazar Patrika

The Ethics Committee after consideration of Additional Secretary, MCI's report noted with satisfaction all the measures taken by the Council. It would like to state that the same circular/notification may also be posted at the website of Medical Council of India and be sent by post to all the Deans/Principals of the medical colleges in India with a request that it be strictly followed and be given vide publicity by circulating it amongst all the staff members of the institute. The matter may be brought to the notice of Secretary, Medical Council of India and the Ethics file may be closed."

v) The Ethics Committee at its meeting held on 11th & 12th August, 2008, while confirming the minutes of the meeting of 30/06/2008, modified the minutes with respect to this matter & the same reads as under:

"The Ethics Committee confirmed the minutes of the meeting held on 30th June, 2008. During the consideration of confirmation of minutes, Dr. P. Kumar, Additional Secretary, pointed out that the minutes in respect of item no. 39 ("Subject : Appeal against the order dated 21/02/2006 passed by the Delhi Medical Council as per order dated 30/11/2007 passed by NCDRC, New Delhi.") need to be modified since the very consideration of the main complaints received and the decision thereof remains pending. The members agreed that the last line in the minutes (which reads : the ethics file may be closed) may be taken as deleted."

vi) The following decision of the Ethics Committee taken at its meeting held on 11th & 12th December, 2008:-

"The Ethics Committee considered the matter with regards to the appeal against order dt. 21.2.06 of Delhi Medical Council and noted that:

I) Hon'ble Member Dr. Uma Pradhan, as requested by Ethics Committee at its earlier meeting, has submitted her report dt. 27.10.08, the operative part of which is as under:-

"We may seek the opinion of experts in Fetel Medicine/Geneticists regarding the Chromosal anomaly present in the fetus leading to fetal abnormalities requiring termination of pregnancy.

Also seek the opinion of experts in Obstetrics so as to ascertain the mode of treatment in including abortion/preterm labour and the drugs used in the case in question."

II) The doctors called for appearing before the Committee, 4(four) namely – Dr. Raj Bokaria, Dr. Alka Gujaral, Dr. Vijay Langar & Dr. Naresh Rustogi have appeared today. One doctor – Dr. Veena Bhat is statedly abroad and could not appear.

The above four doctors submitted documents which were taken on record. All the four doctors have committed to supply their signed statement of defense within 15 days. The brief particulars of the four doctors as stated by them are recorded as under:

Dr. Raj Bokaria

I Dr. Raj Bokaria did my MBBS from SMS Medical College, Jaipur in the year 1975 and did my MD(OBG) in the year 1980 from the same institute. My registration no. is 11716 of Delhi Medical Council. My date of birth is 22.01.1952.

Dr. Alka Gujaral

I Dr. Alka Gujaral did my MBBS from Agra Medical College in the year 1977 and did my MD(OBG) in the year 1981 from the same institute. My registration no. is 12143 of Delhi Medical Council. My date of birth is 15.06.1956.

Dr. Vijay Langar

I Dr. Vijay Langar did my MBBS from Gwalior Medical College in the year 1972 and DA in 1976. I did my MD(Anaesthesia) in the year 1977. My registration no. is 14057 of Delhi Medical Council. My date of birth is 11.01.1945.

Dr. Naresh Rustogi

I Dr. Naresh Rastogi did my MBBS from UCMS, Delhi in the year 1975 and did my MD(Anaesthesia) in the year 1980 from Safdarjung Hospital, Delhi. My registration no. is 13073 of Delhi Medical Council. My date of birth is 8.8.1954

The Ethics Committee decided that the above said four doctors namely Dr. Raj Bokaria, Dr. Alka Gujaral, Dr. Vijay Langar & Dr. Naresh Rustogi should send their written statement about this case within 15 days from the date of meeting. The Ethics Committee noted that all four doctors have agreed to send their statement in this regard".

vii) The written statements from Dr. Raj Bokaria, Dr. Alka Guaral, Dr. Vijay Langar & Dr. Naresh Rustogi vide their letters as mentioned against each:-

Statement of Dr. Raj Bokaria vide letter dated 24.12.2008 which is as under:-

"A meeting was held on 11.12.2008 at 2pm at the Medical Council's office in Dwarka, regarding the case filed by Mr. Atanu Dutta.

During the meeting I was asked in detail by the members of the ethics committee. After the meeting I was orally asked to give my replies in writing to various questions posed by the committee.

I am replying to main questions that were asked.

Question : Can you narrate the case from the beginning?
Answer : The details of the case remain the same as given in the writing earlier.

Question: Was the consent taken?
Answer: Yes, it was taken. The general consent was taken at the time of admission on the admission form. Dr. Roopa Dutta, herself being an obstetrician and gynecologist was well versed with the diagnosis, reason for the admission and all courses of treatment as mentioned on the prescriptions. The consent was taken separately for manual removal of placenta (MRP) & tracheostomy.

Question: What type of diet was advised during the labour?
Answer: As she was not in active labour, soft diet was given for initial two days (was in the pre labour/latent phase). She had her last meal at 8pm on 7.10.2003 and did not had breakfast in the morning of 8.10.2003. She was fasting for almost more than 12 hrs. It's well known that the stomach empty time is delayed up to 24 hrs in pregnancy. Response to syntocinon I.V. drip on 8.10.2003 morning was not anticipated for next 4 to 8 hours looking at the previous two days response to drugs.

Question: Was a feeding history taken before the procedure of MRP.
Answer : Yes, the feeding history was taken by the patient. She didn;t took anything in the breakfast since morning.

Question: Do you think that MRP was required?
Answer : Yes MRP was needed and the decision for MRP was taken by us after observing for almost 1 hr of retained placenta so that further complications of retained placenta could be

avoided. Placenta is expelled out spontaneously within 15 minutes after delivery in both primi & multigravida It is said to retained when it is not expelled out even 30 minutes after delivery of fetus. Manual removal of placenta is done as a standard procedure as its retention is a major cause of serious consequences like shock, sepsis& post partum haemorrhage. However no MRP was required as she spontaneously expelled the placenta.during vomiting.

Question: Was there any bleeding and how much was the bleeding when she was shifted to OT for MRP?
Answer : There was normal bleeding. The pad was soaked superficially when she was shifted to OT. The vitals were stable. MRP was not done as she spontaneously expelled the placenta with membrane completely during vomiting. There was no postpartum hemorrhage before and after the expulsion of placenta.

Question: Were you with the patient in the OT all the time?
Answer: I was not in the operation room initially as. I was scrubbing outside the operation room. for MRP. When I entered the operation room she was being managed by the anesthetic team & I was told that she had aspirated the vomitus.

Question: Was general anesthesia given to her?
Answer: No anesthesia of any kind was given to her.

Question: Do you think that epidural or spinal anesthesia rather than General Anesthesia would have been the choice of anesthesia for her?
Answer: MRP is done under general anesthesia as it requires deep relaxation of uterus (Spinal & epidural anaesthesia. are not the preferred method for MRP)The preference and choice of anesthesia is always decided by the anesthetist. However in this case no anesthesia was given.

Question: Did your team anticipate any surgical intervention in this case?
Answer: No surgical intervention was anticipated in this case. It was a pre term induction of labour in a case who had a previous normal vaginal delivery and there was no history of retained placenta in the first delivery.

Question: Do you think that the course of action adopted by you all was correct?
Answer: Yes to the best of our knowledge we adopted universally accepted & recommended standard protocol of investigation and followed the line of treatment with due care, precaution and skill. Decision of discontinuation of pregnancy made by the patient (being gynaecologist herself) and her husband was agreed by all of us on medical grounds as the stress of fetal abnormality of SUA & chromosome 22 abnormalities was affecting her asthma progression and was affecting her health both mentally & physically. In this hospital we work as a team of gynecologists with qualified specialists residents working under us.

If any other information is required, I shall be pleased to provide the same."

Statement of Dr.Alka Gujral vide letter dt.24.12.08:-

"In reference to my meeting with ethical Committee on 11th December 2008 regarding an appeal filed by Mr. Atanu Dutta against the Order of the Delhi Medical Council. I am submitting my reply to question asked from me.

Question – What was my role in her care?

Answer -That Dr. Rupa Dutta (deceased) was admitted in RAV Unit of the Mool Chand Hospital at 10 a.m. on 06.10.2003 on the advice of Dr. Raj Bokaria. It is submitted that Dr. Raj Bakaria, Dr. Alka Gujral (undersigned) and Dr. Veena Bhatt were working in a unit (R.A.V. Unit) it was the procedure of the said unit that the diagnosis, treatment, procedure and decisions were taken by the doctor, in whose care the patient had been treated. In the present case also the patient was admitted and treated by Dr. Raj Bokaria and I was supposed to assist Dr. Bokaria if and when asked to. I visited her once at 12 noon on 06.10.2003 on my routine round and cerviprime gel was applied, as advised by Dr. Raj Bokaria. I was not in the team of the doctors when the surgery was performed on the wife of the complainant/appellant herein or thereafter she was put on ventilator.

Since the deceased was a qualified doctor and had worked as Senior Resident with the MCKR Hospital in the past, we all knew her and when I came to know that she is on ventilator, I visited to the postoperative recovery room to know about her condition. When I came to know that she has been declared dead at 6.56 p.m. on 09.10.2003, I consoled the husband of the deceased on the demise of her wife, who gave in writing in my presence that "I am not willing to get my wife, Dr. Rupa's, post-mortem". Since I was present there, therefore, I put my signature as a witness on the statement of the complainant/appellant herein.

I was not involved in the treatment of the deceased, the wife of the appellant, therefore, the question of medical negligence against me does not arise.

In view of the aforesaid facts I humbly request you to reject the appeal filed by Mr. Atanu Dutta against me."

Statement of Dr. Vijay Langar_vide letter dated 22.12.2008 which is as under:-

"This meeting was held on 11.12.2008 at 2.pm at the Medical council's office in Dwarka. During the meeting, members of the Ethics Committee asked me various questions regarding the case filed by Mr. Atanu Dutta. I was asked to file written reply to the questions asked by Ethics Committee. Whatever questions I remember, I am giving answers thereto.

Question: Whether consent was taken for the procedure?

Reply by Dr. Vijay Langar: Yes, the consent was taken on hospital consent form which was in use in 2003 and the consent was signed by her husband. Copy of which is attached with this letter.

Question: Whether the feeding history was taken before taking the patient for the procedure?

Reply by Dr. Vijay Langar: Gynae Resident on duty intimated that patient is nil orally since morning inspite of that once the patient come to OT Dr. Rastogi asked Dr. Rupa Dutta if she had anything to drink or eat, which she denied.

If any other information is required, I shall be please to provide the same."

Statement of Dr. Naresh Rastogi vide letter dated 22.12.2008 which is as under:-

This meeting was held on 11.12.2008 at 2.pm at the Medical council's office in Dwarka. During the meeting, members of the Ethics Committee asked me various questions regarding the case filed by Mr. Atanu Dutta. I was asked to file written reply to the questions asked by Ethics Committee. Whatever questions I remember, I am giving answers thereto.

Question: Whether pre anaesthesia check up of the patient was done?

Reply by Dr. Rastogi: Yes, pre anaesthesia check up was done inside the OT itself as it was an emergency case. The examination part of this check up has been written by me in my notes in the case sheet.(Ref. page 17 of the case sheet)

Question: Did you ask about the food intake or feeding history of the patient?

Reply by Dr. Rastogi: Yes, I asked about the feeding history of the patient but she denied any history of food intake to me.

Question: Why did you not document this history in your pre anaesthesia check up notes?

Reply by Dr. Rastogi: Sir, this case was taken up as an emergency and patient developed complication of vomiting and aspiration during an attack of severe bronchospasm before any anaesthesia procedure. We got involved with the patient's management so much that I forgot to write about this feeding history in my notes.

Question: You could have written this in your notes later on or even after 2 days?

Reply by Dr. Rastogi: Initially, I did not realize the importance of documentation. When I realized it later, I thought that it is not legally correct to write or add any thing in the case sheet

once the case notes are deposited with the Medical Record Department. It may have amounted to tempering of records.

Question: Kindly narrate the sequence of events in detail?

Reply by Dr. Rastogi: Sir, as per my OT notes reference page 17 of the case sheet
Anaesthesia Notes (OT Notes) 8.10.2008 10.am to 1pm patient was brought to OT as an emergency case from Labour Room for manual removal of placenta. On Examination Patient has a wheeze as patient was a known case of bronchial asthma. Cardiac monitor was connected to the patient.

Examination at OT Table
O/E
Patient conscious, restless
Pulse-100/minute
BP- 110/70 mm of Hg
Chest- Wheezing bilateral
Oxygen Saturation- 95%

In view of this O2 by mask started and was positioned to see if there is any bleeding.

Patient was given Inj. Perimorm + Inj. Rantac IV mean while patient had sudden bronchospasm. Immediately injection Deriphylline and Inj. Decadron were given. Inj. Fulsed 1mg I/Vwas given as patient was restless.
An attempt to oxygenate the patient was made. Seeing the severe bronchospasm it was decided to intubate the patient to improve the oxygenation but before we could intubate. Patient had a massive vomiting and became further cyanosed.

Question: Was the patient bleeding or not?

Reply by Dr. Rastogi: Sir, I was at the head end of the patient, examining and connecting the cardiac monitor etc. Bleeding site was not visible to me.

Question: Was patient clinically pallor?

Reply by Dr. Rastogi: Yes, patient was looking slightly pale.

Question: Was patient put in lithotomy position?

Reply by Dr. Rastogi: Yes, patient was put in to lithotomy position for examination of any bleeding.

Question: Was the consent taken?

Reply by Dr. Rastogi: Yes, the consent was taken in a common hospital format. We had a common format for consent for all surgical cases. Our hospital had these types of consent forms in year 2003. Now these consent forms have been changed. If we take out any case sheet of operated cases in year 2003 we will have a similar type of consent forms.

Question: Was patient examined pre operatively?

Reply by Dr. Rastogi: Yes, patient was examined on the OT table itself after shifting from the stretcher.

O/E
Patient conscious, restless
Pulse-100/minute
BP- 110/70 mm of Hg
Chest- Wheezing bilateral
Oxygen Saturation- 95%

Question: What did you do then to the patient after examination?

Reply by Dr. Rastogi: Oxygen was started with mask through flowmeter. Bronchodilator and steroids were given as patient was having wheezing.

Question: Was patient given any sedation?

Reply by Dr. Rastogi: Yes, patient was given injection fulsed (midazolam) 1mg IV as patient was quite restless.

Question: Do you think GA can be given in emergency to full stomach patients?

Reply by Dr. Rastogi: Yes, GA can be given to full stomach patients after taking all necessary precautions. Crash intubation is done using cricoid pressure. But this patient had severe episode of bronchospasm after positioning into lithotomy position followed by desaturation, massive vomiting and aspiration before any anaesthesia could be planned or given. We are doing lots of emergency LSCS even in full stomach patients under GA at our hospital.

If any other information is required, I shall be please to provide the same."

viii) The following decision of the Ethics Committee taken at its meeting held on 31st March & 01st April, 2009:

"The Ethics Committee considered the matter and the report dated 27.10.2008 submitted by Dr. (Mrs.) Uma Pradhan, Hon'ble Member of Ethics Committee and decided that the expert opinion from Dr. Alka Kriplani, Prof. of Obs. & Gyanocologist, A.I.I.M.S. may be obtained in terms of the recommendation by Dr.(Mrs.) Uma Pradhan."

ix) the opinion dated 12/05/2009 from Prof. Alka Kriplani, Deptt. of Obst. & Gynaecology, A.I.I.M.S. which is stated as under:

"1. Dr. (Mrs.) Roopa Dutta under went amniocentesis at about 23-24 weeks of pregnancy for karyotyping which revealed abnormal prominent short arm of chromosome 22. To know the clinical significance and outcome of this abnmormality a Genetist/Fetal Medicine expert will be the appropriate person to opine.

2. For termination of pregnancy, patient received cerviprime, syntocinon, and misoprosto. All these drugs are used as standard medication for termination of pregnancy. Use of these drugs led to successful termination by vignal route in this case also."

x) The following decision of the Ethics Committee taken at its meeting held on 21st and 22nd May, 2009:

"The Ethics Committee considered the order dated 30/11/2007 passed by NCDRC, New Delhi against the order dated 21.02.2006 of Delhi Medical Council and noted that Dr.Alka Kriplani, Prof. of OBG, AIIMS, New Delhi has sent her comments/opinion; and now opinion from Prof. & HOD, Deptt. of Genetics from AIIMS, New Delhi may be obtained as recommended."

The Ethics Committee at its today's meeting while noting the above and considering all the documents, the statements of the Doctors and the expert opinion by the consultants decided to warn the treating doctors from Mool Chand Kharaiti Ram Hospital & Research Institute, New Delhi to be careful in their treatment of the patients."

The Executive Committee of the Council further observed that Prof. Alka Kriplani, Deptt. of Obst. & Gynae., AIIMS in her opinion dated 12.5.2009 has stated as under:-

1. Dr. (Mrs.) Roopa Dutta under went amniocentesis at about 23-24 weeks of pregnancy for karyotyping which revealed abnormal prominent short arm of chromosome 22. To know the clinical significance and outcome of this abnmormality a Genetist/Fetal Medicine expert will be the appropriate person to opine.

2. For termination of pregnancy, patient received cerviprime, syntocinon, and misoprosto. All these drugs are used as standard medication for termination of pregnancy. Use of these drugs led to successful termination by vignal route in this case also.

After due and detailed deliberations, the Executive Committee of the Council decided to refer the matter back to the Ethics Committee for reconsideration.

23. Application from Dr. B.B. Chowbey, President, Sonological Society of India seeking information under RTI Act, 2005.

Read: The matter with regard to application from Dr. B.B. Chowbey, President, Sonological Society of India seeking information under RTI Act, 2005 along with the recommendations of the Ethics Committee.

The Executive Committee of the Council considered the matter with regard to application from Dr. B.B. Chowbey, President, Sonological Society of India and decided to reiterate its earlier decision taken at its meeting held on 27.4.2009 which reads as under:-

"The Ultrasonography can be undertaken by a specialist who possess postgraduate qualification in the speciality of Radio-Diagnosis. However, specialist doctor in their speciality can also undertake Ultrasonography for the purpose of certification subject to the condition that he/she has undergone orientation training in the Ultrasonography in the department of Radio-diagnosis in a recognized medical institution under recognized medical teacher for a minimum period of 6 months wherein he has not only observed the procedure of Ultrasonography but also has undergone hands on training to enable him to practice in the field of Ultrasonography for the diagnostic purposes pertaining to his/her speciality."

24. (I) Appeal by Dr. Pramod Batra against order dated 04/02/2008 of Delhi Medical Council (F. No. 77/2008).
(II) Appeal by Dr. Archana Kothari against order dated 04/02/2008 of Delhi Medical Council (F. No. 87/2008).
(III) Appeal by Dr. Pradeep Kharbanda against order dated 04/02/2008 of Delhi Medical Council (F. No. 88/2008).

Read: The matter with regard to
(I) Appeal by Dr. Pramod Batra against order dated 04/02/2008 of Delhi Medical Council (F. No. 77/2008).
(II) Appeal by Dr. Archana Kothari against order dated 04/02/2008 of Delhi Medical Council (F. No. 87/2008).
(III) Appeal by Dr. Pradeep Kharbanda against order dated 04/02/2008 of Delhi Medical Council (F. No. 88/2008) along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 29th and 30th July, 2009 as under:-

"The Ethics Committee considered the ongoing matter of appeals by Dr. Pramod Batra, Dr. Archana Kothari and Dr. Pradeep Kharbanda received at different times but now clubbed together against the same, single order dt. 04.02.2009 of Delhi Medical Council and observed that Mr. Sandeep Gupta, the original complainant in Delhi Medical Council had been requested to appear before the Ethics Committee at its today's meeting i.e. 29th July, 2009 but he has again failed to appear; and therefore the Committee decided to proceed further with the consideration of the matter and noted:-

I. The following decisions of the Ethics Committee taken at its meeting held on 11th – 12th December, 2008:

(i) "The Ethics Committee considered the matter with regards to appeal by Dr. Pramod Batra against order dt. 4.2.08 of Delhi Medical Council and noted that Dr. Pramod Batra was asked to appear before the Ethics Committee and he has attended today. The Ethics Committee

gave a patient hearing to Dr. Batra's narrations/version. Dr. Batra also promised to make available all supporting evidence in his support within 15 days. His brief statement is as under:

"<u>Statement of Dr. Pramod Batra</u>

I Dr. Pramod Batra did my MBBS from LLRM Medical College, Meerut in the year 1979 and I have done DMRD from the same institute in 1986. My registration no. is 14856 of Delhi Medical Council. My date of birth is 10.04.1956.

I hereby undertaking to provide telephonic call records and other supporting evidence in the form of affidavit in my defense and also a written statement.

Sd/-
(Dr. Pramod Batra)
12.12.2008"

The Ethics Committee decided that Dr. Pramod Batra should make available his documents including telephonic call records and other supporting evidence in the form of affidavit and also his written statement within 15 days."

(ii) "The Ethics Committee considered the matter with regards to appeal by Dr. Archana Kothari against order dated 04/02/2008 of Delhi Medical Council. The Ethics Committee allowed Dr. M.C. Gupta to appear on behalf of Dr. Archana Kothari. He has submitted a written statement with annexures which Ethics Committee accepted. The Hon'ble Members of the Ethics Committee held a vide ranging discussion with the representative Dr. M.C. Gupta and found that he is unable to answer many queries regarding the treatment of this particular case. Therefore, the Ethics Committee felt that it is necessary to call Dr. Archana Kothari to be present in person in one of its next meetings before the Ethics Committee to answer these queries.

Dr. M.C. Gupta has been given 15 days time to submit any another material, if he so desires, in this case."

(iii) "The Ethics Committee considered the matter with regards to appeal by Dr. Pradeep Kharbanda against order dated 04/02/2008 of Delhi Medical Council. The Ethics Committee noted that Dr. M.C. Gupta brought out an authority letter from Dr. Pradeep Kharbanda representing him in this particular case. He has not submitted any written statement on behalf of Dr. Pradeep Kharbanda. The Ethics Committee allowed him to submit a written statement on behalf of Dr. Pradeep Kharbanda which he has claimed he would be giving.

The Ethics Committee felt that Dr. M.C. Gupta was unable to answer many points regarding the management of this case. Therefore, the Ethics Committee felt that it will be necessary to call Dr. Pradeep Kharbanda to appear before the Ethics Committee in person in one of its next meetings to reply to these queries. Dr. Pradeep Kharbanda may be called to appear before the Ethics Committee alongwith (i) the original and certified copies of records of this patient. (ii) Registers maintained in Krishna Medical Centre, New Delhi in original (iii) certified copies of reports given to the related authorities under PNDT Act (iv) admission register and other related documents to this case.

The Ethics Committee also decided to request Sh. Sandeep Gupta, husband of the deceased, to appear before the Ethics Committee at one of its next meetings."

II. The following decisions of the Ethics Committee taken at its meeting held on 21st – 22nd May, 2009 :-

(i) "The Ethics Committee considered the matter with regards to appeal by Dr. Archana Kothari against order dated 04/02/2008 of Delhi Medical Council and noted that Dr.Archana Kothari has been asked to appear before the Ethics Committee on 21.05.2009. She has submitted her oral as well as written deposition before the Ethics Committee which is as under:-

<u>Statement of Dr. Archana Kothari</u>

I Dr. Archana Kothari passed MBBS from L.L.R.M Medical College, Meerut in 1996 and done D.G.O from King George Medical College, Lucknow in 1999. My Registration no. 16936 registered with Delhi Medical Council.

Patient namely Mrs. Mamta (21) visited in emergency at 2.10 pm with complaints of excessive bleeding p/v since half an hour on 14.05.07. The patient didn't complied with the directions given on 12.05.07. When she came with history of bleeding p/v off and on since two months with preceding three months amenorrhoea after consuming abortifecient purchased from the local chemist two months back. On examination, her vitals were normal. P/A lower abdomen tenderness present. On P/V clots were present in the vagina os opened one fingure product of conception felt through open os. She was diagnosed as inevitable abortion and need immediate removal of product of conception. Thereafter the patient was shifted to Krishna Medical Centre. She was advised for ultrasound guided emergency D&C under sedation. Procedure was finished around 4.00 pm. The patient was shifted to recovery room by 4.05 pm well conditioned. The patient was regularly monitored and was found to be doing well as recorded in the case sheet recorded from time to time. In view of her satisfactory condition, it was decided to discharge her from the hospital at 7.30 pm. While the patient was coming out from the corridor of the hospital she fainted at 8.10 pm. On examination, she was found to be critical, gasping and had laborious breathing and was cyanosed. Her lungs were full of crepts. Pulse was not palpable, BP was not recordable and she could not be revived and was declared dead at 8.40 pm.

Therefore, I would like to state that condition of the patient at the time of discharge was well oriented and conscious and pulse rate 78/ min, BP 110/70 and there was no bleeding p/v. Abdomen soft. Chest was clear. There was sudden occurrence of gasping and laborious breathing accompanied by cyanosis and lungs full of crepts, suggests some sudden catastrophic event and not a gradual development of hemorrhagic shock. It is not possible to comment on the nature of such sudden catastrophic event. Possible causes might be pulmonary embolism and airways obstruction.

As explained above, the procedure was performed after taking due care as the Radiologist was associated with the procedure. The radiologist had examined the patient before the start of the procedure, was monitoring the patient throughout the procedure and also at the end of the procedure. Since, the radiologist had indicated that the products of conception were removed from the uterus and there was no fluid/blood in the POD, it was assumed that everything was alright. Even during the procedure, there was no indication to suggest that anything abnormal happened during the procedure. The patient was shifted to the recovery room and was examined by me. The condition of the patient was alright and nothing alarming was detected. After having satisfied myself about the condition of the patient I left for Krishna Hospital which was nearby to attend OPD. I again visited the patient, Mamta at 5.00 pm and examined her condition. Her vitals were sound and the patient was not suffering from any adverse condition. There was also no bleeding p/v.

I also instructed the staff at Krishna Medical Centre to regularly examine the patient and communicate the condition to me on telephone as I had to leave for Faizi Charitable Hospital for an emergency. I was regularly informed by the staff at KMC about the condition of the patient which suggested that the patient was doing fine as all her vitals were normal. At around 7.00 pm, I advised Dr. Kharbanda at KMC to discharge the patient as she was examined by him and reportedly in good condition. AS per records of the hospital, the patient was discharged at 7.30 pm on 14.05.07. I was only informed by the hospital at around 9.30 pm that the patient after being discharged died at 8.40 pm.

I would like to mention that seeing the condition of the patient when she had reported to me with excessive bleeding p/v, I had taken all precautions to do my best to help the patient. Since the patient had a large haematoma and was bleeding , I decided to associate radiologist so that the procedure is conducted in the best possible manner. Also the medical centre was a recognized centre by the Delhi Govt. and had the right facilities for the procedure. As mentioned above, the radiologist was associated throughout the procedure who stated that the patient was fine after the procedure was over. I examined the patient after the procedure and also at around 5 pm. The staff at KMC and Dr. Kharbanda, the owner of the centre were regularly monitoring the patient and informing me about the condition of the patient. As stated above, I advised to discharge the patient only after it was reported to me that the patient was fine and was well even after 3 hours after the procedure.

I would like to mention that I had taken all the precautions like associating a radiologist with the procedure, having the procedure done at a recognized medical centre and also the patient was monitored by Dr. Kharbanda and his staff.

I would like to bring out that I have adequate experience as a Gynaecologist as after completing my DGO, I was Sr. Resident in Sanjay Gandhi Memorial Hospital, Mangolpuri, New Delhi for 3 years and thereafter served in different nursing homes.

It is also stated that the Husband of the patient Mamata who had lodged a complaint has subsequently withdrawn his complaint and has stated in his statement that he has no complaint against the doctors who performed the procedure on his wife Mamata. A copy of the withdrawal letter by the complainant Sandeep Gupta to the SHO, Police Station is enclosed please.

I had also consulted my senior colleagues about this particular case and discussed with them about the procedure adopted by me to treat the patient Mamata who had reported to me in a bad condition. I am enclosing a letter by Dr. Vijay Kumar Kadam, Sr. Specialist (Gyne.) & Medical Superintendent, Mother & Child Hospital, GNCTD, Nasirpur, Delhi which also states that there is no evidence of medical negligence in this case and the death of the patient did not occur due to continued bleeding over several hours as a consequence of the D & C but rather it was a sudden, unavoidable catastrophic event unrelated to the surgical procedure, for which no one can be blamed.

In view of above, I would like to say that, I did my best to treat the patient Mamata. Whatever happened which lead to the death of the patient may not be attributed to negligence as I followed all the steps required. It was an unfortunate happening which has also saddened me.

I pray to the members of the Ethics Committee to sympathetically consider in view of the explanation submitted by me.

Q: Did you see the patient at the time of discharge?
A: I was involved in an emergency procedure and could not personally see the patient at the time of discharge. However, the condition of the patient was communicated to me by Dr. Kharbanda and his staff regularly and when they informed me around 7.00 pm that the patient had normal vitals from the time of the ending of the procedure at 4.00 pm till 7.00 pm I advised the KMC Staff to discharge the patient.
Q: Was the patient died in the same hospital where she was treated?
A: Yes.
Q: Is it not a routine practice to see the patients before discharging?
A: Yes, it is a routine practice to see the patients before discharging. However, there are circumstances on certain occasions when other patients report in emergency and have to be treated. In this particular case, I was called at Faizi Charitable Medical Centre for an emergency procedure and I had to rush there. Also the patient was being regularly monitored by Dr. Pradeep Kharbanda and his staff. The patient was discharged only after the condition of the patient was stated to be normal.

Q: If you say that the patient is stable then how the patient collapsed?
A: This fact was discussed by me with Dr. G.S. Vats, MD, Consultant Physician, Rajiv Gandhi Cancer Institute & Research Centre, Rohini who has brought out two possibilities for the same: -

(1) Pulmonary Embolism
(2) Aspiration.
Opinion of Dr. G.S. Vats is also enclosed, please.

Q: Do you agree that you failed to detect the uterine perforation?
A: During the procedure, there was no indication to suggest that the Uterine perforation had taken place. Generally when uterine perforation does take place, there are some indications to suggest the same. May be since the reported perforation did not cause significant bleeding this did not came to notice. However, to rule out perforation during procedure which may occur in 3 to 4% of the cases in the hands of competent surgeons as the literature of the subject suggests, I had associated Dr. Pramod Batra, Radiologist during the entire procedure. As brought out by Dr. Batra in his notes which have been submitted earlier (Copy enclosed) he has stated that after the procedure the cavity was empty and no fluid/blood in POD. Also during the procedure, it was never brought out by Dr. Batra that perforation had taken place. Only on these aspects as I did not notice any adverse incident during the procedure and also as reported by Dr. Batra in his findings, it was concluded that the procedure was rightly done and no perforation or any adverse incident had happened.

Q: Do you think that proper medical monitoring would have saved the life of the patient?
A: In this case, I monitored the patient after the procedure around 4 pm and also at 5 pm. Since I had to proceed for an emergency the patient was monitored by Dr. Kharbanda who is a very senior doctor and his staff. There is no indication to suggest that effective monitoring was not carried out. I and the staff of the hospital regularly monitored the patient.
Q: How the post mortem findings says that the patient died due to hemorrhagic shock caused due to the large perforation of the Uterus. How this perforation of uterus is caused according to you?
A: I would not like to contest the findings of post mortem report. However, I would like to bring out that the large amount of blood found in abdomen at autopsy could have been a leftover of haematoma which was detected by USG on 09.05.2007. Copy of USG report enclosed. This has also been brought out by Dr. G.S. Vats in his opinion which is also enclosed with this statement.

Sd/-
(Dr. Archana Kothari)

The Ethics Committee considered the matter and decided that the final decision would be considered in its next meeting after considering the matter of all appeal(s) filed by other doctors in this very case and which have been taken up separately as agenda items time to time. Accordingly, all agenda items pertaining to this particular case may be clubbed for arriving at a considered decision."

(ii) "The Ethics Committee considered the matter with regards to appeal by Dr. Pradeep Kharbanda against order dated 04/02/2008 of Delhi Medical Council and decided to give Dr. Pradeep Kharbanda and the complainant Mr.Sandeep Gupta one last and final chance to appear before the Ethics Committee in its next meeting failing which the Ethics Committee will be constrained to take ex-parte decision in this case."

(iii) While considering the matter of appeal against the order dated 04/02/2008 of Delhi Medical Council by Dr. Archana Kothari noted that other doctors in the same matter of order dated 04/02/2008 of Delhi Medical Council have also filed appeals at different times and the same are under consideration separately vide different agenda item(s) and therefore decided as under:

"……….. The Ethics Committee considered the matter and decided that the final decision would be considered in its next meeting after considering the matter of all appeal(s) filed by other doctors in this very case and which have been taken up separately as agenda items time to time. Accordingly, all agenda items pertaining to this particular case may be clubbed for arriving at a considered decision."

III. The following decision of the Ethics Committee taken at its meeting held on 08th & 09th July, 2009:-

"The Ethics Committee noted that Dr. Pradeep Kharbanda had been requested to appear before the Ethics Committee and he has appeared today before the Ethics Committee and has conveyed that he is interested to submit his written statement which was permitted by the Ethics Committee and the same is as under:-

Statement of Dr. Pradeep Kharbanda

"It is respectfully submitted that I attended the meeting of the Ethics Committee today, the 8th of July, 2009 as required. I hereby submit the following summary submissions as desired:

1--That I, Dr. Pradeep Kharbanda, passed MBBS from Meerut University, Meerut, in 1979. I had done my residency in Kasturba Hospital, Delhi, and Moolchand hospital, Delhi, for 2 years. Thereafter, in 1983, I started private practice as a family physician at 5/76, DDA Flats, Madangir, New Delhi-110062 at the ground floor. In the year 2004, I started on the first and second floor of the same building an MTP centre duly registered with the authorities. I am registered with the Delhi Medical Council vide Registration no. 9082. I have closed the above centre after the incident in question occurred.

2—That the present inquiry was initiated by the Delhi Medical Council on the complaint of the deceased patient's husband. The inquiry was held against the following: Myself as owner of the nursing home; Dr. Batra, the ultrasonologist and Dr. Archana, the gynaecologist. The Delhi

Medical Council held vide its order dated 4-2-08 that all the three doctors were guilty and suspended their licence to practice for 3 months.

3—It is submitted with respect that I am an MBBS doctor only and have nothing to do with this case except that I provided the facilities for the gynecological procedure and certified the patient as dead when she suddenly collapsed and could not be revived. I had no role to play in the gynecological procedure itself. There was no lapse on my part of any nature.

4—That my detailed appeal against the order of the Delhi Medical Council has already been submitted to the MCI. The present submissions are in addition to the same by way of summary and humble request.

5—That in the circumstances, there is no reason for holding me guilty of medical negligence since I did not provide any specific medical care in the first place. It appears that the patient collapsed some time after the operating surgeon had left the hospital. The ultimate responsibility for carrying out the surgery and anticipating and avoiding complications lies with the surgeon.

6—In the circumstances, it is requested that the finding of medical negligence against me as determined by the Delhi Medical Council may kindly be set aside and the punishment awarded to me may likewise be set aside. I shall be ever grateful for this act of kindness.

7—It is submitted that the complainant has already withdrawn the complaint from the Delhi Medical Council as well as the Police / FIR.. The copies of the same are enclosed.

A copy of the present submissions is being enclosed in the form of a CD also as desired."

Dated: 8 July 2009

Sd/-
DR. PRADEEP KHARBANDA
APPELLANT
5/76, DDA Flats
Madangir, New Delhi 110062

The Committee further noted that the complainant Mr. Sandeep Gupta had also been requested to appear before the Ethics Committee but has failed to do so. The Committee, therefore, decided to give one final chance to Sh.Sandeep Gupta to appear before the Ethics Committee failing which ex-parte decision will be considered."

The Ethics Committee deliberated in the matter in length and noting the above decided as under:-

"The Ethics Committee directs the removal of names of Dr. Archana Kothari (DMC registration No.16936), Dr. Pramod Batra (DMC registration No.14856) and that of Dr. Pradeep Kharbanda (DMC Registration No.9082) for a period of three months from the State Medical register. Restoration of the name of Dr. Archana Kothari, Dr. Pramod Batra and Dr. Pradeep Kharbanda in the State Medical Register will be subject to their attending Continued Medical Education programme in the field of their speciality, within the period of suspension and submitting a compliance report in this regard, to the Council".

The Executive Committee of the Council observed that there is nothing on record available before the Committee which would indicate the negligence by Dr. Pramod Batra who had carried out ultra-sonography on the patient Ms. Mamta.

In view of above, the Executive Committee of the Council decided to refer the matter back to the Ethics Committee for reconsideration.

25. Appeal by Mr. S.M. Jain against the Order dated 29.05.2007 of Delhi Medical Council.

Read: The matter with regard to Appeal by Mr. S.M. Jain against the Order dated 29.05.2007 of Delhi Medical Council along with the recommendations of the Ethics Committee.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 29th and 30th July, 2009 as under:-

"The Ethics Committee considered the ongoing matter with regards to appeal dated 27.07.2007 by Mr. S.M. Jain against the Order dated 29.05.2007 of Delhi Medical Council and observed that Dr. Saket Gupta had been requested to appear before the Ethics Committee at its today meeting i.e. 29th July, 2009 but he has again failed to appear; and therefore the Committee decided to proceed further with the consideration of the matter and noted:-

I. The following decision of the Ethics Committee taken at its meeting held on 10th & 11th August 2007:

"The Ethics Committee considered the matter with regard to appeal against the Order dated 29.05.2007 of Delhi Medical Council complaint made by Mr. S.M. Jain as well as Sir Ganga Ram Hospital, Delhi and the Ethics Committee decided that this case may be taken up as an appeal case and doctors involved viz. Dr. Alok Mathur, Dr. Pankaj Aggarwal, Dr. R.K. Gupta, Dr. Saket Gupta may be asked to send their parawise comments on this matter to the Ethics Committee within 21 days of receipt of this communication."

II. The following decision of the Ethics Committee taken at its meeting held on 6th & 7th December, 2007:

"The Ethics Committee considered the appeal against the order dated 29.05.07 passed by Delhi Medical Council on the complaint made by Mr. S.M. Jain and noted that Dr. Alok Mathur, Dr. Pankaj Aggarwal, Dr. R.K. Gupta & Dr. Saket Gupta were requested to submit their parawise comments on the complaint made by Mr. S.M. Jain as well as particulars of qualification and registration. The Ethics Committee further noted that Dr. Pankaj Aggarwal and Dr. Alok Mathur have sent their comments and particulars. The reply of Dr. R.K Gupta and Dr. Saket Gupta are still awaited. The Ethics Committee decided that a reminder may be sent to them to submit their reply within 15 days".

III. The following decision of the Ethics Committee taken at its meeting held on 07th & 08th July, 2008:

"The Ethics Committee considered the matter with regard to appeal by Mr. S.M. Jain against the order dated 29.05.2007 of Delhi Medical Council and decided to call the complainant and the treating doctors whose comments have been received. The HOD of Medicine, Maulana Azad Medical College, New Delhi may the requested to assist the Ethics Committee by giving his opinion/comments. All the relevant documents pertaining to this case may be sent to the HOD of Medicine at MAMC, Delhi."

IV. The following decision of the Ethics Committee taken at its meeting held on 21st & 22nd May, 2009:

"The Ethics Committee considered the matter with regards to appeal dated 27.07.2007 by Mr.S.M. Jain against the order dated 29.5.2007 of Delhi Medical Council and noted that the complainant Mr.S.M. Jain and the treating doctors – Dr.Saket Gupta, Dr. Alok Mathur & Dr.Pankaj Agarwal had been requested to appear before the Ethics Committee today i.e. 22.05.2009 but only Dr.Pankaj Agarwal and Dr.Alok Mathur have appeared today and their statements are as under:-

Statement of DR. Pankaj Kumar Agarwal

I, Dr. Pankaj Kumar Agarwal passed MBBS from Calcutta Medical College, Calcutta in the year 1981. I did MD (Medicine) from K.G. Medical College, Lucknow in the year 1985 and I have been working in Sir Ganga Ram Hospital since 1989.

At the time when the patient was admitted I was Associate Consultant in the unit of Dr. K.P. Jain i.e. Medical Unit-III and have been part of the treating unit. The patient came to Sir Ganga Ram Hospital on 25th August, 2003 with right lower lobe severe pneumonia at about 10 a.m. with shock. She was admitted in the Intensive Care Unit of the hospital and was treated by the Consultants of Medicine Unit III, Chest Unit of Dr. Neeraj Jain and ICU Unit alongwith other specialists. Her condition kept of worsening inspite of all the treatment given including

mechanical ventilation and she could not be saved. She expired on 28th August, 2003 due to severity of the disease process.

The complainant himself has mentioned on page 8 para 9 of the complaint that serious condition of the patient was told to him by Dr. K.P. Jain, admitting Consultant before admission while examining her in his private clinic. During her stay at Sir Ganga Ram Hospital, various doctors have prognosticated the attendants nine times, as mentioned in the case sheet with date and time, list of which has already submitted. Medical records are in the custody of the hospital administration and Medical Records Department of the hospital and I have no control or authority to give it. The complainant's previous questions and queries have been answered. The patient was being managed by a team of Consultants in the Intensive Care Unit of the hospital rather than by any one doctor but she did not respond to any treatment and expired due to the severity of the illness.

Sd/-
(Dr. Pankaj Kumar Agarwal)

22nd May, 2009.

Statement of Dr.Alok Mathur

I, Dr.Alok Mathur passed my MBBS from MAMC, New Delhi in the year 1978 and after that I started practicing in Vasant Vihar in my own clinic.

On 21.8.2003, Mrs.Jain came to my clinic and complaint of irritation in the throat with slight bodyache for which I prescribed for decongestant syrup and antipyretic for the bodyache. On clinical examination all vitals were normal but slight congested throat. On 24th of August, 2003 I was called at the residence of the patient as she was complaining of severe pain the throat and slight fever. The patient was sitting comfortably all vitals were stable. There was slight congestion in the throat and few scattered crepts in the chest. Considering this as lower respiratory infection I started her on antibiotic and cough expectorant and antipyretic because of pain in throat she was also given tantum gargles. After this there was no response from the patient's end.

Sd/-
(Dr.Alok Mathur)

The Ethics Committee considered the matter and decided that – i) the complainant Mr.S.M. Jain and the treating Dr.Saket Gupta be given a final chance to appear before the Ethics Committee; ii) Dr.Richa Diwan, Prof. & HOD, Medicine, MAMC, New Delhi should be sent a reminder to solicit her expert opinion as earlier decided."

V. The following decision of the Ethics Committee taken at its meeting held on 08th & 09th July, 2009:

"The Ethics Committee considered the ongoing matter of appeal dated 27.07.2007 by Mr. S.M. Jain against the Order dated 29.05.2007 of Delhi Medical Council and noted that Dr.Saket Gupta and Mr.S.M. Jain had been requested to appear before the Ethics Committee on 09.07.09. Dr. M. C. Gupta has appeared before the Ethics Committee on behalf of the complainant Mr. S. M. Jain and discussed the matter verbally and gave the statement on behalf of Mr.Jain, the same is as under:-

Statement of Dr. M. C. Gupta

(Appeared on behalf of the complainant Mr.S.M. Jain)

I, Dr. M. C. Gupta stated that Dr. Alok Mathur did not examine the patient properly, did not make a proper diagnosis because he missed vital findings which were not examined and he gave medicines which were not warranted and which were possibly responsible

for causing serious side effects especially Renal failure, leading to death. He also prescribed the same medicines under two different brand names either knowingly or unknowingly. About the hospital doctors, the Medical Superintendent of the Ganga Ram Hospital did not provide treatment record inspite of personal requests and two legal notices over a period of three years. When the National Commission ordered for supply of records within three days, they were supplied after 13 days. This raises suspicion of tampering with records specially in view of the fact that Dr. R. K. Gupta treated the patient (as shown by the visits made by him and the visiting

charges in the bill and also by the fact that the death certificate was supposed to be sent by him) but the hospital said in their reply that Dr. R. K. Gupta did not treat the patient at all. There is also an affidavit from the complaint's daughter that he used to treat him.

This is my submission.
Thanking you,

Sd/-
(Dr. M. C. Gupta)

The Committee noted that Dr.Saket Gupta had been requested to appear before the Committee but he has failed to do so and therefore the Committee decided that a final chance be given to Dr.Saket Gupta before deciding the matter ex-parte."

The Ethics Committee deliberated in the matter and noting the above decided to uphold the order/decision dt. 29.05.2007 of the Delhi Medical Council, the operative of part of which is as under:-

".....No medical negligence could be attributed in the treatment of the patient and further that a warning is issued to Dr. Alok B. Mathur with a direction to adopt accepted protocol whilst examining patients in future."

After due and detailed deliberations and perusal of the above stated submissions, the Executive Committee of the Council decided to approve the recommendations of the Ethics Committee that "*no medical negligence could be attributed in the treatment of the patient*".

33. Failure of MCI to communicate the decision of its Ethics Committee to Union Health Ministry in the case of expulsion of Dr. C.D. Prashar – Govt. letter dated 22/06/2009 regarding.

Read: The matter with regard to Failure of MCI to communicate the decision of its Ethics Committee to Union Health Ministry in the case of expulsion of Dr. C.D. Prashar – Govt. letter dated 22/06/2009 regarding.

The Executive Committee of the Council observed the following decision of the Ethics Committee taken at its meeting held on 29th and 30th July, 2009 as under:-

"*The Ethics Committee considered the letter dated 22.6.2009 received from the Central Government, Ministry of Health & F.W., New Delhi with regards to failure of MCI to communicate the decision of its Ethics Committee to the Govt. and noted:*

i). The decision of the Ethics Committee taken at its meeting held on 28th & 29th Nov., 2005 with regards to the then ongoing matter of complaint vide letter dated 07/11/2000 against Dr. C.D. Prashar by Brig. V.S. Grover (Retd.).

ii). The Council subsequently received a letter dated 17.10.08 from Brig. V.S. Grover (Retd.) under RTI Act with regards to progress of the case and thereafter certain more related queries under RTI Act were received and replied/ pending.

iii) It's only after the receipt of queries from Brig. V.S. Grover (Retd), it became apparent that there had been no headway in the matter even after the decision of the Ethics Committee in Nov. 2005 and in addition, the related file was not traceable in the Ethics Section.

iv) The President (Acting), as per the advice by the Secretary for initiation of departmental action, directed that this matter of decision of the Ethics Committee having been not placed before Executive Committee/ General Body and the file being purportedly untraceable in section be inquired by Dr. P. Kumar, Additional Secretary.

v) The related enquiry reports – (I & II) - submitted by the Additional Secretary vide letters dated 22.01.09 & 03.07.09 respectively are enclosed in the agenda item and the same are exhaustive and self-explanatory; and these reports are already submitted to the authorities concerned.

The Ethics Committee after noting the above and deliberating in length was unanimously of the opinion that a lapse of such a magnitude of not putting the decision of the Ethics Committee before the Executive Committee and General Body of the Council for such a long interlude of time is a serious lapse on the part of the accountable officer/employee of the Council Office.

The Ethics Committee, after due deliberation, directed that the responsibility of the officer/employee responsible for this lapse – long pendency of the matter and the file going missing - be fixed so that such incidence is not repeated in future and place the same before the Executive Committee alongwith the decision of the Ethics Committee taken at its meeting held on 28th/29th Nov., 2005 for further necessary action."

The Executive Committee of the Council further observed that the relevant file was marked to the then Law Officer of the Council on 23rd December, 2005 as shown in the Movement Register and no further record is available. File could not be found thereafter.

The Executive Committee further observed that Dr. C.D. Prashar has been given enough opportunities to appear before the Ethics Committee by calling him five times but he had failed to appear on all the occasions. He has not provided copies of the certificates of Ph.D. (Germany) degree and FRSTMH/DTM&H with proof that he was a Consultant of CIDA. CIDA has categorically stated that Dr. Prashar was never its Consultant.

In view of above, the Executive Committee of the Council decided to approve the recommendations of the Ethics Committee to recommend to the General Body of the Council that the name of Dr. C.D. Prashar be erased from the Indian Medical Register for a period of 6 months.

34. <u>Proposal for approval of points for the better & efficient way of handling the Agenda & disposal of the cases in time – Suggestion received from the Chairman Ethics Committee.</u>

Read: The certain points of Chairman, Ethics Committee for the better & efficient way of handling the agenda & disposal of cases in time by the Ethics Section & Committee.

The Executive Committee of the Council observed that the Chairman of the Ethics Committee vide his letter dated 28.8.2009 has submitted certain suggestions for better and efficient way of handling the agenda and disposal of cases in time by Ethics Section and Ethics Committee of the Council.

After due and detailed deliberations, the Executive Committee of the Council approved the suggestions of the Chairman, Ethics Committee as under:-

Sr. No.	Suggestion of the Chairman	Remarks
1.	The Ethics Committee has to meet on Wednesday and Thursday of the third week of every month. It can be postponed to fourth week if religious / national holiday falls on that day.	It would be desirable if the Ethics Committee meets twice a month for two days each to clear the pending backlog of cases.
2.	Emergency meeting of the Ethics Committee can be ordered by President / Executive Committee members / Secretary of MCI. Then the Committee can meet on a specified date to discuss those agenda.	The emergency meeting of the Ethics Committee can be called by the President, Chairman of the Ethics Committee or Secretary of the MCI.
3.	Agenda that are referred to the Ethics Committee should be disposed off after careful consideration within three months period, and in extraordinary circumstances the Committee can take time up to six months. The reason for not disposing within three months should be recorded in the minutes.	Regulation 8.7 provides for the period of 6 months for disposal of a complaint by the concerned Medical Council. The same proviso should be made applicable here also and only when the complaint would not be disposed off within the limit of six

		months as prescribed in Regulations, the reasons be recorded in the minutes. However, all efforts should be made for early and expeditious disposal of the complaints.
4.	When persons are called to appear before the Ethics Committee for interrogation, they should be given three opportunities at monthly interval to express their view points. If they fail to appear even after the third opportunity before the Ethics Committee, it will be construed that they have nothing to say against the allegation and ex-party decision will be taken as per the information available on the records.	Accepted.
5.	Review of cases by the Ethics Committee will only be undertaken on the direction of the President, MCI or the Executive Committee of MCI or under the direction of the Hon'ble Court.	The review of the cases by the Ethics Committee will be undertaken under the direction of the President or the Chairman of the Ethics Committee.
6.	Supplementary agenda and Table agenda may be avoided unless it is of urgent in nature.	Accepted
7.	The agenda for the Ethics Committee should be sent 15 days in advance in CD / e-mail to all members of the ethics committee for them to study the agenda in detail as many cases are of quasi judiciary in nature.	
8.	Any punishment recommended by the ethical committee and subsequently approved by executive committee and general body is not only binding on the errand Doctor but also on the Principal and Management Trustee of the institutions, if they are also responsible for that mistake. (Such as in cases of Doctors working in more than one institution simultaneously).	There cannot be blanket order of this kind as there may be instances where the Principal may not be aware that the concerned teacher is working at more than one medical institute simultaneously. Hence, each case has to be decided on merit. Further, if the management trustee is not a medical person, he would not be covered by the code of ethics. The Executive Committee is also recommending lodging the FIR in such cases which is the only applicable action in such cases.
9.	Wherever the medical negligence has caused the death of a patient, the suspension of the doctor from state medical registration should be for a minimum period of 1 year and above.	There cannot be a blanket for minimum period of punishment and each case has to be decided on merit.
10.	Wherever the medical negligence has caused morbidity but not caused mortality the suspension of the doctor from state medical registration should be for a minimum period of six months and above.	This should depend upon the grade of the morbidity caused by the negligence and punishment should commence from censure onwards. Removal for 6 months would be too harsh for minor case.

11.	Wherever the state medical council is functioning the cases are to be referred to the functioning state medical council and are to be disposed of by them within a period of 4 months time and in extraordinary circumstances it should be disposed off within six months time. Any delay in disposing within the stipulated time the reason for the delay has to be informed to the Ethics Committee of Medical Council of India, New Delhi.	Wherever the state medical council is functioning the cases are to be referred to the functioning state medical council and are to be disposed of by them within a period of 6 months time and in extraordinary circumstances it should be disposed off within six months time. Any delay in disposing within the stipulated time the reason for the delay has to be informed to the Ethics Committee of Medical Council of India, New Delhi.
12.	Appeal made against the decision of the state Medical Council or cases directed by the Hon'ble Court should be disposed off by the Ethics Committee within six months time.	Appeal made against the decision of the state Medical Council or cases directed by the Hon'ble Court should be disposed off by the Ethics Committee within six months time as stipulated under Regulations.
13.	Decision already taken by the Executive Committee and the General Body can be reviewed only when directed by Government of India or by the Hon'ble Court.	The review of decision can always be undertaken by the concerned body itself i.e. the MCI. It is not required to restrict the review only when directed by the Government of India or by the Hon'ble Court.

48. <u>Appeal by Vikramkumar D. Sanghvi and Dr. Ravi Patel against order dated 30.05.2009 of Maharashtra Medical Council.</u>

Read: The with regard to Appeal by Vikramkumar D. Sanghvi and Dr. Ravi Patel against order dated 30.05.2009 of Maharashtra Medical Council.

The Executive Committee observed the following decision of the Ethics Committee taken at its meeting held on 8-9th October, 2009 as under:-

"The Ethics Committee considered the matter with regards to appeal by Dr. Vikramkumar D. Sanghvi and Dr. Ravi Patel against order dated 30/05/2009 of Maharashtra Medical Council and noted that the complainant as also the Doctors namely Dr. Vikramkumar D. Sanghvi and Dr. Ravi Patel had been requested to appear before the Ethics Committee at its today's meeting i.e. on 08.10.09. Dr. Vikramkumar D. Sanghvi and Dr. Ravi Patel and Mr.Abdul Qadir on behalf of the complainant have come to appear before the Committee. Their statements are as under:-

<u>Statement of Mr. Abdul Qadir</u>
<u>(on behalf of the complainant)</u>

The Ethics Committee considered the appeal by Dr. Vikramkumar D. Sanghvi and Dr. Ravi Patel against order dated 30.05.2009 of Maharashtra Medical Council and noted that the complainant Dr. Ujala Ambikaprasad Pathak as also Dr. Vikramkumar D. Sanghvi and Dr. Ravi Patel were requested to appear at 2.30 p.m. before the Ethics Committee of the Council.
One Mr. Abdul Qadir has claimed that he is appearing on behalf of complainant Dr. Ujala Ambikaprasad Pathak.

On being asked if he is carrying some authority letter on behalf of the complainant. He replied that he is not carrying any authority letter on behalf of the complainant. One Mrs. Nilofar Quareshi had represented this complainant's case before the Hon'ble High Court of Mumbai and I am her junior and in that capacity I am appearing before the Ethics Committee. A Vakalatnama which the advocate filed on behalf of the complainant before the Hon'ble High Court of Mumbai, a copy of the same is being presented before the Ethics Committee which shows that he is junior to the advocate representing the complainant at the Hon'ble High Court of Mumbai.

Q. Do you want to bring to the notice of the Committee anything new other than what has been already brought out to the notice of the Committee and Hon'ble High Court of Mumbai?
A. I have not prepared anything about the case to represent before the Committee.
Q. Are you aware of the order of the Hon'ble court in the case?
A. I am not much aware of the case.

Sd/-
(Abdul Qadir)
Dated: 08.10.2009

Dr. Vikram D. Sanghvi appeared before the Ethics Committee on 8th October 2009 at 3.00 pm and answered the questions put forward by the Ethics Committee.

Statement of Dr. Vikram D. Sanghvi

I Dr. Vikram D. Sanghvi passed MBBS in 1972 from M.P. Shah Medical College, Jamnagar. My Registration no. 31303 registered with Maharashtra Medical Council. Done M.S. from Bombay University in 1977
Q: 1 Are you the person who operated on the patient, Mr. Alok Pathak?
Ans: Yes.
Q: 2 Who helped you in the operation?
Ans: Dr. Ravi Patel.
Q: 3 What was your clinical diagnosis?
Ans: Cancer of the right buckle mucosa including a retro molar area. It was stage three cancer.
Q: 4 How do you come to the conclusion that it is stage three cancer?
Ans: Because of the muscles involvement, I considered this as a stage three cancer.
Q: 5 Do you asked for the X-ray of the mandible?
Ans: Yes.
Q: 6 Do you know that the mandible was involved or not?
Ans: I don't remember.
Q: 7 Did you asked for the ultrasound of the affected region underneath?
Ans: Yes.
Q: 8 Is there any involvement of the gland in that report?
Ans: I have not seen the report.
Q: 9 Why did you did hemi-mandible in this case?
Ans: It is have a wider margin of excision.
Q: 10 In your opinion it is a major surgery or minor surgery?
Ans: I don't call it as a major surgery but it is also not a minor surgery.
Q: 11 What do you think whether radical surgery is a major surgery or minor surgery?
Ans: It is a major surgery.
Q: 12 How many hours did you take to perform this surgery?
Ans: Total 3 hours including the anaesthesia time that was 20 minutes before and 20 minutes after.
Q: 13 A surgery requiring the time of more than 3hrs is considered as a major surgery. Do you agree?
Ans: Yes. I agree.
Q: 14 From how many years this nursing home is functioning?
Ans: From 1984 onwards.
Q: 15 How many beds are there in this nursing home?
Ans: There are 18 beds in this nursing home.
Q: 16 How many staff nurses are working in this nursing home?
Ans: Total 6 staff nurses are working in this nursing home.
Q: 17 How many residents doctors are working in this nursing home?
Ans: 2 Resident doctors to cover 24 hours.
Q: 18 Is there any Intensive Surgical Care Unit in this nursing home?
Ans: There is no Intensive Surgical Care Unit.
Q: 19 How many surgeries are being done in this nursing home?
Ans: I don't know.
Q: 20 In the recovery room how many beds are there?
Ans: There are two (2) beds in the recovery room.
Q: 21 Do you write the detail notes of the surgery you are doing?
Ans: Yes. I always write.
Q: 22 Have you written any detailed surgical notes in this particular patient's case?
Ans: Yes.
Q: 23 Can you show from the records that you have prepared detailed surgical notes in this case?
Ans: Yes.

Q: 24 When did you see the patient last?
Ans: At 12.30
Q: 25 At what time you started the surgery?
Ans: Around 8.30 a.m.
Q: 26 Did the patient recovered after the anaesthesia?
Ans: Yes.
Q: 27 How do you decided that the patient is recovering from the anaesthesia?
Ans: Because the patient responded to the command that was given to him like open your eyes, open your mouth, show me your tongue. He opened his eyes.
Q. 28 Who removed the stitches from the tongue?
Ans: Theatre Assistant removed the stitches.
Q: 29 At what time the stitches were removed?
Ans: It is removed around 4 O' clock.
Q: 30 Why did the theatre assistant removed the stitches and not the doctor?
Ans: Dr. Patel can answer that?
Q: 31 You agreed that you performed the major surgery as it lasts for three hours. Was there any medical officer present at that particular time?
Ans: No medical officer was present after 3 O' clock in the nursing home.
Q: 32 Who takes the care of the patient when the emergency arises in major cases?
Ans: I and Dr. Patel. Dr. Patel stays nearby the nursing home.
Q: 33 How many kilometres away is Dr. Ravi Patel's residence from the nursing home?
Ans: 1.5 kms away from the nursing home.
Q: 34 In post operative cases, emergency arises at any time. Do you agree?
Ans: Yes.
Q:35 Was the UCG monitor was attached to the patient subsequently?
Ans: Monitor is there in the O.T. and the Recovery Room.
Q: 36 Does the nurse prepares the notes in the post operative period?
Ans: Yes.
Q: 37 Do you have one single nurse from 7 am to 8 pm on that day?
Ans: Yes I agree that the same nurse was attending the patient from 24.09.2007 11 p.m till 25.09.2007 8 p.m. upto the death.
Q: 38 Have you put your post operative note in the case sheet after the operation was over?
Ans: Yes.
Q: 39 The call was sent from nurse regarding the breathing problem to the Dr. Ravi Patel at 6 pm and he reached at 7.40 pm, why did it took so long to Dr. Ravi Patel to reached the hospital?
Ans: Dr. Ravi Patel can answer this question.
Q: 40 At what time you have reached the hospital?
Ans: I reached at 8.05 pm.
Q: 41 Was the patient examined between 6 pm to 7.40pm?
Ans. No.
Q: 42 Did you give any instruction to the nurse when she called you?
Ans: Nurse informed to Dr. Ravi Patel about the patient. I received a call from the patient's son. And Dr. Ravi Patel has already given the instruction to the nurse.
Q: 43 What do you think the cause of death of the patient in your opinion?
Ans: In my judgment it could be sudden cardiac death.
Q: 44 Do you agree that the patient died due to the lung collapsed?
Ans: It can occur.
Q: 45 Why did you choose 25th September being Ganesh Chaturthi, the date of operation?
Ans: I have suggested 26th but the son of the patient insisted for 25th the day for operation.
Q: 46 When there was no ICU and no other facilities were there in the nursing home, why did you operate the patient in that nursing home?
Ans: Because certain operations were already conducted in this nursing home.
Q:47 Do you agree that the fair detailed enquiry was conducted on you by the Ethics Committee?
Ans: Yes.

Sd/-
(Dr. Vikram D. Sanghvi)

Statement of Dr. Ravi Patel

The Ethics Committee enquired Dr. Patel on 8.10.2009 at 4.15 p.m. in the Council Office, and he has given the following answers for the questions put forward by the Ethics Committee of the Medical Council of India.

Q. 1. From how many years, you have been practicing as a surgeon?
A. I am practicing as a Surgeon since 1979, I have done my MBBS in 1975.

Q.2 Did you operate the patient?
A. Dr. Sanghvi was the primary surgeon and I was assisting him in this case.

Q.3. It is a nursing home belongs to you?
A. Yes.

Q.4 When the Nursing Home started?
A. The Nursing home was started in January 1981.

Q.5. How many beds you have in the nursing home?
A. 19 Beds are available in the nursing home.

Q.6. Do you have intensify surgical care room in your hospital?
A. No.
We have recovery room having of two beds. It is very close to the operation theater.

Q.7. Do you have ABG study in your hospital?
A. No, we do not have the same. We sent to Nanawati Hospital, which is very close, if necessary.

Q. 8 How far your home is from nursing home?
A. My home is approx. 1 Km from the nursing home.

Q.9. How much time have you take to reach the nursing home?
A. I have taken 3-4 minutes to reach the nursing home.

Q.10 How long patient in shifted?
A. Patient was shifted at 11.00 am till he was in the recovery room till 8.00 p.m.

Q. 11.Normally how long keep the patient in the recovery room?
A. We keep at least 24 hours. Next day I observe the patient.

Q.12. How many operation you do per day(an average)?
A. Both minor and major, we catch 3-4 operation per day. Average 7-8 major operations in a month including emergency surgery also.

Q.13 Is this a major surgery or minor surgery?
A. It is a major surgery, according to me.

Q.14. What type of anaesthesia was given to the patient?
A. General anaesthesia was given with intubation.

Q.15. In your opinion, did the patient recovered fully in the recovery room?
A. Patient was out of anaesthesia and fully recovered by 12.30 a.m. and responding.
Q.16. Did you see the tongue?
A. Patient showed the tongue. He was moving the tongue.

Q. 17.Who removed the stitches of the tongue?
A. Theater Assistant(trained man) removed the stitches of the tongue.

Q.18. Why the tongue stitches was removed after the doctor had left the hospital?
A. Patient was restless due to pain. Hence it was removed.

Q.19. Whom did he complain about the tongue pain?
A. He was complaining about the tongue pain to the nurse and nurse informed me telephonically. I give him instructions on telephone to remove the stitches.

Q.20. When did you leave the hospital?
A. I left the hospital at about 3.00 p.m.

Q. 21.If you take 2-3 minutes to reach the hospital, why did you instruct theater assistant to remove the stitches?
A. Because the patient was alright at 3.00 p.m. and I decided to leave the hospital as all the parameters were O.K.

Q.22. Who had seen the patient from 3.00 p.m.? Was any doctor available after 3.00 p.m.?
A. I have seen the patient at 3.00 p.m. No doctor was available after 3.00 p.m. Only nurse and theater assistant were available in the hospital.

Q.23 Do you know that duty doctor has left the hospital?
A. Due to Ganesh Visarjan, I give him the permission to leave the hospital.

Q.24. Why did you take up the surgery on that particular day as you know that day was a bad day in your opinion?
A. From the request of the patient, I did the operation. I made a mistake that I had left the hospital at 3.00 p.m. and I, myself permitted duty doctor to leave the hospital at 3.00 p.m.

Q.25. When do you know the condition of the patient was bad?
A. At 6.00 p.m., patient was finding difficulty in breathing.

Q.26 What instructions you given to the nurse?
A. I asked the nurse to give an injection of Efcorlin over telephone.

Q.27 Why did you given Efcorline to the patient (a post-operative patient)?
A. I thought it was lung spasm.

Q. 28 Why did you given Deriphyllin without seeing the in the post operative period?
A. I thought that it was a bronchitis.

Q. 29.As per the nurse, condition of the patient became better after Efcorlin?
A. Again nurse telephoned at 6.30 p.m. as the condition was bad and I reached the hospital at 7.40 p.m.

Q.30 What did you do after reaching the hospital at 7.40 p.m.?
A. At 7.40 p.m., patient was having difficulty in breathing. I intubated the patient immediately and given him ventilation through Ambu bags. The patient was not conscious at that time.
Q.31 You reached at 7.40 p.m. and intubated the patient, was the patient conscious at that time?
A. Patient was unconscious at that time.

Q.32 How did you diagnosed a cardiac arrest at 7.40 p.m.?
A. By Stethoscope.

Q.33. When did you recognise the cardiac arrest?
A. After intubation I realise the patient had cardiac arrest.

Q. 34 How do you know the heart has stopped?
A. The heart sounds were not heard. That time the patient was not on monitor.

Q.35. What time monitor had been disconnected and why?
A. At around 5.00 p.m.

Q.36. Did you have a defibrillator?
A. Yes.
Q.37. Why did you disconnected the monitor at 5.00 p.m. and who disconnected the monitor?
A. The nurse disconnected the monitor.

Q.38 Who instructed the nurse to disconnect the monitor when a medical officer was not there?
A. The patient was moving too much, nurse herself disconnected the monitor. She had informed me and after informing me she removed the monitor.

Q. 39.Did you record the same in the case file?
A. It has not been recorded in the records that monitor was disconnected.

Q.40. Was the throat suction done in this patient?
A. Yes

Q.41. Is it in the record?
A. No it has not been in the record.

Q.42 How do you know, it has been done?
A. I do not know whether it has been done or not. I know the suction was done because I have belief in my staff.

Q.43 Do you expected intravenus adrenaline to be effective when there was no circulation in the patient due to cardiac arrest?
A. I do not expect it to be effective.

Q.44 Did you record ECG of this patient after cardiac arrest?
A. ECG was not recorded.

Q.45 Did you contact any doctor or physician for this emergency?
A. I contacted the doctor at 7.30 p.m. but because of traffic problem he could not reach.

Q.46 Has any Chest x-ray was done of this patient?
A. No.

Q.47 Do you think that ECG and x-ray are vital test when patient was suffering from breathing problem?
A. Yes.

Q.48. Insulin was given, Do you think that Insulin may have produced hypoglycaemia, which leading cardiac arrest?
A. I don't think so.

Q. 49 What do you think the cause of death in this case?
A. Sudden cardiac arrest, because of the patient was already suffering certain diseases like diabeties.

Q.50 Don't you think, it is all the more a serious reason for duty medical officer to be there in the post operative period?
A. Yes

Q.51. Do you think the patient was died because of aspiration and pulmonary collapse?
A. I do not agree.

Q.52 The post-mortem showed there is a partial lung collapse and there was blood in the lungs?
A. Yes

Q.53. Do you think that the Ethical Committee is fair in questioning you?
A Yes

Q.55 Do you want to say anything else or any extra points want to recorded?
A. No

Thanking you,

Sd/-(. Ravi Patel)

The members of the Ethics Committee discussed and deliberated in detail in the case and noted the following salient points from the records available with them and answers replied for questionnaire put before them. They have also read in detail various affidavits, statements, Maharashtra Medical Council proceedings.

1. *It is said by Dr. Vikramkumar D. Sanghvi that "he (patient relative) inspected PNH and facilities available at operation theatre, recovery room, patient accommodation etc. very carefully and then said he is satisfied". There is nothing in the record to confirm that statement.*

2. *Dr. Sanghvi has said in his statement "inspite of comprehensive treatment nearly 25 to 30% recurrence of cancer are observed and cure cannot be guaranteed". The doctor has not recorded this in the case sheet while taking concurrence from the patient.*

3. *Dr. Sanghvi left PNH after 12.30 p.m.. After that he has not come back and examined the patient when he was alive.*

4. *The Blood Sugar of the patient was 267 mg at 1.30 p.m. After that there is no record of Blood Sugar done for in a diabetic patient during post operative period.*

5. *Dr. Ravi Patel left PNH at 3.00 p.m. After that no Medical Officer neither he nor any other medical officer had examined the patient till 7.40 p.m.*

6. *Tongue stitches removed at 4.00 p.m. by Theatre Assistant and not by a doctor or staff nurse.*

7. *As per the statement of Dr. Sanghvi he received phone calls from Dr. Pathak around 7-7.15 p.m. , he has informed that he has not received any phone call from the staff nurse about breathing difficulty and perspiring.*

8. *At 6.00 p.m. when the patient was suffering from breathing difficulty the instruction to give Efcorlin and Deriphyllin was given by Dr. Ravi Patel without examining the patient.*

9. *No Physician was requested to see the patient when he was alive even though a Physician is claimed to be attached with the Nursing Home.*

10. *No ECG or X-ray Chest was done when the patient had breathing difficulty and sweating.*

11. *Dr. Ravi Patel said when he reached hospital at 7.40 p.m. he observed the BP was not recordable and the patient was gasping for breath. Even at that time neither ECG nor X-ray Chest nor Blood Gas Study was done.*

12. *No pressor agent like dopamine was given to raise the B.P. when B.P. was not recordable.*

13. *Dr. Ravi Patel has said that he used to come in short notice to the Nursing Home when he gets a phone call from the staff nurse during emergency. In this case, he had taken one hour and 40 minutes to reach the Nursing Home.*

14. *As per their exhibit number 9 Ventilator was available and 3 Suction Machines were available. Patient was not put on Ventilator when his condition was serious, nor any evidence available in the case sheet about usage of suction apparatus during post operative stay in the recovery room.*

15. *There was no Surgical ICU in the Nursing Home.*

16. *Why Deriphyllin and Efcorlin was given without examining the patient by the doctor, the doctor was unable to answer properly. For cardiac arrest, Adrenaline was given intravenously and not by the intracardiac route.*

17. *No ECG Monitor was attached when the patient became bad after 6 p.m. In fact, during questioning Dr. Ravi Patel has admitted that the Monitor was removed at 5.00 p.m. by the staff nurse.*

18. *There were only 6 staff nurses for 24 hours coverage for the entire Nursing Home which has 19 beds.*

19. *There was only one duty doctor at a time to cover all the 19 patients in the Nursing Home. Total 2 R.M.O. were working by shift system.*

20. *On the day of incidence, the one doctor who was R.H.O. was permitted by Dr. Ravi Patel to leave at 1.00 p.m. and no coverage by any doctor nor any alternate arrangement were made to take care of the post operative patients.*

21. *Ketones in Urine had not been checked during post operative period in a Diabetic patient who had undergone a major surgery.*

22. *It is seen from the Post mortem report, atherosclerotic changes were seen in the coronary arteries but there is no evidence of obstruction resulting in Mycardial Infaction as cause of death in this patient.*

23. *Both the lungs were partially collapsed and cut section of the lungs showed bloody frothy fluid.*

24. *Stomach showed 200 ml of dark coloured fluid blood.*

25. *Larynx, Trachea and bronchi showed redish froth.*

26. *The above findings strongly indicate that he had been bleeding and aspirating and swallowing the blood.*

27. *Page 485 Sl.No. 11 as per exhibit B Dr. Sanghvi received phone call at 7.10 p.m. and 8.01 p.m. and Dr. Ravi Patel received phone call at 7.30 p.m., 7.37 p.m. and 7.46 p.m., thereby indicating that they would not have received any information about the patient's condition earlier than 7.10 p.m.*

28. *The notes written by the staff nurse is unbelievable because the hand writing was the same from 11.00 p.m. on the previous day till 8.00 p.m. on the day of death.*

29. *The patient died at 8.00 p.m. but Police was informed only at 9.00 p.m. There is delay in informing the Police.*

30. *Hand written chart of B.P., I.V.Fluid, Fluid intake and out put chart from day 24.09.2007 to 25.09.2007 from 11.00 p.m. on the previous day to 8.00 p.m. on the second day were written by the same person at one time. According to exhibit P-2 history sheet of the patient B.P. not recordable while B.P. chart shows B.P. of 90/60. This indicates B.P. chart is not genuine. It is observed from the record on page 529 "If it is considered the said chart is genuine then at 8.00 p.m. when the patient was declared dead, the patient had B.P. of 70/60".*

It is further observed from the statement made by Dr. Vikramkumar D. Sanghvi on 08.10.2009. He answered the following:-

Q: 1 Did you ask for the ultrasound of the affected region underneath?
Ans: Yes.

Q: 2 Is there any involvement of the gland in that report?
Ans: I have not seen the report – This is a lapse by the doctor.

Q: 3 What do you think whether radical surgery is a major surgery or minor surgery?
Ans: It is a major surgery.

Q: 4 Is there any Intensive Surgical Care Unit in this nursing home?
Ans: There is no Intensive Surgical Care Unit - This is a lapse for major surgery.

Q: 5 You agreed that you performed the major surgery as it lasts for three hours. Was there any medical officer present at that particular time?
Ans: No medical officer was present after 3 O' clock in the nursing home - This is a major lapse in the management and is a negligence.

Q: 6 Do you have one single nurse from 7 am to 8 pm on that day?
Ans: Yes I agree that the same nurse was attending the patient from 24.09.2007 11 p.m till 25.09.2007 8 p.m. upto the death- This is unbelievable.

Q: 7 Was the patient examined between 6 pm to 7.40pm?
Ans. No – This is a lapse.

Q: 8 When there was no ICU and no other facilities were there in the nursing home, why did you operate the patient in that nursing home?
Ans: Because certain operations were already conducted in this nursing home - This is also a lapse.

<u>*Statement of Dr. Ravi Patel made on 08.10.2009 before the Committee*</u>

Q.1. Do you have ABG study in your hospital?
A. No, we do not have the same. We sent to Nanawati Hospital, which is very close, if necessary.
Q.2. How much time have you take to reach the nursing home?
A. I have taken 3-4 minutes to reach the nursing home.
Q.3. Is this a major surgery or minor surgery?
A. It is a major surgery, according to me.
Q. 4. Who removed the stitches of the tongue?
A. Theatre Assistant – This is not acceptable.
Q.5. Why it was removed?
A. Patient was restless.

Q.6. Was any doctor available after 3.00 p.m.?
A. No doctor was available after 3.00 p.m. Only nurse and theater assistant were available in the hospital- This is a major lapse.
Q.7. Do you know that duty doctor has left the hospital?
A. Due to Ganesh Visarjan, I give him the permission to leave the hospital – Wrong deed.
Q.8. Why did you take up the surgery on that particular day as you know that day was a bad day in your opinion?
A. From the request of the patient, I did the operation. I made a mistake that I had left the hospital at 3.00 p.m. and I, myself permitted duty doctor to leave the hospital at 3.00 p.m. – This is a major negligence.
Q.9. When do you know the condition of the patient was bad?
A. At 6.00 p.m., patient was finding difficulty in breathing.
Q.10. What instructions you given to the nurse?
A. I asked the nurse to give an injection of Efcorlin over telephone – Wrong procedure.
Q. 11. Why did you give Deriphyllin without seeing the in the post operative period?
A. I thought that it was a bronchitis – Wrong procedure.
Q.12. What did you do after reaching the hospital at 7.40 p.m.?
A. At 7.40 p.m., patient was having difficulty in breathing. I intubated the patient immediately and given him ventilation through Ambu bags. The patient was not conscious at that time.
Q.13. You reached at 7.40 p.m. and intubated the patient, was the patient conscious at that time?
A. Patient was unconscious at that time.
Q.14 How did you diagnosed a cardiac arrest at 7.40 p.m.?
A. By Stethoscope – Professional inefficiency.
Q.15. Why did you disconnected the monitor at 5.00 p.m. and who disconnected the monitor?
A. The nurse disconnected the monitor.
Q. 16. Did you record the same in the case file?
A. It has not been recorded in the records that monitor was disconnected.
Q.17. Was the throat suction done in this patient?
A. Yes – Not believable.
Q.18. Is it in the record?
A. No it has not been in the record.
Q.19. How do you know, it has been done?
A. I do not know whether it has been done or not. I know the suction was done becuase I have belief in my staff.
Q.20. Do you expected intravenus adrenaline to be effective when there was no circulation in the patient due to cardiac arrest?
A. I do not expect it to be effective – Wrong management.
Q.21. Did you record ECG of this patient after cardiac arrest?
A. ECG was not recorded – Major negligence.
Q.22. Did you contact any doctor or physician for this emergency?
A. I contacted the doctor at 7.30 p.m. but because of traffic problem he could not reach.
Q.23. Has any Chest x-ray was done of this patient?
A. No - Negligence.
Q.24. Do you think that ECG and x-ray are vital test when patient was suffering from breathing problem?

A. Yes.
Q.25. Has any Chest x-ray was done of this patient?
A. No – Negligence.
Q.26. Do you think that ECG and x-ray are vital test when patient was suffering from breathing problem?
A. Yes.
Q.27. Insulin was given, Do you think that Insulin may have produced hypoglycaemia, which lead to cardiac arrest?
A. I don't think so.
Q. 28. What do you think the cause of death in this case?
A. Sudden cardiac arrest, because of the patient was already suffering certain diseases like diabeties.
Q.29. Don't you think, it is all the more a serious reason for duty medical officer to be there in the post operative period?
A. Yes – Serious lapse in management.
Q.30. Do you think the patient was died because of aspiration and pulmonary collapse?
A. I do not agree.
Q.31. The post-mortem showed there is a partial lung collapse and there was blood in the lungs?
A. Yes
Q.32. Any major point you want to be recorded?
A. No.

The above facts were carefully analysed and deliberated and the members of the Ethics Committee came to unanimous conclusion as follows:-

1. *The patient should not have been operated on 25.09.2007 as it was a day of religious festival where the procession was being taken and doctors could not reach the Nursing Home during the time of emergency.*

2. *Having well known the above facts to both the doctors, they should not have left the hospital at 12.30 p.m. and 3.00 p.m. respectively. More so when a major surgery was done on a patient more particularly when permission was given to duty RMO to leave at 1.00 p.m.*

3. *There was no Medical Officer from 3.00 p.m. till 7.40 p.m. when the patient developed Cardiac arrest.*

4. *The post operative management care was so much deficient that Blood Sugar Monitoring for Diabetic patients, post operative, recording of ECG at the time of cardiac arrest, doing the x-ray chest when the patient was having chest problem was not done and the patient was left at the mercy of one staff nurse alone.*

5. *There is a gross negligence in the management of patient during post operative period for a major surgery.*

6. *Even the Medical Officer Dr. Patel who attended the patient at 7.40 p.m. gave intravenous injection when there was a total circulatory arrest secondary to cardiac arrest. This indicate a total lack of knowledge in the management of patient during cardiac arrest.*

7. *Neither Dr. Patel nor Dr. Sanghvi has made any effort to call the physician to help the patient.*

8. *There is nothing on record to show that frequent throat suction have been done to the patient to prevent aspiration and swallowing of the blood.*

9. *It is clear from the post mortem report that 200 ml. of dark coloured blood fluid and partial collapse of lung with blood frothy secretions in the lungs; and blood in larynx, trachea and bronchi indicate that this patient would have aspirated and swallowed a considerable amount of blood leaking from the operative site. If this has been taken care of at by periodical examination, evaluation and proper intervention during the post operative period, the death of the patient could have been avoided.*

10. *Post mortem report clearly stated that it is an unnatural death. It is clear from the report that there was no myocardial infarction and there was only atheroma which was non obstructive. So*

the Medical Officer cannot take a defence by saying that the patient died due to coronary arteries disease.

11. *The nurse's report is false, as it is in the same hand writing from 11.00 p.m. of the previous day up to the death of the patient, thereby indicating a false record in the case file.*

12. *Again the B.P. recording of 70/60 mm when the patient was declared dead is a clear proof of false records.*

13. *Regarding the hospital facilities, there is no Intensive surgical care ward when major surgeries are being conducted from 1981.*

14. *There are only 2 Resident Medical Officers of which one was on duty at a time.*

15. *The nursing management as available from the record is poor which the doctor should have overseen and corrected.*

Conclusion – The members of the Ethics Committee after taking into consideration of the above facts unanimously opined that due to gross medical negligence, negligence of duty by the doctors, inappropriate postoperative care on the patient resulted in the death of Mr. Ambikaprasad Sarangdhar Pathak. The names of 2 doctors namely Dr. Vikramkumar D. Sanghvi and Dr. Ravi Patel (Dr. Ravinderkumar V. Patel) be removed temporarily from the Indian Medical Register for a period of 6 months being a violator of Code of Medical Ethics for guilty of negligence, violation of Professional Etiquettes and Professional Misconduct."

The Executive Committee of the Council further observed that as per the statement of Dr. Vikram Kumar D. Sanghvi as recorded by the Ethics Committee, he had seen the patient for the last time at 12.30 p.m. on 25th September, 2009 and at that time and the patient had recovered after anaesthesia. It is also stated by him that the patient responded to the command given to him like "open your eyes, open your mouth, show your tongue" and he opened his eyes. This has not been contravened at any stage. It was further observed that the postmortem findings of a partial long collapse and presence of blood in the longs has not been co-related with the radical surgery and the subsequent post operative event.

In view of above, the Executive Committee of the Council decided to refer the matter back to the Ethics Committee for reconsideration.

Lt. Col (Retd) Dr. A.R.N. Setalvad)
Secretary

Place: New Delhi
Date: 13.10.2009

APPROVED

(Dr. P.C.Kesavankutty Nayar)
Vice–President