Medicolegal Corner

KK AGGARWAL*, IRA GUPTA

CAN A PATIENT DICTATE AS WHAT ALL A DOCTOR SHOULD WRITE INSTEAD OF FOLLOWING THE PROTOCOL?

No, the patient cannot dictate any doctor as to what write and doctors have to follow their protocol. As per the provisions of Clause 7.7 of the Indian Medical Council Professional Conduct, Etiquette and Ethics Regulations, 2002, the name of the doctor will be deleted from the register of Medical Council, if he is found to have signed or given under his name any certificate, report, etc., which is untrue or misleading. The provisions of Clause 7.7 are reproduced hereunder:

7.7 Signing Professional Certificates, Reports and other Documents: Registered medical practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give certificates, notification, reports and other documents of similar character signed by them in their professional capacity for subsequent use in the courts or for administrative purposes, etc. Such documents, among others, include the ones given at Appendix –4. **Any registered practitioner who is shown to have signed or given under his name and authority any such certificate, notification, report or document of a similar character which is untrue, misleading or improper, is liable to have his name deleted from the Register.**

Thus, in view of the above clause 7.7 if the doctor writes what is dictated by the patient without following the proper protocol, procedure and the same is untrue, misleading or improper then the doctor shall have to delete his name from the Register of the respective Medical Council in which the doctor is registered. Accordingly, the doctor shall be debarred from practicing medicine.

ARE DOCTORS SUPPOSED TO SHARE THE PICTURES OR VIDEO RECORDING OF SURGERY OR ANY CASE NOTES OTHER THAN THE DISCHARGE SUMMARY WITH THE PATIENT OR HIS RELATIVE?

Yes, it is obligatory for doctors, hospitals to provide the copy of the case record or medical record and also share the pictures or video recording of surgery or any case notes other than the discharge summary to the patient or his legal representative as the patients generally have a right to review them, demand copies of them, and to demand their confidentiality as per the MCI ethics regulations.

As per the provisions of Clause 1.3 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation, 2002 the doctor is under an obligation to maintain the medical record and to provide the same to the patient and/or his relative, if the patient and/or his relative ask for the same. The provisions of Clause 1.3 is reproduced hereunder:

> *"**1.3 Maintenance of medical records:***
>
> *1.3.1. Every physician shall maintain the medical records pertaining to his/her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as **Appendix 3.***
>
> *1.3.2. If any request is made for medical records either by the patients/authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.*
>
> *1.3.3. A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he/she shall always enter the identification marks of the patient and keep a copy of the certificate. He/She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.*
>
> *1.3.4. Efforts shall be made to computerize medical records for quick retrieval."*

MCI ethics regulations 7.2 further clarifies that not giving records can amount to professional misconduct:

"7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of three years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it as per the regulation 1.3.2."

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Further, in the matter titled as **Medi. Supri. Loknayak Jaiprakash Narayan Hospital & Ors. V/s. K.M. Santosh. F.A. No. 244/2008, decided on 14/03/2016, the Hon'ble National Consumer Disputes Redressal Commission** has observed that:

> *"5. It is the primary responsibility of the hospital to maintain and produce patient records on demand by the patient or appropriate judicial bodies. However, it is the primary duty of the treating doctor to see that all the documents with regard to management are written properly and signed. An unsigned medical record has no legal validity. The patient or their legal heirs can ask for copies of the treatment records that have to be provided within 72 hours. The hospital can charge a reasonable amount for the administrative purposes including photocopying the documents. Failure to provide medical records to patients on proper demand will amount to deficiency in service and negligence. It is the duty of doctor or hospital to preserve, maintain the medical record for certain specified period under different laws like Limitation Act, Consumer Protection Act and the Directorate General of Health Service (DGHS), Prenatal Diagnostic Test Act, 1994, the Clinical Establishments (Registration and Regulation) Act, 2010 (Central Act No. 23 of 2010). These records are required in medical negligence, accident, insurance claims and in criminal cases also in the Labour Courts. Hon'ble Supreme Court and the National Consumer Commission in various judgments held the hospitals/ doctors liable for medical negligence for non-production of medical record.*
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> Thus, in view of above, with the enforcement of the MCI Regulations, 2002, it is made clear that the patient has a right to claim medical records pertaining to his treatment and the hospitals are under obligation to maintain them and provide them to the patient on request.

WHAT ACTION CAN BE TAKEN IF PATIENT THREATENS FILING AN FIR?

Threatening any person i.e., criminal intimidation is a criminal offence under Section 503 of Indian Penal Code and the same is punishable under Section 506 of the Indian Penal Code. If any person threatens the doctor, then the doctor can lodge an FIR under Section 503/506 IPC against the said persons for committing the offence of criminal intimidation.

The relevant provisions of Indian Penal Code are reproduced hereunder:

> *"**Section 503. Criminal intimidation.** Whoever threatens another with any injury to his person, reputation or property, or to the person or reputation of any one in whom that person is interested, with intent to cause alarm to that person, or to cause that person to do any act which he is not legally bound to do, or to omit to do any act which that person is legally entitled to do, as the means of avoiding the execution of such threat, commits criminal intimidation.*
>
> *Explanation: A threat to injure the reputation of any deceased person in whom the person threatened is interested, is within this section.*
>
> ***Section 506. Punishment for criminal intimidation.** Whoever commits, the offence of criminal intimidation shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both; If threat be to cause death or grievous hurt, etc.—And if the threat be to cause death or grievous hurt, or to cause the destruction of any property by fire, or to cause an offence punishable with death or 1 [imprisonment for life], or with imprisonment for a term which may extend to seven years, or to impute, unchastity to a woman, shall be punished with imprisonment of either description for a term which may extend to seven years, or with fine, or with both."*

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High-sensitivity C-reactive Protein

- High-sensitivity C-reactive protein (hs-CRP) is considered the most useful inflammatory marker for clinical practice.
- Values should be reported in mg/L. hs-CRP <1 mg/L = low risk; 1-3 mg/L = intermediate risk; 3-10 mg/L = high risk.
- Among patients with known coronary heart disease (CHD), a value >3 mg/L is appropriate for predicting outcomes in patients with stable CHD; a threshold >10 mg/L may be more predictive in patients with an acute coronary syndrome (ACS).
- Patients with known CHD and hs-CRP <1 mg/L on contemporary medical therapy, including statins are at particularly low risk.
- Use hs-CRP in conjunction with LDL-cholesterol to adjust the dose of statin therapy in patients with established CHD to achieve both an optimal LDL-C <70 mg/dL and, ideally, hs-CRP <1 mg/L.

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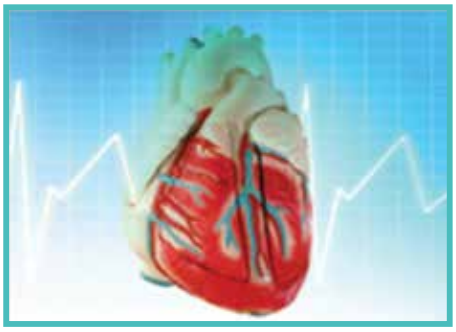

Cardiology Facilities Laboratory

Other Facilities

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Corporate Office

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