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*** IN THE HIGH COURT OF DELHI AT NEW DELHI**

Pronounced on: 03.07.2023

\+ W.P.(C) 2242/2010

DR. PRAMOD BATRA ..... Petitioner

Through: Mr. Siddharth Aggarwal, Sr. Advocate with Mr. Vishwajeet Singh and Mr. Rudrali Patil, Advs.

versus

MEDICAL COUNCIL OF INDIA & ANR. ..... Respondents

Through: Mr. T. Singhdev, Mr. Bhanu Gulati, Ms. Michelle B. Das, Mr. Abhijit Chakravarty and Ms. Raman Preet Kaur, Advs. for R-1

CORAM:
HON'BLE MR. JUSTICE C.HARI SHANKAR

% **JUDGMENT**
03.07.2023

1. The petitioner, a practising radiologist, assails, in this writ petition under Article 226 of the Constitution of India, order dated 20 March 2010 issued by the Ethics Committee of the erstwhile Medical Council of India (MCI), to the extent the said order directs removal of the name of the petitioner from the Indian Medical Register temporarily for a period of three months for falsifying records. The operative portion of the impugned order reads thus:

> "After due deliberations, the General Body of the Council at its meeting on 11/03/2010 and decided that the patient was not followed by the doctor who did D & C till the time of discharge and patient died in the veranda of the hospital due to haemorrhagic shock which was a preventable cause of death & the owner of the Nursing Home cannot shrug his responsibility in taking care of the patient when she was admitted in his hospital. It was further decided that Dr. Archana Kothari and Dr. Pradeep Kharbanda whose names may be removed from the Indian Medical Register temporarily for a period of six months *and to remove the name of Dr Pramod Batra from the Indian Medical Register temporarily for a period three months for falsifying the records as observed by the Delhi Medical Council and affirmed by the Ethics Committee of the Council.*"
>
> (Emphasis supplied)

2. Clearly, as is correctly submitted by Mr. Siddharth Aggarwal, learned Senior Counsel for the petitioner, the petitioner has been found guilty for falsifying records, and of nothing else. The Court is, therefore, only required to examine whether the said finding can sustain the scrutiny of Article 226 of the Constitution of India.

3. While doing so, the Court has to balance twin considerations, each as important as the other. On the one hand, the Court has to defer, to the extent necessary, to the expertise of the MCI and the subjective satisfaction at which it has reached, keeping in mind the fact that the Court lacks professional expertise in the field. On the other, the Court has to bear in mind the fact that the removal of the name of a practising medical professional from the Indian Medical Register partakes, somewhat, of the character of a civil and professional death, apart from the professional and societal ignominy that such a practitioner would face, possibly for the rest of his career. The degree of Article 226 scrutiny would, in such a case, be more

penetrative, but, if the order weathers the scrutiny, the Court would be loath to substitute its subjective satisfaction for that of the MCI.

4. While issuing notice on the present petition on 7 April 2010, this Court stayed the operation of the impugned Order. That order of stay continues in force till today.

5. Having heard Mr Siddharth Aggarwal for the petitioner and Mr T. Singhdev, learned Counsel for the MCI, at length, this judgment seeks to bring a quietus to the dispute.

Facts

6. The case that the petitioner has sought to set up, in the writ petition, seen in conjunction with the documents filed therewith, is this.

6.1 Mamta Gupta ("Mamta", hereinafter), a 21 year old lady, reported to Dr. Archana Kothari, a gynaecologist at Krishna Medical Centre, New Delhi ("KMC", hereinafter), on 12 May 2007, with a complaint of amenorrhoea[1] with intermittent vaginal bleeding since two months, following consumption of abortifacient drugs, and an Ultrasonogram (USG) report dated 9 May 2007, indicating threatened abortion with a large uterine haematoma[2]. Dr. Kothari diagnosed threatened abortion and referred Mamta to the Safdarjung Hospital for further management.

[1] Absence of menstrual periods
[2] A pool of clotted blood

6.2 Mamta, however, again reported to KMC at 2.10 pm on 14 May 2007 with excessive vaginal bleeding since half an hour. She was diagnosed as a case of inevitable abortion with bleeding P/V[3] and was advised, and scheduled for, Dilation and Curettage (D & C)[4] at 3 pm on the same day.

6.3 At about 3.10 pm on 14 May 2007, the petitioner received a call from KMC, informing him that a patient was suffering from vaginal bleeding and that his ultrasonological services were urgently required. While en route, the petitioner received another call, from KMC, at about 3.25 pm. The petitioner has placed, on record, the Call Detail Record (CDR) of his cell phone number 9811805560, verified with the computer records and certified to be correct, which indicates that, at 3.28 p.m. the petitioner did indeed receive a call from Cell Phone No. 9999499403.

6.4 The petitioner reached KMC at about 3.35 p.m. He proceeded to conduct the ultrasonography (USG) of Mamta, whereupon he observed that her uterine cavity contained products of conception ("POC", hereinafter) and blood clots. Dr Archana Kothari, the gynaecologist attending to Mamta, requested the petitioner to assist in removal of the blood clots and POC. Towards that end, the patient continued ultrasonological examination of Mamta till about 4 p.m. After satisfying himself that no blood clots or POC remained in the uterine cavity of Mamta, the petitioner left.

[3] per vaginam, meaning "through the vagina"
[4] See para 6.5 *infra*

6.5 A brief medical aside here, to facilitate understanding of the issue: Mamta had apparently suffered an abortion of her foetus. The POC and blood clots, therefore, represented what remained of the earlier live foetus. In such cases, it is of essence that the POC and other material in the uterus are promptly removed, as, otherwise, life-threatening infection may develop. This process involves dilation of the cervix, which is the lower, narrow part of the uterus and removal of the uterine contents using a surgical instrument known as a curette. It is, therefore, known as "dilation and curettage" or, in abbreviated medical parlance, "D & C". What was performed on Mamta between 3.35 pm and 4 pm, therefore, according to the petitioner, was D & C, resulting in emptying of the uterine cavity. Though the surgical part of the process was performed by Dr. Kothari, the petitioner provided the necessary ultrasonological assistance, as the process was required to be ultrasonically guided.

6.6 According to the assertions in the petition, while removing the machine by which the D & C had been performed, the petitioner noted that Dr. Kothari was doing the final check curettage of the empty uterine cavity of Mamta.

6.7 Mamta, unfortunately, died later on the same day, i.e., 14 May 2007. She was shifted to Safdarjung Hospital, where she was declared as having been brought dead.

6.8 During inquest, the family members of Mamta alleged that she had died because of medical negligence during her treatment at KMC. In the circumstances, the Police authorities at P.S. Ambedkar Nagar sent a notice, under Section 91 of the Code of Criminal Procedure, 1973 (Cr PC) to the petitioner on 28 May 2007, directing him to produce the record of medical treatment of Mamta along with accompanying documents.

6.9 Though the petitioner was not in possession of the records of KMC, he responded to the Section 91 notice on 31 May 2007, as under:

> "On 14/5/2007, after receiving urgent call from Krishna Medical center. D.D.A. Flats. MadanGir. I immediately rushed there.
>
> At that time, one patient Mamta W/O Sandeep, was lying on Table in Operation theatre & Dr. Archana Kothari (Gynaecologist) was present there.
>
> On Ultrasound examination on this patient, I noticed some products of conception & old blood clots in uterine cavity.
>
> Evacuation of products was done by Dr. Archana Kothari.
> In my opinion there was no untoward happening during the procedure.
> I left the Operation theatre after this procedure was over."

6.10 The Police authorities at P.S. Ambedkar Nagar deemed it appropriate to seek the opinion of the Delhi Medical Council (DMC) on the issue. The DMC wrote to the petitioner on 11 June 2007, and the tenor of the following passage from the letter indicates that negligence was being attributed to the petitioner as well, in the untoward demise of Mamta:

"Whereas, a representation from P.S. Ambedkar Nagar, seeking medical opinion in respect of death of late Mamta w/o Shri Sandeep r/o L-32/36, Sangam Vihar, Delhi, who received treatment at Krishna Medical Centre and subsequently died on 14.5.2007, allegedly due to medical negligence of the doctors of Krishna Medical Centre including yourself, is being examined by Delhi Medical Council."

The petitioner was, therefore, directed to submit his statement of defence with supporting documents to the DMC.

6.11 The petitioner replied to the DMC, on 22 June 2007, thus:

"Respected Sir,

On 14/5/2007, I received an urgent call from Krishna medical Centre, Madan Gir, New Delhi for Ultrasound examination of a patient, Late MAMTA W/O Sh. SANDEEP having profuse Bleeding per vagina.

I Immediately rushed there with my portable U.S.G machine & at that time the patient was in Operation Theatre & Treating Gynaecologist Dr. Archana Kothari was also present there.

The U.S.G. Examination I noticed some products of conception & blood clots in the uterine cavity & diagnosis was conveyed to treating gynaecologist.

Dr. Archana Kothari decided to remove the products of conception & I was requested by her to help in the procedure WITH ULTRASONOGRAPHIC GUIDANCE, AS TO CONFIRM THAT .... illegal...PRODUCTS WERE REMOVED COMPLETELY.

Products of conception were removed by Dr. Archana Kothari & No untoward happening was appreciated during the procedure.
After that I Left the Operation theatre.

Sir, I have to say that I HAD NOTHING TO DO WITH THE TREATMENT & MANAGEMENT OF THIS PATIENT.

Thanking You,

Yours Faithfully,

DR. PRAMOD BATRA"

6.12 According to the petitioner, Dr. Kothari misrepresented to the DMC, during hearing, that the petitioner had conducted USG twice, firstly at 3.30 pm and thereafter at 4 pm and had found the uterine cavity to be empty on both occasions. The petition avers that this could not have been possible, as the petitioner had received a call, from KMC, on his Cell Phone number, at 3.28 pm. The petition further alleges that the records produced by Dr. Kothari before the DMC were also fabricated to make it appear that the petitioner had conducted two ultrasonographic examinations on Mamta.

6.13 Hospital Notings

6.13.1 It is relevant, at this point, to reproduce the notings in the Note Sheet of the KMC on 14 May 2007, as filed by Dr. Archana Kothari before the Delhi Medical Council (DMC) and the separate Noting made by the petitioner himself, to the extent relevant (the drugs administered are being omitted):

Noting submitted by Dr Archana Kothari to the DMC:

Date	**Notes**
14.5.2007 2.25 pm	Patient seen by Dr Archana Kothari in Krishna Hospital with C/o Excessive bleeding P/vagina since ½ hour and did not complied with the direction given on dated 12.5.2007 about consulting to Safdarjung Hospital and also had opted essential investigation so advised on 12th. Pt is conscious and (illegible) oriented. O/E

	P/R 92/minute R/R 16/minute BP 112/78 mm Hg Temp 98.4^{o} F CVS, Chest, CNS – NAD P/A (Illegible) abd Tenderness P/V done by Archana at 2.10 pm. <u>Findings</u> - Blood and clots present in vagina - OS open one finger - Products of conception felt <u>Diagnosis</u> INEVITABLE ABORTION WITH BLEEDING PER VAGINA <u>Advised by Dr Archana Kothari</u> for US Guided D & C under sedation.
14/5/07 3 pm	Procedure – USG guided D & C under sedation (Fortwin + Phenargan) done Dr P Batra joined at 3 pm (His notes attached separately) <u>Report received</u> ***** Vitals checked Pt put in lithotomy position. Postr vaginal wall retracted by (illegible) speculum. Antr lip of Cx hold by vabellum forcep. Product of conception removed by Ovum forcep followed by check curettage done. Procedure finished at 3.30 pm. Pt allow to shift to post operative recovery room. (Product of conception handed over to husband.) <u>3.45 pm</u> PR – 80/min BP – 110/70

	Chest – clear BPV – Nil Advised - Watch for vitals ½ hrly for 3 hrs - I.V. fluid continued - Rest

Separate Noting by petitioner

Date	**Notes**
14/5/07	USG (illegible) Call attended at 3.10 p.m. for U.S. Guided D & C, done by Dr Archana Kothari. - POCs are removed. Cavity was empty after the procedure was completed. No fluid seen in POD[5] 4.00 P.M. U.S.G. - Cavity is empty - No fluid/blood in POD Sd/- (Dr Pramod Batra)
14.5.2007 4.00 p.m.	Pt is conscious Well oriented P/R 80/minute

[5] Pouch Of Douglas, a retrouterine cavity found in females; absence of fluid or blood in the POD usually indicates a successful procedure without residual infection – alternatively referred to as *cul de sac*

	BP 110/70 mm Hg Chest clear No collection in *cul de sac* checked by Ultrasonologist (Dr Pramod Batra) Sd/- (Dr Pradeep Kharbanda)
4.30 p.m.	Pt comfortable P/R 78/minute BP 110/70 mm Hg Sd/- (Dr Pradeep Kharbanda)

It is asserted, in the writ petition, that the petitioner signed only once on the Note Sheet, after recording the results of one USG examination conducted on Mamta.

6.13.2 The Note Sheets of KMC, thereafter, till the Discharge Slip issued at 7.15 p.m. on 14 May 2007, record satisfactory progress of Mamta. *Sans* the drugs prescribed, the Discharge Slip read (to the extent relevant) thus:

"DISCHARGE SLIP

MRS MAMTA 21 yr/F

Consultant Incharge – Dr Archana Kothari

Date of Admission 14.5.2007 at 2.25 pm

Date of Discharge 14.5.2007 at 7.15 p.m.

Pt seen in Krishna Hospital with c/o excessive bleeding. Case was seen by Dr Archana Kothari Consultant Gynaecologist. Pt came conscious well oriented with stable vitals. CVS, CMI NAD Chest clear. There was lower abdomen tenderness. P/V done by Dr Archana Kothari showed Blood and clot in vagina. OS was open one finger. Pt admitted with the Diagnosis of INEVITABLE ABORTION WITH BLEEDING PER VAGINA WITH PREVIA LSCS.

MANAGEMENT – US Guided D & C under sedation done on 14.5.2007 at 3.00 p.m.

INVESTIGATION Hb 10.6 g/ml. BT 3 minutes 30 sec. CT 5 minutes 30 sec. P.T. 14 sec (control 12 sec). ECG within normal limits.

Condition at the time of discharge Pt was well oriented conscious P/R 78/minute BP 110/70. No (illegible) of bleeding (illegible). Abdomen soft. CVS CNS NAD. Chest clear.

Sd/-
(Dr Pradeep Kharbanda)"

6.13.3 At 8.10 p.m, however, the following Noting came to be recorded:

"At the time patient husband informed to me that patient is still in the corridor of medical centre as he failed to arrange medical to remove the patient and pt Mamta has fainted in corridor. I immediately rushed to patient immediately.

At that time patient was looking critical having laboured breathing and gasping. Patient immediately put on bed nearby. Patient was pale with cold and clammy skin. O/E chest was full of crepts at back and lower half of the chest. Heart and S1 S2 was not audible. Pulse was not palpable and BP was not recordable. Patient was … (Nearly completely illegible)

(Illegible)

Pt did not show any improvement. (Illegible) given at 8.30 pm and cardiac massage continued.

Patient pupil was dilated and fixed. (Illegible)

> Patient declared Dead at 8.00 pm and explained to husband. Cause of Death could not identified and explainable and to be identified on autopsy.
>
> Patient's husband became panic and wanted to remove patient to Safdarjung Hospital or AIIMS immediately.
>
> His Direction complied. Pt put in personal car and shifted to Safdarjung Hospital where pt declared brought dead.
>
> Sd/-
>
> (Dr Pradeep Kharbanda)"

6.13.4 The Post Mortem report at Safdarjung Hospital recorded the cause of death of Mamta as "haemorrhagic shock, consequent upon perforation of the uterus, following surgical intervention".

6.14 On 5 December 2007, the petitioner submitted a further representation to the DMC, stating thus:

> "As stated earlier, D & C done under Ultrasonographic guidance & Products of conception were removed by the Gynaecologist. At no point of time, Gynaecologist suspected any perforation or uterine wall or any feeling of giving way.
>
> AT THE TIME OF COMPLETION OF PROCEDURE, NO PRODUCTS OF CONCEPTION WERE APPRECIATED IN UTERINE CAVITY & NO FLUID BLOOD WAS SEEN IN PELVIS.
>
> AFTER THIS I LEFT THE PREMISES WITH MY USG MACHINE & NEVER PERFORMED ANY ULTRASOUND EXAMINATION AGAIN."

6.15 Further representations were addressed by the petitioner to the DMC on 30 December 2007, 11 January 2008 and 16 January 2008. To the extent relevant, extracts from the representation dated 30 December 2007 may be reproduced thus:

"I had attended my last Hearing before the Disciplinary Committee of Delhi Medical Council on 20th December, 2007, I was shocked to listen to a statement made by Dr Archana Kothari (Gynaecologist) that I had examined the concerned patient twice.

After that I have procured the photocopy of the case records submitted with D.M.C.

Sir, The records submitted are totally false. Written afterwards by correlating with my timings noted on separate sheet.

Only D & C was performed under Ultrasonographic guidance.

DR ARCHANA KOTHARI DID NOT SUSPECT ANY UTERINE WALL PERFORATION OR ANY FEELING OF GIVING WAY DURING THE PROCEDURE. I HAD ONLY THE SUPPORTIVE ROLE IN THIS CASE, ONLY SO AS TO CONFIRM THAT IS EVACUATION IS COMPLETE. NO PRODUCTS OF CONCEPTION OR ANY COLLECTION IN PELVIS WAS SEEN AT TIME OF COMPLETION OF PROCEDURE."

6.16 The representation dated 11 January 2008 also relied on the following representation of Dr. Pradeep Kharbanda to the DMC:

"To

The Secretary,
(Dr Girish Tyagi),
Delhi Medical Council, N. Delhi.

Ref. No.: DMC/14/2/Comp. 411/2007/31316

Respected Sir,

I WILL LIKE TO INFORM THE DISCIPLINARY COMMITTEE THAT ON 14/5/07, DR PRAMOD BATRA HAD IMMEDIATELY LEFT THE OPERATION THEATRE JUST AFTER THE COMPLETION OF PROCEDURE ON PATIENT, NAMED MAMTA. HE WAS NEVER CALLED AGAIN FOR ANY SONOGRAPHIC EXAMINATION OF THIS PATIENT.

Thanking You,

Yours Faithfully,

Dr. PRADEEP KHARBANDA"

6.17 Consequent to grant of personal hearing, the DMC, *vide* Order dated 4 February 2008, observed, with respect to the petitioner, thus:

> "Dr Pramod Batra stated that he did the ultrasound only once and that too during the D&C procedure. On being asked by the Council that if the ultrasound was done on only one occasion then why two findings of the ultrasonologist (Dr Pramod Batra) are mentioned in the medical records i.e. one at 3.10 p.m. "POC's are removed, cavity was empty after the procedure was complete; no fluid seen in POD" and the other at 4.00 p.m. "USG cavity is empty; no fluid/blood in POD", no satisfactory explanation was given by Dr. Pramod Batra."

The Order concluded with the following findings:

> "In light of the findings made hereinabove, the Council makes the following observations[6]:-
>
> 1. The patient being a case of inevitable abortion with bleeding per vaginam was rightly taken up for D & C (USG guided in the present case due to readily available USG in OT). Dr. Pramod Batra stated before the Council that continuous monitoring was done with the ultrasound probe during the surgical procedure.
>
> Uterine perforation is a known complication of D & C procedure, if done blindly. Ultrasound guidance for the procedure is used to alert the surgeon if going in false track.
>
> 2. The post-mortem findings of uterine perforation and large quantity of blood (3 litres) in the peritoneum are evidence of the fact that there has been lapse in monitoring the clinical condition of the patient which lead to irreversible shock and eventually death of the patient. *A second ultrasound done after the completion of procedure at 4.00 pm should have detected blood/fluid in the pelvic cavity.*
>
> The patient going into haemorrhagic shock is a gradual process and happens over a period of time. The patient

[6] The words "findings" and "observations" should, more appropriately, be interchanged.

starts exhibiting the symptoms, which if monitored diligently, can be managed by initiating timely remedial measures. The fact that post operatively the condition of the patient is reported to be stable and that she was discharged at 7.30 pm reflects total lack of exercise of reasonable degree of skill and knowledge in the assessment of the clinical condition of the patient. A patient who is under the care of a medical professional in a hospital set up cannot go into haemorrhagic shock just within forty minutes after having been found to be stable enough to merit a discharge, unless the doctor has been careless in failing to notice the gradual deterioration in the patient's condition. It is unlikely that the patient remained in stable condition at 5.00 pm (1 ½ hours after D & C) when 3 ltrs haemoperitoneum has been documented in the post-mortem.

3. The averment made by Dr. Archana Kothari and Dr. Pradeep Kharbanda in their written statement in reference to the patient when she has been discharged at 7.30 pm but was still in hospital premises at 8:10 PM as to "what happened "God Knows" the patient suddenly collapsed in corridor", is highly unbecoming of individuals were supposed to have a rational mind of a medical professional and also reflects the lack of knowledge in comprehending the clinical condition of the patient.

It is, therefore, the decision of the Delhi Medical Council that Dr. Archana Kothari failed to exercise reasonable degree of skill, knowledge and care whilst monitoring the condition of the patient after D & C, as even at 5.00 pm, when Dr. Archana Kothari purportedly left the said Centre, as per her notes in the medical records, the condition of patient had been reported to be stable. The failure of Dr. Pramod Batra to detect fluid/blood in the pelvic cavity after half an hour of the completion of D & C procedure in the ultrasound done at 4.00 pm reflects the lack of exercise of reasonable degree of skill, knowledge and care in monitoring the clinical condition of the patient.

Dr. Pradeep Kharbanda was closely monitoring the clinical condition of the patient, did not exercise reasonable degree of skill, knowledge and care as he failed to notice the deteriorating condition of the patient which warranted timely remedial treatment to manage the complication arising from perforation of the uterus. The clinical condition of the patient as noted in the medical records are not in consonance with the autopsy findings and in fact supports the assertions of Shri Sandeep that post-operatively late

Mamta was not looked after by any doctors. It is pertinent to mention that on being asked as to why the medical records pertaining to treatment of late Mamta at Krishna Medical Centre were on the letterhead of Dr. Pradeep Kharbanda Krishna Memorial Hospital Pvt Ltd and not of Krishna Medical Centre, no satisfactory explanation was forwarded by Dr. Pradeep Kharbanda. It is also noted that the consent for USG guided D & C as the obtained on the letterhead of Krishna hospital. It is further noted that it is the Krishna Medical Centre which is registered with Directorate of Family Welfare not Krishna Hospital. These all observations raise a strong suspicion as to credibility of the medical records.

The signs and symptoms of a patient going into haemorrhagic shock exhibit, are so apparent (like fall in blood pressure, tachycardia etc.) that no ordinary competent doctor exercising ordinary skills is expected to miss.

In view of the opinion of the Delhi Medical Council as expressed hereinabove, the Delhi Medical Council directs the removal of names of Dr. Archana Kothari, Dr. Pramod Gupta and that of Dr. Pradeep Kharbanda for a period of 3 months from the State Medical Register of daily Medical Council. Restoration of the name of Dr. Archana Kothari, Dr. Pramod Batra and Dr. Pradeep Kharbanda in the State Medical Register of Delhi Medical Council will be subject to the attending 15 Continued Medical Education programmes in the field of radiology or medical/surgical/gynaecological emergencies, within the period of suspension and submitting a compliance report in this regard, to the Council.

The opinion of the Delhi Medical Council holding the above named doctors is guilty of medical negligence is final. However, the Order directing the removal of names from the State Medical Register of captaincy Medical Council shall come into effect after 30 days from the date of this Order.

Matter stands disposed."

6.18 The petitioner appealed against the aforesaid Order dated 4 February, 2008 of the DMC to the MCI, under Regulation 8.8 of the Code of Ethics Regulations 2002. In the appeal, the petitioner

maintained the stand that he had conducted only one USG of Mamta and that the records of KMC had been fabricated to suggest otherwise.

6.19 The petitioner's appeal was first placed before the Ethics Committee of the MCI which, in its meeting dated 29 and 30 July, 2009, reiterated, verbatim, the decision of the DMC, to remove, from the State Medical register, the names of Dr. Archana Kothari, Dr. Pradeep Kharbanda and the petitioner and to subject the restoration of their names on the State Medical register to their attendee continued Medical Education program in the field of their speciality within the period of suspension and submitting a compliance report in that regard to the MCI.

6.20 The decision of the Ethics Committee was put up to the Executive Committee of the MCI which, observing thus, remitted the case, *qua* the petitioner, to the Ethics Committee for reconsideration:

> "The Executive Committee of the Council observed that there is nothing on record available before the Committee which would indicate that negligence by Dr. Pramod Bartha who had carried out ultrasonography 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."

6.21 The matter was reconsidered by the Ethics Committee in its meeting dated 17 November 2009. Having noted, briefly, the facts of the case, the allegations against the various doctors, the decision of the DMC, and the respective defence statements of the doctors, the Ethics Committee observed and held as under:

"1. A 21 year young lady who came for inevitable abortion for D & C. The D & C was done under the guidance of ultrasound.

2. The patient was not followed by the doctor who did D&C till the time of discharge which was 07:30 pm.

3. The patient died in the veranda of the hospital due to haemorrhagic shock which was a preventable cause of death.

4. The doctor who had done the D&C had not seen the patient before discharge.

5. The owner of the nursing home cannot shrug his responsibility in taking care of the patient when she was admitted in his hospital.

6. Dr. Pramod Batra made the statement, indicating that all the case facts noted in the records are totally false, whole story is cooked and written in a planned manner, just to misguide the law and members of Disciplinary Committee.

7. The Delhi Medical Council is observed that ultrasound was done only once that too during D&C procedure but there are two findings of ultrasound one at 3:30 p.m. at another one at 04:00 p.m. for which no satisfactory explanation was given by Dr. Pramod Batra.

8. Dr. Archana Kothari conducted D&C procedure with the use of suction cannula and not with ovum forceps as claimed by Dr. Archana Kothari.

9. Post mortem revealed that there was perforation of uterus with blood collection in the abdomen.

The Members of the Ethics Committee unanimously decided that there has been a gross medical negligence on the part of Dr. Archana Kothari and Dr. Pradeep Kharbanda. Their names may be removed from the Indian Medical Register temporary for a period of six months for their medical negligence and has to go for continuing medical education in his speciality during that period under intimation to this Council.

> Dr. Pramod Batra's name has also to be removed from the Indian Medical Register temporary for a period of three months for falsifying the records as observed by the Delhi Medical Council."

6.22 The above decision of the Ethics Committee was approved, in *toto*, both by the Executive Committee of the MCI and, thereafter, by the General Body of the MCI in its meeting dated 11 March 2010.

6.23 Aggrieved by the decision of the MCI, the petitioner, Dr. Pramod Batra has invoked the extraordinary jurisdiction vested in this Court by Article 226 of the Constitution of India.

Rival Contentions

7. Submissions of Mr. Siddharth Aggarwal on behalf of the petitioner

7.1 Mr. Siddharth Aggarwal, learned Senior Counsel for the petitioner, submits that the basis on which punishment has been imposed on the petitioner by the MCI is foreign to the case initially set up against him and which he was given an opportunity to defend. The allegation against the petitioner, from the beginning, was of medical negligence. Having held, on that issue, in favour of the petitioner, Mr. Aggarwal submits that the MCI was required, per consequence, to exonerate the petitioner. Instead of doing so, the petitioner has been punished on the ground of falsifying records without even a complaint against him on that account. Ironically, points out Mr. Aggarwal, it

was the petitioner who was alleging the fabrication of records by Dr. Archana Kothari.

7.2 Mr. Aggarwal submits that the MCI has acted with completely non-application of mind in failing to notice that the medical records of KMC had been manipulated to make it appear that the petitioner had conducted the USG of Mamta twice. In fact, he submits, the petitioner was only assisting Dr. Kothari in carrying out the USG guided D&C, and was not requested to undertake any further exercise. Once the D&C was over, therefore, the petitioner left KMC.

7.3 The fact that Dr. Archana Kothari had fudged the medical records of KMC, submits Mr. Aggarwal, is apparent from the telephone call, received by the petitioner's at 3:28 p.m. It was impossible, therefore, for the petitioner to have been assisting in the D & C from 3 p.m. onwards. Indeed, submits Mr. Aggarwal, the petitioner received the first call from KMC only at 3.10 p.m, and could reach KMC only at about 3:30 p.m. The fact that, once the D & C was over, the petitioner did not carry out any further ultrasonological examination of Mamta stood vouchsafed by the letter of Dr. Pradeep Kharbanda to the DMC as well. Despite the said letter having been brought to the notice of the DMC as well as the MCI, neither authority paid heed thereto.

7.4 Mr. Aggarwal further submits that the want of application of mind on the part of the MCI is also manifest from its concluding decision to uphold the allegation of falsification of records, allegedly

confirmed against the petitioner by the DMC. In fact, submits Mr. Aggarwal, no such finding had been returned by the DMC against the petitioner. The DMC had recommended removal of the name of the petitioner from the State Medical register for three months, not on the ground of falsification of medical records, but on the ground of medical negligence. That finding having been reversed by the MCI, the only *sequitur*, in Mr. Aggarwal's submission, could have been the exoneration of the petitioner.

8. Mr. Singhdev, appearing for the MCI, submitted that the duty discharged by the MCI in cases such as this is purely quasi-judicial in nature. He submits that the justification, for the concluding findings of the MCI against the petitioner, is to be found in the impugned Order itself. As is noted in the impugned Order, the petitioner was unable to explain why, in his noting on the official record of KMC, he was shown to have carried out USG on Mamta twice, contrary to his assertion that he had carried out the USG only once, and had not conducted USG after the D&C was over. The finding being purely one of fact, arrived at on the basis of the material on record, Mr. Singhdev's submission is that no occasion arises for a writ court to interfere therewith.

Analysis

9. To my mind, the impugned Order of the MCI, even by itself, renders the outcome of this litigation a foregone conclusion. The petitioner is, clearly, entitled to succeed.

10. In the impugned Order, the MCI has dropped the allegation, against the petitioner, of medical negligence. The petitioner has been mulcted with the punishment of removal of his name from the Indian Medical register on the ground of falsification of records.

11. At no stage, prior to the passing of the impugned Order by the MCI, was the petitioner ever charged with falsification of records. Commencing from the initial communication dated 11 June 2007, received from the DMC, the allegation against the petitioner was medical negligence, which contributed to the unfortunate death of Mamta.

12. The allegation of medical negligence has been categorically found, by the MCI, to be without substance. The petitioner never having been put to show cause regarding any other allegation, including the allegation of falsification of records, the sequitur to the finding that the petitioner was not guilty of medical negligence had, as Mr. Aggarwal correctly submits, necessarily to be his honourable exoneration. It is one of the most fundamental principles of natural justice, partaking of the character of *audi alteram partem*, that a person cannot be condemned for a misdemeanour of which he is not accused, and regarding which he has been given no opportunity to defend himself. One may refer, in this context, to ***Mohinder Singh Gill v. The Chief Election Commissioner***[7].

[7] **(1978) 1 SCC 405**

13. That is, however, precisely what the impugned Order of the MCI does. Even on that sole ground, the Order, insofar as it punishes the petitioner, deserves to be set aside.

14. That apart, it is not possible to glean, even from an incisive reading of the impugned Order, as to what falsification of record is precisely being alleged against the petitioner. Mr. Singhdev has referred to the para, from the order dated 4 February 2008 of the DMC, reproduced in para 6.17 *supra*. What is stated in the said paragraph is that the petitioner was unable to reconcile his assertion that he had not conducted USG examination of Mamta twice with his noting of 14 May 2007 in the KMC records. To my mind, the question of whether the petitioner conducted USG of Mamta once, or twice, really does not arise, as the entire D&C procedure, carried out by Dr. Archana Kothari, was admittedly under the ultrasonographic guidance provided by the petitioner. Frankly, I fail to understand how, in such procedure, it can precisely be stated that the petitioner conducted USG of Mamta a finite number of times. Mamta was under ultrasonographic evaluation, by the petitioner, as part of the assistance provided in the D&C procedure carried out by Dr. Archana Kothari, throughout the process. That being so, it cannot be said that there was any falsification, by the petitioner, of the record of KMC.

15. If one reads the impugned order, one finds no observation, or finding, to sustain the conclusion that the petitioner had falsified the hospital records. There is no reference to the precise record which the petitioner had allegedly falsified. Falsification of records is an

extremely serious matter. It partakes of crime, and is coloured by criminal intent.. Where the falsification takes place in connection with treatment of a patient, especially where the patient is dead, the seriousness of the misdemeanour increases manifold. A finding of falsification of records cannot, in such circumstances, be lightly arrived at. The order must be precise and exact, regarding the record which was falsified, the manner in which it was falsified at the time when such falsification took place. Prior to arriving at such a finding, the concerned doctor has to be put on notice regarding all these aspects, so that he is in a position to respond. The impugned Order merely reiterates the finding of the DMC in this regard. The defence of the petitioner, including the reference to the phone call received by him at 3:28 p.m., have not even been extended the courtesy of a cursory glance.

16. On reading the impugned order, I am constrained to observe that, having found that no allegation of medical negligence could sustain against the petitioner, the MCI confirmed, against him, the allegation of falsification of records, which was never even raised against him in the first place, merely so as to justify imposition of punishment on the petitioner. This is an extremely unhappy situation. Striking off, from the Indian Medical Register, of the name of a doctor, partakes of the character of a civil death, insofar as the professional career of the doctor is concerned. The familial and societal ramifications of such a decision, which is bound to garner publicity, are also far and wide reaching.

17. While it is true that a medical professional is expected to possess a certain minimum standard of competence, failing which he has no justification for dispensing medical treatment, and that conduct which fall short of even that minimum medical standard, or display callous negligence to the welfare of a patient, has to be dealt with severely, it is equally true that the scalpel cannot be wielded by a shaking hand. Baseless targeting of doctors, unmindful of the consequences, is bound, in the ultimate eventuate, to seriously prejudice public interest.

18. No more need be said on that count, in the present case, as the MCI has, quite fairly, discharged the petitioner of the charge of medical negligence. Having so held, the MCI could not proceed, nonetheless, to punish the petitioner, for falsification of records. Even if it were to be assumed that the charge of falsification of records could be confirmed by the MCI despite no such allegation having been made against the petitioner at any earlier point of time, such a charge, in order to sustain, has to be based on clear, cogent and comprehensible material, which has been put to the concerned Dr. and which the doctor that opportunity to rebut.

19. The impugned Order fails to meet the necessary standard as would persuade this Court to sustain the finding, against the petitioner, of falsification of records or, consequently, the punishment that the MCI has deemed appropriate to award to the petitioner on that account.

Conclusion

20. The impugned Order dated 20 March 2010 cannot, therefore, sustain on facts or in law. It is, accordingly, set aside.

21. The petition, accordingly, succeeds.

22. There shall be no order as to costs.

C.HARI SHANKAR, J

JULY 3, 2023