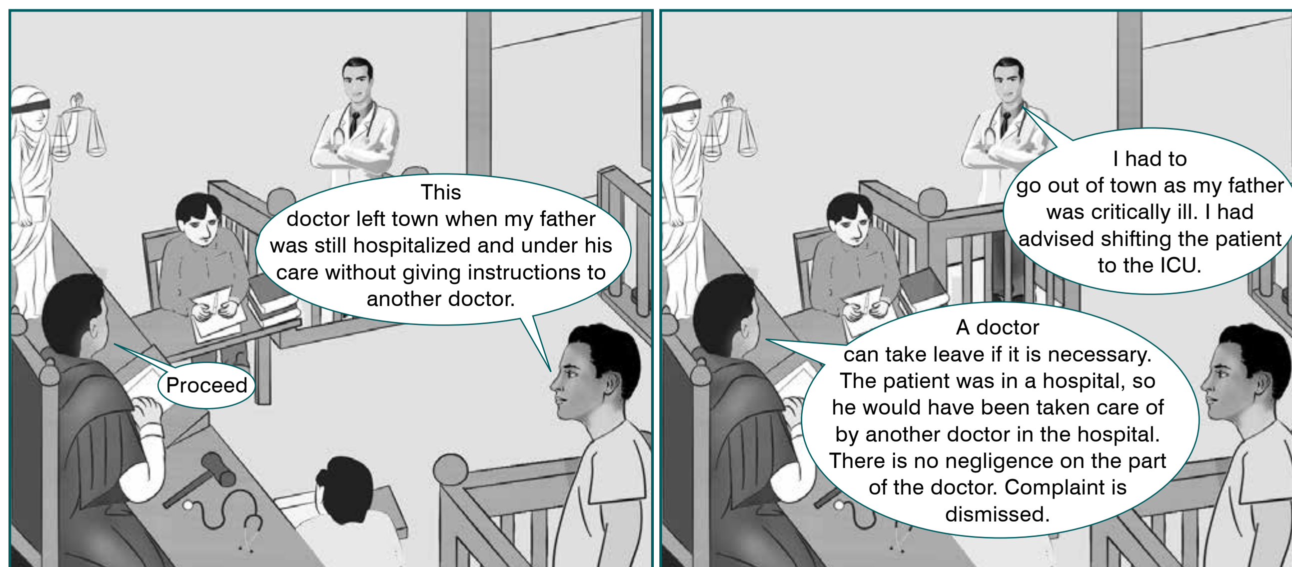
A Doctor, Like Any Other Professional, can Take Leave if Felt Necessary by Him



Lesson: In a judgement, the NCDRC said, "A doctor, like any other professional can take leave if felt necessary by him on account of his personal reasons or otherwise. If that happens it is for the hospital in which the patient is admitted to make alternative arrangement for the treatment of the patient in the hospital… the patient was admitted in a hospital and not in the clinic of Dr…, who could not have been expected to remain with the patient or in the hospital 24 hours of the day. Like other normal human being he also needs to take rest and his meals and then get ready for the duty to be performed on the next day." *Shri Manishbhai Kantilal Joshi vs Sheth P. T. Surat General Hospital, Surat, National Consumer Disputes Redressal Commission, New Delhi, Consumer Case No. 366 of 2014, dated: 09 Feb 2016.*

COURSE OF EVENTS

- 19.11.2012: The patient, an 86-year-old man was hospitalized in Hospital X (*hereby referred to as Opposite Party No. 1*). He was admitted another doctor, but was later put under the treatment of Dr 'A' (*hereby referred to as Opposite Party No. 2)*, a chest physician.
- 20.11.2012: The patient was under the care of Dr 'B' (*hereby referred to as Opposite Party No. 3)*, after Dr 'A' had retired for the day.
- 21.11.2012: The patient died at about 2.30 am while on ventilator in the ICU.

COMPLAINANT ALLEGATIONS

The son of the patient (*hereby referred to as complainant*) filed a complaint of negligence in the treatment of his father before the National Consumer Disputes Redressal Commission (NCDRC) seeking compensation of Rs. 2 crores along with cost of litigation quantified at Rs. 50,000/-.

- Dr 'A' had left for outstation when the deceased was still admitted in the hospital and was under his treatment.
- Dr 'A' left without giving the instructions to Dr 'B'.
- Dr 'B' was not a qualified specialist in the relevant field.

SOME SALIENT COURT OBSERVATIONS

- Dr 'A' (OP 2) stated that the patient had chronic end-stage respiratory disease, severe chronic obstructive pulmonary disease, fibrotic lung lesion and bronchiectasis. Though the patient had been admitted under another doctor, he had also been treating the patient since last few months as an outpatient.

- The patient had been on nebuliser and home oxygen therapy for 6 months prior to his death. His advanced age ruled him out as a good lung transplant candidate and so steroid treatment was started.
- Dr 'A' (OP 2) planned to leave on 20.11.2012 as his father had taken critically ill in the evening on the same day. He therefore advised that the patient be moved from the ward to the intensive care unit (ICU), where the patient was first put on noninvasive ventilation, and then shifted to invasive ventilatory support on account of the worsening condition after taking the consent from the complainant. The patient's condition was informed to the family members before taking the consent.
- Dr 'A' (OP 2) last saw the patient on 20.11.2012 around 8 pm. "*It is stated in the reply that the patient was duly taken care of treating his treatment in the hospital and there was absolutely no negligence in the said treatment*." In his reply, Dr 'A' (OP 2) said that the patient succumbed to long existing chronic end-stage respiratory disease.
- In their statement, both Dr 'B' (OP 3) and Hospital X (OP 1) have concurred with Dr 'A' (OP 2) and stated that "*the patient was admitted with past history of Bilateral Centrilobulor Emphysema in the form of Hyperinflated lung with flattening of lobes, Minimal subpleural opacity in the right upper lobe suggest fibrotic/old granulomatous lesion, Atherosclerotic aortic changes and degenerative spinal changes along with Rounding of Trachea and filling defect in upper trachea*." And that the patient had been treated as per the standard protocol by Dr 'A' (OP 2) "*but the patient succumbed to the chronic disease despite adequate treatment given to him*." They also said that Dr 'B' (OP 3) is "*a qualified doctor, who was employed on regular basis with the OP 1*."

COURT OPINION

- The Commission found no merit in the allegation that Dr 'A' (OP 2) had left "*without giving proper instructions*" to Dr 'B' (OP 3) about the treatment of the patient.
- There was no evidence to support the complainant's allegation that Dr 'A' (OP 2) had left town on 20.11.12. The medical records also corroborate the statement by Dr 'A' (OP 2) that he had last seen the patient at 8 pm on 20.11.12. "*Be that as it may, even if we proceed on the assumption that Dr 'A' had taken leave and left for outstation on 20.11.2012 that by itself does not make out any negligence on his part in the treatment of the patient*."

  "*A doctor, like any other professional can take leave if felt necessary by him on account of his personal reasons or otherwise. If that happens it is for the hospital in which the patient is admitted to make alternative arrangement for the treatment of the patient in the hospital. We have to keep in mind that the patient was admitted in a hospital and not in the clinic of Dr ... Therefore, in the absence of Dr … the patient was to be treated by some other doctor available in the hospital or called by the hospital* from outside. No case of negligence *on the part of the Dr … is therefore made out even if we assume that he had left for outstation on 20.11.2012*."
- In response to the complainant's allegation that Dr 'A' had left without giving instructions to Dr 'B', the Commission observed that the patient records maintained by the hospital include all relevant information of the patient such as clinical history, treatment administered. Any "*suitably qualified doctor attending the patient*" could manage the patient in the absence of the previous doctor. Hence, "*no such briefing would be necessary*".
- "*So long as the doctor treating the patient in the absence of the previous doctor is a competent doctor he should have no difficulty in treating the patient on the basis of the record prepared in the hospital*." And Dr 'B' (OP 3) has not stated that "*he was handicapped in any manner in the treatment of the patient on account of having not been adequately briefed*" by Dr 'A' (OP 2). The Commission did not accept the complainant's contention that the leave taken by Dr 'A' (OP 2) was responsible for his father's death.
- Dr 'B' (OP 3) could manage the patient as he had an MD degree and "*it is not as if only a super specialist in chest related disease can treat such a patient*." The Commission observed: "*A doctor, who has done Post Graduation in Medicine, in our opinion, is fully competent to treat the patient. In fact, in almost all the hospitals, Senior Doctors normally retire for the day in the evening/night and it is only Junior Doctor such as Junior Residents and Senior Residents who remain on duty. The consultant is called if necessary, depending upon the condition of the patient*." Hence, the commission disregarded the allegation that Dr 'B' (OP 3) was not qualified enough to treat the father of the complainant in the absence of Dr 'A' (OP 2).
- Dr 'A' (OP 2) had last seen the patient on 20.11.2012 at about 8 pm. The patient died at about 2.30 am on 21.11.2012 i.e., "*within a span of 6 ½ hours*" after he had left the hospital.

FINAL JUDGEMENT

The Commission ruled in favour of Dr 'A' (OP 2) and said that "*he could not have been expected to remain with the patient or in the hospital 24 hours of the day. Like other normal human being he also needs to take rest and his meals and then get ready for the duty to be performed on the next day.*" As there was no evidence of any negligence on the part of Dr 'A' (OP 2) in leaving the hospital and the patient being treated by Dr 'B' (OP 3) in his absence, the Commission dismissed the allegations of the complainant with no order as to costs.

REFERENCE

1. Shri Manishbhai Kantilal Joshi vs Sheth P. T. Surat General Hospital, Surat, National Consumer Disputes Redressal Commission, New Delhi, Consumer Case No. 366 of 2014, Hon'ble Mr. Justice V.K. Jain, Presiding Member and Hon'ble Dr. B.C. Gupta, Member, Dated: 09 Feb 2016.

Over 25% Rise in Alcohol-related Deaths in the US in First Year of Pandemic

According to research published in the *Journal of the American Medical Association*, there was an increase of 25.5% in the number of deaths related to alcohol in the US between 2019 and 2020. A total of 78,927 alcohol-related deaths were reported in 2019, while 99,017 were reported in 2020, including accidents that happened due to driving after drinking. Alcohol-related deaths accounted for 2.8% of all deaths in 2019 and 3% in 2020.

Researchers state that such behavior was common owing to the increased stress levels due to the adversities of the pandemic. An increase of 16.6% was seen in deaths caused by any reason during this period but alcohol-related deaths surpassed other causes. Data from the CDC showed that January 2021 was the month with the highest number of alcohol-related deaths for the period from January 2019 to June 2021. The jump in alcohol-related deaths was seen across all age groups, with the age group between 35 and 44 years accounting for about 40% increase. Moreover, women exceeded the list.

The scenario was highly concerning and people needed counseling to cope with their stress levels in a healthy way. (*CNN, March 18, 2022*)

Booster Dose of Covishield after two Doses of Covaxin Boosts Antibodies Sixfold: Study

The preliminary scientific evidence submitted by the Christian Medical College (CMC), Vellore, to the Drugs Controller General of India (DCGI) suggested that a booster dose of Covishield after two doses of Covaxin enhanced the immunity 6 times. But, satisfactory data was not available for administering Covaxin as a precaution dose after two doses of Covishield. The study conducted by CMC, Vellore is the first Indian evidence stating the impact of mixing of vaccines on COVID. The study was approved by the DCGI in September 2021. Reports stated that the National Technical Advisory Group on Immunisation (NTAGI) would take the decision on administering a different vaccine as the third dose based on the final data.

Meanwhile, various other studies are being conducted which are studying the effects of mixing Corbevax, Covavax and Biotech's intranasal vaccine. (*ET Healthworld – TOI; March 18, 2022*)

Marinus Pharma's Lead Drug Approved by FDA to Treat Genetic Disorder

Recently Marinus Pharmaceuticals Inc's drug 'Ztalmy' received approval from the US FDA for the treatment of seizures linked with a rare genetic disorder. The drug has been approved for use in patients 2 years of age and older.

The oral drug is indicated for seizures associated with CDKL5 deficiency disorder, a rare form of genetic epilepsy. The regulatory approval was based on a late-stage study that included 101 patients. It showed a mean reduction of 30.7% in 28-day major motor seizure frequency in the drug-treated group compared to the placebo group.

Chief Executive Officer Scott Braunstein said that the drug would cost around $133,000 per patient per year at the wholesale level and the discounted amount would be $105,000 per patient per year, including for Medicaid patients. It was expected to be available in the US commercially in July. (*ET Heathworld – Reuters, March 19, 2022*)