TULANAM

A Medico-legal Bulletin of
Bangalore Society of Obstetrics and Gynaecology

Volume 1 | Issue 2 | June 2012

Dear friends,

The only desired outcome in Obstetrics is a healthy baby and a happy mother. Anything short of this expectation is an 'adverse outcome'. Adversities in Obstetrics come in all shapes and sizes, from minor morbidity to near-misses or even mortality. In this era of litigations, the practice of Obstetrics has almost become synonymous with managing adverse outcomes! To quote Arthur Golden (Memoirs of a Geisha), 'Adversity is like a strong wind. It tears away from us all but the things that cannot be torn, so that we see ourselves as we really are.' Having a protocol for managing adverse situations is important for all – the patient and the practitioner included. A suggested protocol is included in this issue.

The issue of vicarious responsibility in medical practice is explicitly brought out in the invited article by Dr. Gopinath Shenoy. Our responsibility in notifying births & deaths to the authorities cannot be overstated. Quite often, maternal deaths do not get notified for want of awareness amongst us. The article on 'How to notify maternal death' enlightens the reader on this matter.

Our pages on 'Do You Know' and 'good practice points' continue, in our modest endeavor to enlighten our fraternity on medico-legal matters.

Arulmozhi Ramarajan

E-mail
bsogmlc@gmail.com

Tulanam in Sanskrit means - weighing, assessing, comparing, rating, examining and estimating

Invited Article

Hospitals Vicariously Responsible for Acts of the Doctors

Dr. Gopinath N. Shenoy*
MD, LLM, PhD (Consumer Law),
DGO, DFP, FCPS, MNAMS

Liability which is incurred for, or instead of, another is defined as vicarious liability. Every person is responsible for his own acts or omissions but there are circumstances where, for the acts committed by a person, the liability comes to lie, not on that person, but on someone else.

Salmond in his book Law of Torts observed: "In general, a person is responsible only for his own acts, but there are exceptional cases in which the law imposes on him vicarious responsibility for the acts of others however blameless himself."

The most common instance of vicarious liability in medical practice is in (a) Employer – Employee Relationship where there is a liability cast on the employer for the wrongs committed by his employee – example - physician employed as full timers and (b) Principle - Agent Relationship where there is a liability cast on the employer for the wrongs committed by his agent – example - physician employed part time (honorary) or on a contract.

Principles on which vicarious liability is based on are **(i) Qui Facit Per Alium Facit Per Se** and (ii) **Respondeat Superior.**

(i) **Qui Facit Per Alium Facit Per Se:** This maxim means he who does an act through another is, in law, deemed to have done it himself.

(ii) **Respondeat Superior:** This maxim means let the superior be responsible. This maxim has its origin in the legal presumption that all acts done by the employees/agents in and about their employer's business are done by his employer's express or implied authority, and are in truth the acts of the master.

The main reasons for the recognition of the two maxims are the difficulty in the way of proving authority and that the employers usually are, while their servants are not, financially capable of bearing the burden of civil litigation.

It is evident that imposition of such a liability on the employer helps to prevents accidents because the employer himself would be more careful in choosing the employee/agent then he would have been if the rule were otherwise. Moreover in the absence of such a rule, a rich man who employs a poor employee to commit a wrong would go scot-free if he discontinues the employee from services and the person who has been wronged would never be compensated.

In UK, Denning LJ is credited to have brought about radical changes in the laws of vicarious liability. The **Roe** case was a landmark cases inasmuch as the law, after this case, holds the hospital authorities entirely responsible for all acts and omission of the entire hospital staff.

In **Roe v. Minister of Health and Anr.** and **Woolley v. Minister of Health and Anr.** [Court of Appeal. (1954) 2 QB 66], each plaintiff developed, due to injection of spinal anaesthetic contaminated with phenol, a condition of spastic paraplegia and was permanently paralysed from the waist down. Each sued Dr. Graham the anaesthetist, and the hospital authority. The risk of this happening was first drawn to the attention of the medical profession by a book published in 1951. The trial court dismissed the case.

Held: (i) the hospital authority was liable for Dr. Graham; (ii) the hospital had explained how the accident occurred; applying the standard to be imputed to competent anaesthetist in 1947, Dr. Graham was not negligent in failing to appreciate the risk. Dr. Graham was acquitted.

---

* Dr. Gopinath N. Shenoy is an Obstetrician and a Gynaecologist and a medico legal consultant who exclusively defends the doctors in the Consumer Courts and the Medical Councils all over India. He was a Member of the Consumer Court - Mumbai Suburban District, Government of Maharashtra. For any telephonic advice, help or assistance, call 09869877871. For all in Karnataka, it is free of charge.

Lord Denning also held:

"I think that the hospital authorities are responsible for the whole of their staff, not only for the nurses and the doctors but also for the anaesthetist and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. The hospital authority is responsible for all of them. The reason is because even if they are not servants, they are the agents of the hospital to give the treatment. The only exception is the case of consultants and anaesthetists selected and employed by the patient himself."

The Supreme Court of India in Smt. Savita Garg v. The Director, National Heart Institute 2004 AIR 5088 held:

"The patients once they are admitted to such hospitals, it is the responsibility of the said hospital or the medical institutions to satisfy that all possible care was taken and no negligence was involved in attending the patient. …….. The burden cannot be placed on the patient to implead all those treating doctors or the attending staff of the hospital as a party so as to substantiate his claim. Once a patient is admitted in a hospital it is the responsibility of the Hospital to provide the best service and if it is not, then hospital cannot take shelter under the technical ground that the concerned surgeon or the nursing staff, as the case may be, was not impleaded ….."

"The institution is private body and they are responsible to provide efficient service and if in discharge of their efficient service there are couple of weak links which has caused damage to the patient then it is the hospital which is to justify the same and it is not possible for the claimant to implead all of them as parties".

"Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor/or hospital. Therefore, in any case, the hospital which is in better position to disclose that what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors being employed on job basis or employed on contract basis, it is the hospital which has to justify and by not impleading a particular doctor will not absolve the hospital of their responsibilities".

In Prasanth S. Dhananka v. Nizam's Institute of Medical Sciences and Ors. 1986-99 CONSUMER 3299 (NS) Original Petition No. 124 of 1993, it was held;

"In the result, OP 1 to OP 5 are liable to pay the compensation as determined hereunder. Since, however, OP 1 is the institution in which OP 2 to OP 5 are employed, we hold that OP 1 is singularly responsible for payment of compensation".

The Government is vicariously liable for acts of its doctors in State run hospitals. In Achutrao Haribhau Khodwa and others v. State of Maharashtra and others, 1996 ACJ 505, the case dealt with the fallout of a sterilization operation. The vicarious liability of the State on account of medical negligence of doctor in a Govt. hospital was confirmed. The theory of sovereign immunity was rejected.

Thus, it is the Hospital that is finally responsible to pay compensation for acts or omission done by any person i.e. the doctors, nurses, ward boys, etc., who may be appointed full time, part time or on contract.

The doctrine of vicarious liability is not applicable to criminal liability.

He is not dead, he is electroencephalographically challenged.

❁ ❁ ❁

"Are you an organ donor?"
"No, but I once gave an old piano to the Salvation Army."

❁ ❁ ❁

What is a double-blind study?
Two orthopaedists reading an electrocardiogram.

D&C

Dr. Susheela Rani B S

About the operation

A dilatation and curettage procedure, also called a D&C, is a surgical procedure in which the cervix (lower, narrow part of the uterus) is dilated (expanded) so that the uterine lining (endometrium) can be scraped with a curette (spoon-shaped instrument) to remove abnormal tissues. A suction D&C uses suction to remove uterine contents. This is sometimes called a dilatation and evacuation (D&E).

Reasons for D&C

A D&C may be used as a diagnostic or as a therapeutic procedure for abnormal bleeding.A D&C may determine the cause of abnormal or excessive uterine bleeding to rule out cancer, or may be a part of infertility (inability to become pregnant) investigations.

A D&C may be used following a miscarriage to remove the fetus and other tissues if they have not all been naturally passed. Infection or heavy bleeding can occur if these tissues are not completely removed. This type of D&C may also be called a surgical evacuation of the uterus or a D&E.

Occasionally following childbirth, small pieces of the placenta (afterbirth) remain adherent to the endometrium and are not passed.This can cause bleeding or infection. A D&C may be used to remove these fragments so that the endometrium can heal properly.

There may be other reasons for your physician to recommend a D&C like …….

Risks of the procedure

As with any surgical procedure, complications may occur. Apart from the risks due to anesthesia, some possible complications of a D&C may include, but are not limited to, the following:

- Heavy bleeding
- Infection
- Perforation of the uterine wall or bowel
- Adhesions (scar tissue) may develop inside the uterus

Patient's consent

I acknowledge that the doctor has explained to me about;

- ☐ my medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific tome.
- ☐ the anaesthetic required for this procedure. I understand the risks, including the risks that are specific to me.
- ☐ other relevant procedure/treatment options and their associated risks.
- ☐ the risks of not having the procedure.
- ☐ that no guarantee can be given that the procedure will improve my condition even though it has been carried out with due professional care.
- ☐ that the procedure may include a blood transfusion.
- ☐ that tissues and blood may be removed and could be used for diagnosis or management of my condition, or stored and disposed of sensitively by the hospital.

I give my consent to Dr. _____

_____ and/or his/her

assistant _____ to

perform the D& C procedure on me.

Signature Name

Date:

"What you are aware of you are in control of;
what you are not aware of is in control of you."

DID YOU KNOW?

Compiled by Dr. Shobha N Gudi

1. Criminal law is applicable to all individuals and doctors are no exception to it. According to the provisions of Indian Penal Code 1860 (IPC) any act of commission or omission is not a crime unless it is accompanied by a guilty mind (in latin 'MENS REA '). Most of the times doctors treatment is in good faith, with the consent of the patient and hence most of the provisions of IPC are not applicable to the doctors unless or until there is rashness or gross negligence. The Supreme Court of India describes negligence as the breach of duty exercised by omission to do something which a reasonable man would do or doing something which a prudent man would not do.
2. A case of criminal abortion is treated as septic abortion. The duty of a medical attendant as a citizen is to report the matter to the police but as a doctor, his medical code is to keep the matter confidential. In a given situation one has to exercise discretion for a compromise of these two lines of action. If a woman is dying police has to be informed to record the dying declaration. In case of her death, the police must be informed immediately.
3. For all surgeries or procedures, even for a minor procedure like D& C, the surgeon must ensure that the name of the anaesthetist is specifically recorded in medical records of the patient as well as the surgery / procedure notes.

Medical Law Cases – for doctors, pg 11, Vol 4:1, Jan 2011.

4. Informed consent is very important in MTP. In a case before the National Consumer Forum, compensation up to Rs. 50 lakhs has been asked because pregnancy continued after MTP. The woman had a large fibroid. Though she went on to deliver a healthy child, she filed a case against the doctor claiming mental agony and possible harm to the baby. 'Chowdhury NN Roy, General Survey of Maternal Mortality, Morbidity, Complications and Sequelae of MTP, Manual on Medical Termination of Pregnancy "An Update", 3rd edition, Pg: 12, FOGSI Publications.

HOW TO NOTIFY MATERNAL DEATHS:

Dr. Arulmozhi Ramarajan

As caregivers to our pregnant women, we are deeply concerned about maternal deaths. If we must bring down our MMR, one of the important issues to be addressed is MDR or maternal death review. It is important that we notify each and every maternal death to the concerned authorities, apart from reporting to the local Registrar of births and deaths, so as to enable them to analyze the cases and identify the gaps in healthcare delivery. Such information will help implement measures to save lives. We are required to notify maternal deaths to:

1. The Government of India (in the FBMDR format : Ref. : http://www.gujhealth.gov.in/Portal/Tender/2/15_guidelinemetirial.pdf)
2. The FOGSI Maternal Mortality Survey (To Dr. P K Sekharan, National Co-ordinator, FOGSI Maternal Mortality Survey, PVS Hospital, Calicut – 673002, Kerala)

All Maternal deaths occurring in the hospital, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy should be informed immediately by the Medical officer who has treated the mother and was on duty at the time of occurrence of death to the Facility Nodal officer (FNO). All medical officers must be aware of the MDR program and oriented on the use of the FBMDR form. All pregnant and postpartum women that were treated, and died, in other departments than the OB/GYN department, must also be reported and investigated.

Notification for Bangalore Urban:

- The FBMDR format: to be sent to the Medical Officer (RCH), BBMP within 24 hours, with copy of case records.
- Death report: to the designated Sub-health Office of BBMP in the area.

MANAGING ADVERSE SITUATIONS

Arulmozhi Ramarajan

Obstetric practice is full of uncertainties and unexpected complications. The case cited below is an example. In spite of the best efforts, mishaps are likely to occur; cases are likely to be filed. If duty is done with reasonable care one will not be held negligent even if treatment was not successful. Having a protocol to handle adverse outcomes and volatile situations is useful.

PPH at Cesarean section:

A primi with twin pregnancy 35 weeks was taken up for LSCS for breech presentation of first twin with PROM. Patient requested GA. Twin babies extracted, placentae removed. Atonic PPH followed, which settled with oxytocin, methergin and carboprost. The large placental site was extending into the lower segment, and there was blood welling up from the lower segment. Ligation of the uterine arteries did not improve the situation. Senior obstetrician was called for help. The situation was explained to the family, and consent for hysterectomy SOS as a life saving measure was taken. Condom tamponade was done and this controlled the lower segment bleeding. Two units of PRBC were given on table. Patient was shifted to ICU, where she received further transfusions. Subsequent recovery was uneventful.

What helped:

- Multiple pregnancy & GA were known risk factors for PPH – the family was informed of possible need for blood transfusion.
- The obstetrician and the anesthetist had counseled the woman on SAVs GA. However, patient autonomy and choice was respected and GA provided.
- Informed consent for surgery, anesthesia and blood transfusion were taken.
- A senior obstetrician was kept informed, called, and reached, without delay.
- Staff was trained in emergency measures such as condom tamponade.
- Intra-op communication and consent for hysterectomy and further transfusions was obtained.
- Hemorrhage on table - quick decision on conservative surgical measures saved the uterus in a young primi – this came in as a major relief for the family.
- Debriefing to the family immediately after the surgery and to the patient after recovery.
- Clear and complete documentation in chronological order.
- Concern and counseling continued in the ward.

Every patient is a potential litigant:

- Professional indemnity is a must.
- Renewal should be done without break of even one day.
- Inform hospital authorities of the possibility of problem.
- Inform insurance company of the possibility of litigation.
- Engage the services of a medico-legal consultant.
- If reasonable care has been provided, one will not be held negligent even if treatment was not successful.
- Prepare to prove that standard care was provided, that there was no act of negligence, that standard protocols were followed.
- Documents alone will speak in the court of law. What is not documented did not happen.

A middle aged woman had a heart attack and was taken to the hospital. While on the operating table she had a near death experience. Seeing God she asked "Is my time up?" God answered, "No, you have another 40 years, 2 months and 8 days to live."

Upon recovery, the woman decided to stay in the hospital and have a facelift, liposuction, and a tummy tuck. She even had someone come in and change her hair color. Since she had so much more time to live, she figured she might as well make the most of it.

After her last operation, she was released from the hospital. While crossing the street on her way home, she was hit by a car and died immediately.

Arriving in front of God, she demanded, "I thought you said I had another 40 years, why didn't you pull me from out of the path of the car?"

God replied, "I didn't recognize you."

WORDS OF WISDOM

Dr. Padmini Isaac
Former H O D, Dept of OBG ,
St Martha's Hospital

I congratulate the B.S.O.G. for their forethought and wisdom in forming a Medico Legal Committee and bringing out the bulletin TULANAM. Going through the first issue, I found it to be both informative and educative especially the article regarding Cesarean Section Do you know? By Dr. Shobha N Gudi
I offer my personal opinion on the key points emerging in court decisions regarding maternal fetal conflict

a) A mentally competent woman can refuse any treatment

The rapport developed between the couple and the Obstetrician over a period of 6 to 8 months should be used to avoid such situations. Making the patient aware of the pros and cons of the intended mode of management is our responsibility. We also need to discuss various alternatives openly. While the final decision regarding what to do lies with the patient, this seems only right, as they are the ones who face the consequence as well. And I daresay they occasionally prove to be superior to our considered opinion.

b) The fetus has no legal standing

This is a difficult clause when the raging debate the world over today is "When does life begin?" So this is an issue still to be resolved

c) The pregnant woman's refusal cannot be overruled in the interest of the fetus

In my experience, I have found that involving the extended family i.e. parents, parents- in- law, siblings and especially the husband helps in its resolution and I leave them to convince the mother in the interest of the child.

d) If the capacity of the pregnant woman to refuse necessary treatment is doubted an application should be made to the court

This situation rarely arises in India and at the speed of our judicial system, the woman would have completed her family before the court decision comes.

e) Res ipsa loquitor the importance of maintaining proper records cannot be emphasized enough. It is the savior on many occasions.

Dr Rajat from Australia at one of the many conferences organized by the BSOG on THE DILLEMA FACED BY DOCTORS FACED WITH A MEDICO LEGAL SUIT made a very important point. He said that of all cases of medico legal litigation, doctors were convicted in only 4% of the cases, but many many more valuable , honest, sincere doctors go through such emotional and mental trauma during this time that quite a few of them opt out of the practice of medicine and tragically, a few even opt out of life. A Society like this will go a long way in providing support and emotional comfort at this difficult phase of a busy Obstetricians life. Thank you once again Medico Legal Committee of BSOG

Dr. Girija Uchil : As a founder member, I have witnessed the growth of BSOG from its inception. With medico-legal cases on rise, it is heartening to note that we have a medico-legal cell under the banner of BSOG. With this, our members have a certain amount of help & assurance during difficult times. Inspite of being in a competitive world, it is necessary to practice medical ethics. Second opinion on cases should be strictly professional without criticism. Untoward incidences must be discussed in meetings and not in the public domain. We members of the society need to stay together in good & bad times. Despite our best efforts, things can still go wrong and we stand exposed to the risk of litigation. Let the medico-legal cell remain as the backbone to all our members & I wish it all success.

A man needing a heart transplant is told by his doctor that the only heart available is that of a sheep. The man finally agrees and the doctor transplants the sheep heart into the man. A few days after the operation, the man comes in for a checkup. The doctor asks him "How are you feeling?" The man replies "Not BAAAAD!"

1. Beatty MN, Blumenthal PD. The levonorgestrel-releasing intrauterine system: Safety, efficacy, and patient acceptability. Ther Clin Risk Manag. 2009 Jun; 5(3):561-74. Epub 2009 Aug 3.

2. Andersson K. The levonorgestrel in intrauterine system:more than a contracepative. Eur J Contracept Reprod Health Care. 2001 Jan;6 Suppl 1:15-22.

3. A comparative study of the levonorgestrel-releasing intrauterine system Mirena versus the Copper T380A intrauterine device during lactation: breast-feeding performance, infant growth and infant development. Shaamash AH, Sayed GH, Hussien MM, Shaaban MM. Department of Obstetrics and Gynecology, Faculty of Medicine, Assiut University, Assiut, Egypt. Contraception. 2005 Nov;72(5):346-51