July-December 2019 Volume 28 Issue 2
PRINT ISSN: 2277-1867
ONLINE ISSN: 2277-8853

JOURNAL OF FORENSIC MEDICINE SCIENCE AND LAW

Official Publication of Medicolegal Association of Maharashtra

MULTISPECIALITY, MULTIDISCIPLINARY, NATIONAL
PEER REVIEWED, OPEN ACCESS, MLAM (SOCIETY) JOURNAL

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Journal of Forensic Medicine Science and Law 28 (2) (2019) 37-39

JOURNAL OF FORENSIC MEDICINE SCIENCE AND LAW
(Official Publication of Medicolegal Association of Maharashtra)
Email.id: mlameditor@gmail.com

PRINT ISSN: 2277-1867
ONLINE ISSN: 2277-8853

Review Article

Duty of Candour in Indian Context: How Much Information is too Much for Our Patients?

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Article Info

Key words
Physicians,
Patient interest,
Inadvertent complications,
Compensation.

Abstract

Introduction:
Duty of candour is the requirement of all physicians i.e., being open and honest with their patients especially when things are likely to go wrong or have gone wrong. This is very crucial especially in high risk branches such as obstetrics and gynaecology where two lives, mother and baby are at stake.
Background:
Following this duty of candour can be very tricky in present day Indian scenario, when patient trust is difficult to gain and every move of the physician is taken by patient as a means of monetary gain.
Method:
We present a review article with stimulated examples of commonly encountered scenarios in obstetrics and gynaecology where physician duty and patient interest are at stake. These are followed by discussion.
Conclusion:
The current scenario in Indian subcontinent is such that doctors are afraid to tell in detail about any inadvertent complications patients may file lawsuit or claim monetary compensation or damage the hospital.

Introduction:

In the branch of Obstetrics and Gynaecology things can go very wrong sometimes and what is expected to be a straightforward case can have serious complications. 97% of all obstetrics patients have no complications and have good outcomes. It's the ones who have unexpected outcomes that we have to be careful in management, documentation and communication. But unless things go wrong we do not know which patient needed to have adequate and detailed communication and documents.

Professional "Duty of condour" as described by Nursing and Midwifery Council[1] is that each and every doctor should be frank and truthful with his/her patients and when any treatment or surgical

How to cite this article: Tambawala ZY, Kale DP, Duty of Candour in Indian Context: How Much Information is too Much for Our Patients? J For Med Sci Law 2019;28(2):37-39.

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procedure that goes wrong or causes, or has the potential to cause, harm or distress the doctor must tell the patient or his family when something has gone wrong, apologise to the patient offer an appropriate remedy or support to put matters right (if possible), explain fully to the patient the short and long term effects of what has happened.[1,2]

This is absolutely essential in correct medical practice, but in present day Indian Scenario, with relation to obstetrics and gynecology patients things can be quite tricky. As honorable doctors it makes complete sense to give complete and accurate information, but this information itself can antagonize the patient and may increase hostility.

Scenario 1:

A 24 year old primigravida with 39 weeks of pregnancy with high blood pressure not being controlled on medications. She need to be delivered early and is offered induction of labour. She and her family want to know the possible options and their outcomes. They are counseled in detail by the treating physician that her baby size is small for gestation age, possibly due to the pregnancy induced hypertension, they are also explained in detail about chances of failure of induction of labour, prolonged stay in hospital for mother and baby, detailed information about labour increased time taken by a primigravida to respond to labour pain told. Chances and risks of cesarean sections explained. Risks of complications in future pregnancy if this one ends up in cesarean also explained. Another option of immediate cesarean section also offered. Small chance of baby requiring NICU (neonatal ICU) also told. Prolonged hospitalization, risk of convulsions in mother if not delivered soon explained. After discussion they opt for induction of labour.

The mother takes 3 prostaglandin pessaries sequentially every 8 hours and then is started on oxytocin augmentation after artificial rupture of membranes. The entire process takes more than 36 hours. Still she is nowhere near delivery, the physician offers her cesarean for failure of induction, but the family wants to wait more. They wait for another 6 hours though are constantly urged by the physician to go cesarean as there are no changes in bishop's score (which indicates chances of normal delivery). Finally, the fetal heart becomes abnormal on cardiotocography and reluctantly they agree for cesarean on persistent counseling by the doctor. The baby is 2.3 kg and handed to neonatologist but needs admission to NICU for 5 days. Mother has post partum hemorrhage and is also admitted in ICU for 4 days before being sent home.

The family gets upset and refuses to settle bills claiming this to be a complication by the doctor. They accuse the doctor of also trying to pressurize them for cesarean from the beginning itself. They accuse him of planning the prolonged stay and cesarean in advance to make more profit. The doctor thinking that it was his duty to inform about all outcomes but this itself is taken against him and the patient relative refuse to settle the bills and take him to consumer court for malpractice.

There is a general perception in the public that most obstetricians want to do cesarean section directly without giving trial of labour. But in reality in most developed countries with adequate heath infrastructure the rate of cesarean section is about 25%. In fact, WHO has identified 15% cesarean section rate as a marker for adequate healthcare for pregnant women.[3] This rate of cesarean also is increased in women for whom labour is induced which could be due to multiple reasons. In fact the chances of caesarean in case of induction of labour are known to be close to 22%.[4]

But unfortunately Indian doctors are losing trust from their patients and their families and are constantly being accused of unnecessary interventions for generating profits, though these interventions may only be offered for the best interest of the patient. If the cesarean was done 6 hours earlier, as advised by the doctor in the above case, possibly the baby's NICU admission could have been avoided.

Scenario 2:

34-year-old patient trying to conceive for 3 years, she and her husband have tried multiple medications but to no avail. They have tried ovulation induction with clomiphene, injectable gonadotropins and finally opted for invitro fertilization(IVF). As duty of candour the fertility specialist informed them the chances of success of

invitro fertilization could be upto 30% per cycle. Increased risk of miscarriage, preterm and multiple gestation were explained. They were also informed about chances of congenital malformation are increased in IVF pregnancies and could be 2-5%. They underwent the first cycle of IVF which was unsuccessful, after taking a break for a month they opted for their second cycle and were fortunate to conceive. They conceive triplets and unfortunately one of the babies had a congenital heart condition and required multiple surgeries post delivery. Being triplet pregnancy the baby was also preterm and this increased morbidity.

The couple were informed in detail about chances of malformation in the baby and risks of preterm. Since, it has long term implications and very high morbidity for the baby it was imperative for the couple to be informed about the possible implications.

Scenario 3:

28-year-old gravid 2 para 1 was 8 weeks pregnant and she suffered a missed miscarriage, she opted for surgical management of miscarriage and underwent a suction evacuation under general anaesthesia. Unfortunately, she had a uterine perforation during the procedure. The doctor identified the mistake but since she was vitally stable did not do any further procedure. Post operative after the patient regained consciousness, she informed the patient in detail about the events. She also informed the patient about the chances of delayed peritonitis, as there is a small possibility that she may have delayed onset of the symptoms. Also need for caution in future pregnancies explained, close monitor and possible cesarean at term to avoid uterine damage explained.

This doctor shows exemplary duty of candour. When an inadvertent complication arises it's the duty of the doctor to inform it in detail to the patient as in this case it can have implications in future fertility of the patient as well. Peritonitis is a life threatening condition and patient was made aware of all its symptoms so she could avoid immediate medical help necessary.

Conclusion:

The professional duty of candour is vital, even if it meant risking a possible litigation from the patient side for the complication.

However, the current scenario in Indian subcontinent is such that doctor are afraid to tell in detail about any inadvertent complications patients may file lawsuit or claim monetary compensation or damage the hospital. This culture of fear will be more detrimental to the patients' best interest in the future as doctor and other health care professional may hide or under report any possible complications to avoid reprimand. This will harm patient interest. This will also bring down the level of care that Indian physician are known for world over.

Strict laws should be made to protect doctors from litigation when they disclosed complete information to the patient in a timely and systematic manner.

References:

1. Gray, T. G., Jha, S., Bolton, H.. Duty of candour: the obstetrics and gynaecology perspective. *The Obstetrician & Gynaecologist*. 2019; 21: 165– 168. DOI: 10.1111/tog.12586.
2. https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/#appendix_one.
3. WHO recommendations non-clinical interventions to reduce unnecessary caesarean sections. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.
4. Inducing labour; Clinical guideline [CG70]Published date: July 2008. www.nice.org.