IN THE HIGH COURT OF DELHI AT NEW DELHI

% Judgment delivered on: 10.08.2018

\+ **W.P.(C) 807/2016 & CM No. 3689/2016**

DR MEENA HARSINGHANI & ANR ...Petitioners

Versus

MEDICAL COUNCIL OF INDIA AND ORS ...Respondents

Advocates who appeared in this case:

For the Petitioners	:Mr Abhishek Paruthi.
For the Respondents	:Mr Tarun Verma, Ms Amandeep Kaur, Mr T. Singhdev, Ms Puja Sarkar and Ms Michelle for MCI/R-1. Mr Jawahar Narang and Mr Parshant, for R-2. Mr Pankaj Seth for R-3. Mr Praveen Khattar with Mr Bapi Das, Advocates for R-4 with L.D.S. Uppal, Assistant Secretary, DMC.

CORAM
HON'BLE MR JUSTICE VIBHU BAKHRU

JUDGMENT

VIBHU BAKHRU, J

1. The petitioners have filed the present petition under Article 226 of the Constitution of India impugning the order dated 14.01.2016 (hereafter 'the impugned order') passed by the Medical Council of India (hereafter 'MCI'), whereby the MCI has enhanced the punishment imposed on petitioner no.2 and upheld the punishment imposed on petitioner no.1 by the Delhi Medical Council (hereafter

'DMC'); the MCI has directed removal of petitioner no.2's name for a period of three months and petitioner no.1's name for a period of fifteen days from 18.01.2016, from the Indian Medical Register.

2. The impugned order was passed in an appeal preferred by the petitioners against an order dated 23.07.2014 passed by the DMC.

Factual Background

3. The petitioners are qualified doctors. Petitioner no.1 (Dr Meena Harsinghani) is a Gynaecologist & Obstetrician. She is the proprietor of Deepak Nursing Home. Petitioner no.2 (Dr Narayan Harsinghani) is an anesthetist by profession and the husband of petitioner no.1. Petitioner no.2 had completed his post graduate diploma in anesthesia (D.A) from Maulana Azad Medical College in 1979.

3.1 On 28.11.2008, respondent no.2 (hereafter 'the Complainant') was admitted to Deepak Nursing Home for labour pains during her second pregnancy. She was in care of petitioner no.1 during her pre-natal period. After examination, she was informed by petitioner no. 1 that the fetus had passed stool (meconium) in the uterus and that could be dangerous as the fetus could breathe the meconium into his/her lungs. Therefore, the complainant was rushed to the operation theatre in emergency.

3.2 The Petitioners claim that the anesthesiologists on the panel of the Nursing Home were not available. Therefore, petitioner no.2 being an anesthesiologist and available during the emergency, was contacted

and requested to attend to the Complainant. He agreed to do so and administered anesthesia in the spine of the complainant. The petitioners claim that there was free flow of CSF in first prick itself and it was atraumatic (no blood came through the spinal needle).

3.3 The Complainant delivered the baby without any further complications. However, the complainant complained of severe pain in the back. She also complained of a restless night and heaviness in the lower part of her body. The Complainant was examined on the morning of 29.11.2008. In view of her complaints, petitioner no.1 called a consulting neurologist – Dr Nirmala Lahoti – to examine the patient. Dr Nirmala Lahoti examined the Complainant on 29.11.2008. Her examination revealed that the Complainant had 1/5 power in hip flexors and in extensors and 1-2/5 power in knee extensors on the left side and 0-1/5 in the right hip and knee flexors and extensors. She advised treatment like steroids and physiotherapy and advised MRI in case of poor response to the steroids. This is disputed by petitioner no.1, who claims that Dr Lahoti did not advise any MRI.

3.4 Thereafter, on 30.11.2008, the Complainant's MRI was conducted and it was found that she had suffered from Epidural Hematoma. Admittedly, this was a post spinal anesthesia complication and has left the complainant with permanent paraplegia. Admittedly, if the complication had been discovered at an earlier stage, the same could have been addressed to a significant extent.

4. The Complainant filed a complaint with the DMC. Notice of the

said complaint was served on the concerned parties. After hearing the complaint, the petitioners and Dr Nirmala Lahoti, the Disciplinary Committee of DMC observed as under:-

> "1. The spinal anaesthesia is a blind procedure. The complainant suffered a known complication of spinal anaesthesia, however, it is apparent from the record that the said complication was neither noted, nor ascertained through clinical examination or investigation in a timely fashion. The complainant was administered spinal anaesthesia for purposes of delivery on 28th November, 2008. Post-operatively, the complainant complained of acute pain in the spinal region which was attributed to normal pain associated with the procedure and was, managed by administering injection voveran pain killer. It was only on 29th November, 2008 in the morning; the spinal complication, was noted and neurological consultation was sought. Dr. Nirmala Laihoti examined the patient in afternoon on 29th November, 2008 and after Assessment advised Injection solumedrol. The treating team failed to assess the gravity of the clinical condition of the complainant. It is observed that when the complainant was diagnosed as having neurological deficit on 29th morning, it would have been desirable to get an urgent MRI which would have assisted in confirming the diagnosis and prompted an early surgical intervention in the form of evacuation of epidural hematoma which would have resulted in better outcome.
>
> 2. The conduct of Dr. Narayan Harisinghani of indulging in private practice, inspite of being in Government service needs to be looked into by the Government."

5. In view of the above, the Disciplinary Committee (DMC) concluded that the petitioners had failed to exercise reasonable degree of skill, knowledge and care, as was expected of an ordinary prudent

doctor, in the treatment administered to the Complainant at Deepak Nursing Home. Accordingly, the Disciplinary Committee recommended that the names of the petitioners be removed from the State Medical Register for a period of 15 days.

6. The recommendations of the Disciplinary Committee were placed before the DMC and a meeting was held on 04.06.2014. After considering the same, the DMC remanded the matter to the Disciplinary Committee to reconsider the following issues :-

> "(a) What is the time duration for permanent damage and recovery in cases of epidural hematoma?
>
> (b) What is the time duration within which the complication should have been noted and treated?
>
> (c) Was it a case of error of judgment or negligence?"

7. Thereafter, the Disciplinary Committee reconsidered the issues as mentioned above and, by an order dated 11.07.2014, reconfirmed the earlier recommendations with the following observations:-

> "(a) & (b) As per medical literature, the time for permanent damage is 8 to 10 hours post event. After this time complete neurological recovery is unlikely. Therefore the complication should have been noted and managed by the treating team within 8 to 10 hours.
>
> (c) In this case error of judgment constituted an act of medical negligence."

8. On 17.07.2014, the DMC accepted the recommendations of the

Disciplinary Committee of the DMC and directed removal of the name of the petitioners from the State Medical Register for a period of fifteen days. The same was communicated to the petitioners by an order dated 23.07.2014.

9. The petitioners preferred an appeal before the MCI against the aforesaid order dated 17.07.2014 of the DMC.

10. The Ethics Committee of MCI heard the concerned parties including Dr Lahoti. It is the Complainant's case that after the delivery of the baby neither the gynecologist nor the anesthetist checked her leg movement and sensation to ascertain whether power had come back. She claimed that the attendant doctors visited her after fifteen hours and that too on her complaint. She stated that she had severe pain in her spine and thighs but the doctors took it very lightly. She stated that the Neurologist (Dr Lahoti) visited her at around 2.00 p.m. on 29.11.2008 and advised steroids, which also caused her a lot of pain. She stated that she was taken for an MRI on 30.11.2008 at about 10 AM and the MRI was done at around 12.00 noon on that date.

11. The petitioners had asserted before the Ethics Committee of MCI that the Complainant had complained of heaviness of limbs only in the morning of 29.11.2008. She was thereafter examined by petitioner no.2 who found some movements in both the limbs. However, he advised that a Neurologist be called urgently. Dr Nirmala Lahoti (practicing Neurologist) saw the complainant at about 12.00 noon and recorded her observations, which form a part of the medical

record. The petitioners claim that Dr Lahoti advised injection Solumedrol 500mg OD in 100 ml N saline over half hour; injection Neurokind IN AST OD; Tablet Gabapin 200mg BD; Injection Razo 20mg OD and physiotherapy as and when 3 days. The petitioners emphatically stated that Dr Lahoti had advised a conservative treatment and had not advised an MRI. Dr Lahoti controverted the aforesaid statement. She reiterated her stand that she was called for consultation on 29.11.2008, which was about 18 hours after administration of anesthesia. She also asserted that by that time the Complainant had already suffered maximum neurological damage. She stated that she had prescribed standard medical treatment like steroids and physiotherapy and had also advised that the Complainant be taken for MRI in case of poor response of steroids. She also alleged that the medical records had been tampered because her notes, as produced, appeared to be incomplete and her signatures were missing on the photocopy of the case sheet. She also alleged that various notes had been added as an afterthought and requested the Ethics Committee of the MCI to direct production of original records.

12. After considering the submissions made by the parties, the Ethics Committee concluded as under:-

> "The Ethics Committee was convinced that there was a gross delay in identifying & managing the complication of Epidural Hematoma on the part of Dr Narain Harsinghani. The Neurological opinion was not sought promptly. Moreover, as per records available Dr. Narain Harsinghani was working in a Government Hospital and as Anesthesiologist did not take due care in the post

operative care of the patient which resulted in permanent disability to the patient.

Taking into consideration that there was negligence committed by Dr. Narain Harsinghani, Anesthetist in identifying post spinal anesthesia complication which could have significantly reduced the morbidity to the patient, if it was identified and managed in time. As this was not done in time, the young lady developed permanent paraplegia. Besides, Neurologist has also informed that there has been tempering of records and hence taking into account the above, the Ethics Committee is of the view that the name of Anesthestist, Dr. Narain Harsinghani, be removed from the IMR Register for a period of 3 months. The Ethics Committee also decided to upheld the decision of Delhi Medical Council in case of Dr. Meena Harsinghani."

13. The recommendations of the Ethics Committee were approved by the Executive Committee of MCI at a meeting held on 21.09.2015 and 28.09.2015.

14. The learned counsel appearing for the petitioners has assailed the impugned order, essentially, on three fronts. First, he submitted that the medical examination conducted by Dr Lahoti clearly indicated that the Complainant had sensation in her limbs and, therefore, the conclusion that the damage had been done by that time is erroneous. He submitted that the complications could have been addressed at that time if Dr Lahoti (who was a specialist) had advised an immediate MRI. He contended that since she had not done so, the petitioners could not be faulted by not taking immediate steps for advising a MRI. Second, he submitted that the petitioners had no opportunity to counter the statements made by Dr Nirmala Lahoti before the Ethics

Committee. He submitted that she had appeared before the Ethics Committee at a meeting held on 26.05.2015, which was after the petitioners had been heard. Lastly, he submitted that the Ethics Committee of MCI had accepted that the petitioners had tampered with the records. However, no such allegation was communicated to the petitioners and they had no opportunity to deal with the same.

Discussions and Reasons

15. At the outset, it is relevant to observe that the scope of judicial review of the decision as to what medical treatment ought to have been provided to the Complainant is very limited. The proceedings before the DMC and MCI are in the nature of peer reviews. Unless, the petitioners are able to establish that the view of the MCI and the DMC that MRI ought to have been done urgently and effective steps to address the Complainant's condition should haven been taken within 12/13 hours is perverse, no interference would be warranted by this Court on that count. It is the petitioners' case that the necessary surgery to address the complication could have been done even after 18 hours of administration of anesthesia if it was so advised. However, both, the DMC as well as the MCI have concluded that the initial period of 12 to 13 hours was crucial and the Complainant had a better chance of recovery if she was taken to surgery within that period. This Court finds no material to doubt the said finding.

16. The Ethics Committee of the MCI had concluded that there was gross delay in identifying and managing the complication of Epidural

Hematoma on the part of petitioner no.2. The Ethics Committee had also concluded that the post spinal anesthesia complication could have significantly reduced the morbidity to the patient, if it was identified and managed in time.No interference with the said conclusion is warranted as this Court is unable to accept any flaw in the decision making process or the said finding.

17. The contention that Dr Nirmala Lahoti had not advised an immediate MRI and, therefore, the petitioners could not be faulted is also unpersuasive. The petitioners were the treating doctors. The Complainant was in the care of petitioner no.1 since pre-natal period and petitioner no.2 had administered anesthesia for the operation conducted on 28.11.2008. It is the Complainant's case that she was suffering from severe pain in her spine and thighs; however, petitioner no.2 had examined her only in the morning of 29.11.2008, which was about 14-15 hours after the operation. Clearly, the primary duty to identify the complication would rest with the petitioners. Admittedly, they had taken no steps for either advising an MRI or to consult a specialist within the crucial period (12-13 hours) after the operation.

18. There is little doubt that the correct course would have been to get an MRI done,which would have disclosed that the Complainant had suffered an Epidural Hematoma.

19. It is clear that Dr Lahoti (Neurologist) had also failed to advise that an immediate MRI be done. According to her, she had prescribed steroids and further advised that MRI be done at the earliest in case of

poor response to steroids. There is some controversy in this regard since the petitioners' claim that Dr Lahoti had not advised that MRI be done but had suggested that conservative treatment be followed. However, even according to Dr Lahoti, she did not advise an immediate MRI but advised that the same be done if the response to steroids was poor.. In this view, perhaps there is some negligence on her part as well. However, that does not absolve the petitioners of their obligations to the Complainant. Undisputedly, they should have reacted in a timely manner and recognized the gravity of the problem at an earlier stage. The DMC had faulted the petitioners for not taking the timely action and this Court finds no reason to interfere with the said finding.

20. In view of the above, the decision of the MCI to uphold the punitive measure against petitioner no.1 does not require to be interfered with in these proceedings. However, in so far as petitioner no.2 is concerned, it is seen that MCI has enhanced the punishment imposed on him by the DMC. The impugned order indicates that one of the principal factors considered by the Ethics Committee of the MCI for enhancing the punishment imposed on petitioner no.2 is its acceptance of the allegation leveled by Dr Lahoti that there was tampering of records. Concededly, no notice of this allegation was served on the petitioners. Further, the petitioners also had no opportunity to respond to the same as such allegation was made much after the petitioners had been heard by the Ethics Committee.

21. In the aforesaid view, of the impugned order to the extent it

enhances the punishment in case of petitioner no.2, is set aside. However, it is clarified that the MCI would not be precluded from initiating any action against the petitioners in respect of tampering of records. However, in case MCI decides to initiate any proceedings in this regard, it shall do so in accordance with law and in accordance with the principles of natural justice.

22. The petition is disposed of with the aforesaid observations. The pending application also stands disposed of.

VIBHU BAKHRU, J

AUGUST 10, 2018
pkv