

Uncontrollable Immune Crisis Cascades in Medicine: A Medico-Legal Defense Framework

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ABSTRACT

Fatalities in clinical practice may arise from **autonomous immune crisis cascades** that are biologically uncontrollable and independent of physician conduct. These cascades typically begin with a **cytokine storm**, progress to **disseminated intravascular coagulation (DIC)**, and culminate in **multiorgan failure (MOF)**. Once triggered, the process is self-perpetuating, resistant to therapeutic intervention, and irreversible despite maximal supportive care. Such crises are **unpredictable, unforeseeable, and not treatment-induced**, making attribution of liability to the treating physician medically unsound and legally unjust. This pleading seeks judicial recognition of these syndromes as **recognized uncontrollable fatal pathways**, thereby protecting practitioners from wrongful negligence claims.

KEYWORDS

• Cytokine Storm • Disseminated Intravascular Coagulation (DIC) • Multiorgan Failure (MOF) • Immune Crisis Cascade • Systemic Inflammatory Response • End-of-Life Syndromes • Medical Liability • Uncontrollable Fatality • Medico-Legal Defense • Physician Protection

INTRODUCTION

In practice of medicine there are known medical conditions where a disease episode, for unexpected and unforeseeable reasons, enters into crisis cascade that leads to fatality. The crisis is self triggered and not dependant on the treatment. The crisis is triggered by the hypersensitive self-

perpetuating, self-damaging immune response of the patient. Once it sets in, it is uncontrollable, only symptomatic support measures are available that cannot reverse or stall the cascading crisis. The treating physician should not be held liable for the fatality. Unfortunately they are not factored into judicial consideration while assigning causal

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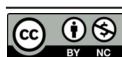
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relationship. Since these crisis cascades are technically too complex, they cannot be effectively articulated except by a super specialist. It is essential for the vast medical fraternity to be aware of these to effectively place before the court.

The end-of-life life-threatening **systemic inflammatory syndrome** where the body's immune response becomes maladaptive, causing widespread damage to tissues and organs. While these conditions can occur separately, they often act as a cascade: a triggering event (e.g., sepsis, severe anaphylaxis, or COVID-19) triggers a **cytokine storm**, which leads to **disseminated intravascular coagulation (DIC)**, ultimately resulting in **multiorgan failure (MOF)**.

Q. Please define and elaborate on pathophysiology and interplay between these conditions for them to constitute uncontrollable crisis syndromes so that they become part of the pleading in appropriate cases

Here's a structured medico-legal articulation of the **pathophysiology and interplay** between cytokine storm, disseminated intravascular coagulation (DIC), and multiorgan failure (MOF), framed to highlight why these constitute **uncontrollable crisis syndromes** beyond physician liability.

1. Cytokine Storm: The Trigger

- **Definition:** A cytokine storm is a hyperactive immune response where pro-inflammatory cytokines (IL-6, TNF- α , IL-1 β , interferons) are released in massive, uncontrolled amounts.
- **Pathophysiology:**
 - Triggered by infections (sepsis, COVID-19), autoimmune flare, or drug reactions.
 - Causes widespread endothelial activation, capillary leak, and tissue edema.
 - Leads to **systemic inflammatory**

response syndrome (SIRS), which is self-perpetuating and resistant to therapeutic modulation.

- **Clinical consequence:** Rapid progression to acute respiratory distress syndrome (ARDS), shock, and organ dysfunction.

2. Disseminated Intravascular Coagulation (DIC): The Amplifier

- **Definition:** DIC is a pathological activation of the coagulation cascade, leading to widespread microthrombi and consumption of clotting factors.
- **Pathophysiology:**
 - Cytokine storm activates tissue factor pathways → uncontrolled thrombin generation.
 - Microvascular thrombosis causes ischemia in vital organs.
 - Simultaneous consumption of platelets and clotting factors → catastrophic bleeding risk.
- **Clinical consequence:** Patients oscillate between **microvascular clotting** and **massive hemorrhage**, both uncontrollable once cascade begins.

3. Multiorgan Failure (MOF): The End Point

- **Definition:** Progressive, simultaneous failure of ≥ 2 organ systems due to systemic inflammation and ischemia.
- **Pathophysiology:**
 - Cytokine storm → endothelial damage → capillary leak → hypoperfusion.
 - DIC → microthrombi → ischemic necrosis.
 - Mitochondrial dysfunction and apoptosis amplify irreversible organ shutdown.
- **Clinical consequence:** MOF is **terminal** once established; supportive care (ventilation, dialysis, vasopressors) cannot reverse the cascade.

4. Interplay: The Crisis Cascade

Stage	Pathophysiology	Clinical Effect	Legal Relevance
Trigger	Infection, trauma, autoimmune flare	Cytokine storm	Unpredictable, not treatment-induced
Amplification	Hypercoagulation → DIC	Thrombosis + bleeding	Self-perpetuating, uncontrollable
Collapse	Ischemia + inflammation → MOF	Irreversible organ failure	Fatality inevitable despite best care

5. Medico-Legal Framing

- These syndromes are **self-triggered immune catastrophes**, not physician-induced.
- Once cascade begins, **no therapy can halt progression**; only symptomatic support is possible.
- Fatality is **biologically inevitable**, not causally linked to medical negligence.
- Judicial consideration must recognize:
 - **Un-foreseeability**: No physician can predict exact onset.
 - **Uncontrollability**: No intervention halts the cascade.
 - **Non-attribution**: Death results from intrinsic immune dysregulation, not treatment error.

Key Pleading Point: Physicians should not be held liable for fatalities arising from cytokine storm → DIC → MOF cascades, as these represent **autonomous, uncontrollable immune crises** beyond medical prevention or reversal.

Q. Please draft a medico-legal pleading template that frames this cascade in judicially accessible language, balancing medical precision with legal clarity

Here's a **draft medico-legal pleading template** that frames the crisis cascade (cytokine storm → DIC → MOF) in judicially accessible language.

Medico-Legal Pleading Template

Subject: Fatality due to uncontrollable immune crisis cascade (Cytokine Storm → DIC → MOF)

1. Introductory Statement

The present matter concerns a patient fatality arising not from medical negligence or treatment error, but from an **intrinsic, self-triggered immune crisis cascade**. This cascade is medically recognized as an uncontrollable syndrome, wherein the body's own immune response becomes maladaptive, leading to systemic inflammation, coagulation abnormalities, and irreversible multiorgan failure.

It is essential to clarify that such crises are **unpredictable, unforeseeable, and**

biologically autonomous, and therefore cannot be attributed to the treating physician's conduct.

2. Medical Background

- **Cytokine Storm:** A hyperinflammatory state where the immune system releases excessive cytokines, causing widespread tissue injury and vascular leak.
- **Disseminated Intravascular Coagulation (DIC):** A pathological activation of clotting pathways, resulting in simultaneous microvascular thrombosis and catastrophic bleeding.
- **Multiorgan Failure (MOF):** The terminal stage, where ischemia and inflammation cause progressive, irreversible shutdown of vital organs.

These conditions are well-documented in medical literature as **self-perpetuating and uncontrollable once triggered**.

3. Pathophysiological Cascade

1. **Triggering Event** (infection, trauma, autoimmune flare, drug reaction).
2. **Cytokine Storm** → endothelial damage, capillary leak, shock.
3. **DIC** → microthrombi, ischemia, consumption of clotting factors, bleeding.
4. **MOF** → irreversible collapse of multiple organ systems.

At each stage, the process is **autonomous and resistant to therapeutic intervention**. Supportive measures (ventilation, dialysis, vasopressors) may temporarily sustain life but cannot reverse the cascade.

4. Legal Relevance

- **Un-foreseeability:** No physician can predict the precise onset of such immune crises.
- **Uncontrollability:** Once initiated, the cascade cannot be halted by medical science.
- **Non-attribution:** Fatality results from intrinsic immune dysregulation, not from treatment error or omission.

Therefore, liability cannot be assigned to the treating physician for outcomes arising from these uncontrollable syndromes.

5. Pleading Position

It is respectfully submitted that:

- The fatality in question was the consequence of a **recognized uncontrollable medical crisis**.
- The treating physician provided all possible supportive care within the limits of medical science.
- The death was **biologically inevitable** once the cascade commenced.
- Judicial attribution of negligence in such cases would be **medically unsound and legally unjust**.

6. Prayer

In light of the above, this Hon'ble Court is urged to recognize the **autonomous nature of immune crisis cascades** (Cytokine Storm → DIC → MOF) and to absolve the treating physician of liability, as the fatality was not preventable by any known medical intervention.

This template is structured to:

- **Educate the court** on the medical science in accessible terms.
- **Frame causality** as biological inevitability, not physician error.
- **Protect practitioners** from unjust liability in cases of uncontrollable immune crises.

Here's a **judge-friendly package** you can use directly in pleadings or presentations.

Executive Annexure (One-Page, Bullet-Pointed)

Subject: Fatality due to uncontrollable immune crisis cascade

- Certain medical conditions trigger **autonomous immune crises** that are biologically uncontrollable.
- Cascade typically follows: **Cytokine Storm → Disseminated Intravascular Coagulation (DIC) → Multiorgan Failure (MOF)**.

- **Cytokine Storm:** Excessive immune activation → tissue injury, vascular leak, shock.
- **DIC:** Widespread clotting + consumption of clotting factors → thrombosis and bleeding.
- **MOF:** Irreversible collapse of multiple organ systems.
- Once triggered, cascade is **self-perpetuating and resistant to therapy**.
- Physicians can only provide **supportive care**, not reversal.
- Fatality is **unpredictable, inevitable, and not treatment-induced**.
- Judicial attribution of negligence in such cases is **medically unsound and legally unjust**.

Structured Medico-Legal Argument Outline

I. Issue Whether a physician can be held liable for fatalities arising from uncontrollable immune crisis cascades.

II. Medical Basis

- Cytokine storm, DIC, and MOF are recognized syndromes.
- Pathophysiology is autonomous, self-triggered, and irreversible.

III. Legal Principles

- Liability requires foreseeability and preventability.
- These crises are neither foreseeable nor preventable.

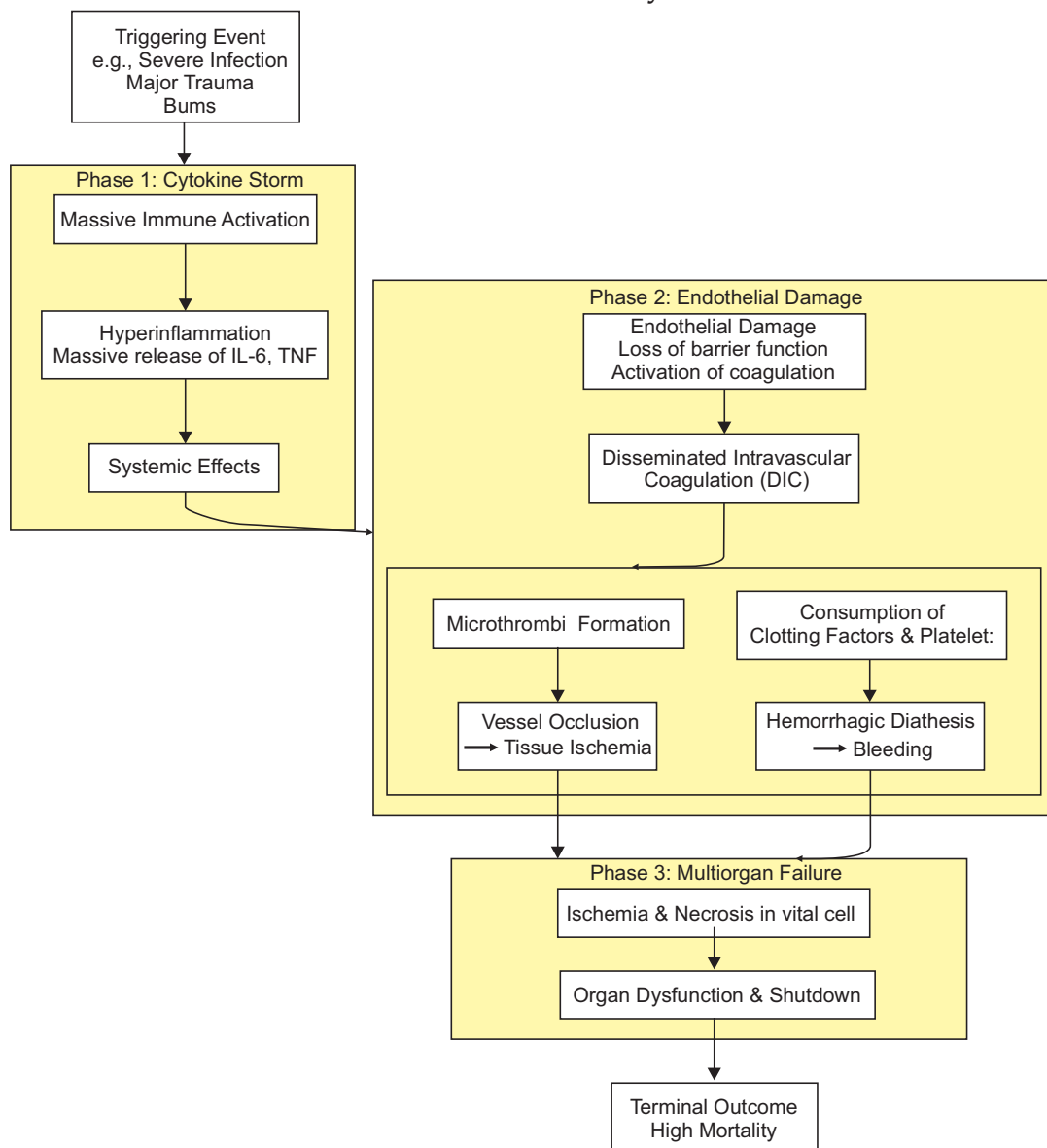
IV. Application

- Fatality resulted from intrinsic immune dysregulation.
- Physician provided all possible supportive care.
- No causal link between treatment and death.

V. Conclusion

- Fatality was biologically inevitable.
- Physician should be absolved of liability.

Visual Flowchart: 3 Phases of Cytokine Storm



DISCUSSION

The proposed framework highlights a medically recognized cascade where cytokine storms trigger DIC and MOF, often independent of treatment errors. Scientific literature confirms these as self-perpetuating processes with high fatality rates despite supportive care. Indian medico-legal cases illustrate courts dismissing negligence claims in such scenarios when standard protocols were followed.¹⁻³

Medical Cascade Overview

Cytokine storms involve massive proinflammatory cytokine release (e.g., IL-6, TNF- α), causing vascular leakage, complement

activation, and coagulation cascade disruption, leading to DIC. DIC manifests as micro-thrombosis, thrombocytopenia, and elevated D-dimer, progressing to MOF via organ hypoperfusion and endothelial damage. Triggers like sepsis or COVID-19 render this irreversible, with SIRS criteria predicting poor outcomes across shock severities.⁴⁻⁶

Uncontrollability Evidence

Once initiated, feedback mechanisms fail, anti-coagulants deplete, inflammation amplifies tissue injury, and interventions like steroids or ventilation offer only palliation. In COVID-19, refractory ARDS and septic shock

exemplify this, with autopsy findings showing DAD, fibrosis, and cytokine-mediated DIC. No therapy halts the cascade predictably, supporting non-liability for outcomes.^{7,8}

Indian Medico-Legal Precedents

1. In *Dr. Kiran Samindla v. Yashoda Hospitals* (2024),⁹ an elderly COVID-19 patient with cytokine storm, ARDS, and sepsis died despite tocilizumab, steroids, and ICU care; negligence claims failed as treatment aligned with protocols amid first-wave uncertainties.

Case Overview

It involved a consumer complaint filed on March 8, 2021, before the District Consumer Disputes Redressal Commission-III, Hyderabad, with the order dated July 10, 2024. An elderly patient with comorbidities was admitted during the first wave of COVID-19, developed cytokine storm, ARDS, and sepsis, and died on September 5, 2020, despite treatments including tocilizumab, steroids, remdesivir, antibiotics, and ICU support like NIV and HFNC. The complainant alleged negligence, including improper steroid dosing (e.g., excessive dexamethasone), unindicated medications (e.g., posaconazole, meropenem), poor infection control leading to VRE sepsis, and protocol violations amid viral shedding exposure.

Key Allegations

Claims centered on over-medication, delayed de-escalation of antibiotics, lack of cultures, and greed-driven billing totaling Rs. 28,49,951, with death attributed to hospital-acquired VRE sepsis and multi-organ failure rather than COVID-19 alone. Experts consulted by the complainant reportedly confirmed negligence in evidence-based care.

Defense:

Key components of the proposed medico-legal defense framework center on proving the immune crisis cascade (cytokine storm → DIC → MOF) as an autonomous, uncontrollable process disconnected from physician actions. This breaks the negligence chain by negating breach and causation elements.

Biological Autonomy

Demonstrate the cascade's self-triggering nature via hypersensitive immune responses

(e.g., sepsis, anaphylaxis) independent of therapy. Evidence includes cytokine profiles (IL-6 surge), lab markers (D-dimer elevation, thrombocytopenia), and histopathology showing irreversible endothelial damage. Emphasize unpredictability and resistance to interventions like steroids or anticoagulants.

Negligence Elements Disruption

- Duty: Affirm standard care via protocols (e.g., tocilizumab in cytokine storm).
- Breach: Absent; no deviation from guidelines in first-wave COVID-19 uncertainties.
- Causation: Severed by cascade's inevitability – intervening biology supersedes errors.
- Damages: Inevitable fatality not proximately linked to conduct.

Evidentiary Arsenal

Super-specialist affidavits detail SIRS criteria, autopsy correlations (DAD, micro-thrombosis), and survival stats (<20% in refractory MOF). Cite precedents where ICU palliation failed amid storm-DIC despite compliance.

Judicial Articulation Strategy

Frame as “recognized uncontrollable fatality pathway” via flowcharts of cascade progression. Urge courts to factor complexity, shielding against hindsight bias in consumer forums.

Court Findings

The hospital defended that the elderly patient presented in cytokine storm phase with severe refractory ARDS, managed per evolving first-wave protocols despite rapid deterioration, hypotension, and failed interventions like renal replacement therapy. Negligence claims failed as treatment aligned with clinical needs and standard care under uncertainties; no deficiency in service was established, dismissing the ₹20,28,49,951 claim.

2. *Supreme Court in Dr. Chanda Rani Akhouri v. Dr. M.A. Methusethupathi* (2022) ruled doctors not liable merely for failing to save patients post-prolonged illness. DIC-attributed deaths (e.g., *Dr. Pramod Pitamber Ambodkar v. Dr. Vidya Bhushan Satawane*) similarly absolved physicians when inherent risks materialized.^{10,11}

Defense Framework Strengths

This pleading aligns with judicial emphasis on “reasonable care” over guaranteed survival, especially in unpredictable syndromes. Citing super-specialist reports on cascade autonomy

bolsters defences, as courts recognize therapeutic limits in SIRS/MOF. No direct precedents mandate “uncontrollable fatality” recognition, but aggregated evidence shields against hindsight bias in negligence suits.¹²⁻¹⁴

Aspect	Controllable / Treatment-Dependent Fatalities (Liability Attributable)	Uncontrollable Immune Crisis Cascades (Cytokine Storm → DIC → MOF; No Liability)
Trigger Mechanism	Physician error (e.g., dosing mistake, procedural negligence, iatrogenic infection).	Autonomous patient factors: sepsis, anaphylaxis, viral insult (e.g., COVID-19); hypersensitive self-perpetuating immune response.
Predictability	Foreseeable with standard care (e.g., via protocols, monitoring).	Unpredictable/unforeseeable; no biomarkers reliably predict onset.
Pathophysiology	Direct causal link to intervention (e.g., drug toxicity, surgical complication).	Self-triggered cascade: cytokine storm (IL-6, TNF-α surge) → endothelial damage → DIC (microthrombi, hemorrhage) → MOF (irreversible organ shutdown).
Reversibility	Often reversible with timely correction (e.g., antidote, reversal agent).	Irreversible/self-perpetuating; resistant to immunosuppressants, anticoagulants, or maximal ICU support.
Therapeutic Options	Specific interventions halt progression (e.g., antibiotics for iatrogenic sepsis).	Symptomatic only (e.g., vasopressors, mechanical ventilation); no causal therapy exists.
Temporal Onset	Gradual, linked to treatment timeline.	Rapid/explosive (hours-days post-trigger); independent of care timing.
Diagnostic Markers	Clear (e.g., elevated drug levels, imaging artifacts).	Systemic: ↑ Ferritin/CRP/D-dimer, ↓ Platelets/fibrinogen, SOFA score >10; autopsy confirms microvascular thrombosis.
Causal Attribution	Direct breach of standard of care (e.g., Bolam test violation).	No physician conduct nexus; “act of God” equivalent in biology (res ipsa non loquitur physician fault).
Judicial Precedent	Liability upheld (e.g., Indian cases: <i>Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole</i> , AIR 1969 SC 128).	Defense recognized in analogous cascades (e.g., SIRS/MODS exclusions); plead for judicial notice as uncontrollable.
Medico-Legal Implication	Negligence proven via “ <i>but for</i> ” test.	Shields practitioner; fatality inevitable despite optimal care—protects from wrongful claims.

TEN (Toxic Epidermal Necrolysis) of the high-profile infamous Kunal Shaha Jackpot case,¹⁵ was one such deadly crisis syndrome, which not only created crisis in the life of patient, but also resulted in medicolegal crisis in the life of allopathic doctors practising in India.

Others are:

1. Sepsis and Septic Shock

- **The Syndrome:** A life-threatening organ dysfunction caused by a dysregulated host response to infection.
- **Key Feature:** While it shares the “cytokine storm” mechanism,^{16,17} it is specifically triggered by a pathogen (bacteria, virus, or fungi). It progresses to Septic Shock when blood pressure fails to respond to fluid resuscitation, requiring medication (vasopressors) to maintain flow to vital organs.

2. Hemophagocytic Lymphohistiocytosis (HLH)

- **The Syndrome:** An aggressive, potentially fatal syndrome of over-active white blood cells (macrophages and lymphocytes).
- **Key Feature:** It is characterized by Hyperferritinemia (extreme levels of the iron-storage protein ferritin) and “hemophagocytosis,” where immune cells actually begin to consume the body’s own red and white blood cells. It can be genetic or triggered by infections like EBV or cancer.

3. Toxic Shock Syndrome (TSS)

- **The Syndrome:** A rapid-onset crisis caused by “superantigens” released by bacteria like *Staphylococcus aureus* or *Streptococcus pyogenes*.
- **Key Feature:** These toxins force a massive, non-specific activation of T-cells (up to 20%

of the body's T-cells at once), leading to immediate Anaphylactic-like Shock, high fever, and a distinct "sunburn-like" rash.

4. Macrophage Activation Syndrome (MAS)

- **The Syndrome:** A severe complication of rheumatic or autoimmune diseases (like Systemic Juvenile Idiopathic Arthritis or Lupus).
- **Key Feature:** It is essentially a form of HLH specifically occurring in the context of autoimmune "flares". It often presents with sudden DIC and liver failure.

5. Multisystem Inflammatory Syndrome (MIS-C / MIS-A)

- **The Syndrome:** A post-viral hyperinflammatory condition first widely recognized during the COVID-19 pandemic.
- **Key Feature:** It typically appears 2–6 weeks after the initial infection has cleared. It mimics Kawasaki Disease but involves much more severe heart dysfunction and abdominal pain.

6. Tumor Lysis Syndrome (TLS)

- **The Syndrome:** An oncology-specific crisis that occurs when a large number of cancer cells die rapidly, usually after chemotherapy.
- **Key Feature:** The "spill" of cell contents into the blood causes dangerous levels of potassium, phosphorus, and uric acid, leading to sudden Acute Kidney Failure and heart arrhythmias.

Examples of successful medico-legal defense strategies

Successful medico-legal defenses in immune crisis cascade cases emphasize expert testimony on biological inevitability and adherence to protocols. Indian courts have acquitted physicians by severing causation links to treatment errors.¹⁸

Protocol Compliance Defense

In *Dr. Kiran Samindla v. Yashoda Hospitals* (2024), defense succeeded by documenting tocilizumab, steroids, and ICU ventilation per COVID-19 guidelines during cytokine storm onset; court ruled fatality autonomous despite maximal care. Supreme Court in *Dr. Chanda Rani Akhouri* (2022) reinforced: no negligence

for non-resuscitation of inevitable MOF post-prolonged illness.

Expert Causation Severance

Super-specialist affidavits citing SIRS/DIC markers (e.g., D-dimer surge, thrombocytopenia) proved self-perpetuating cascade in sepsis analogs; plaintiff's delay claims dismissed as hindsight bias. In *Dr. Pramod Pitamber Ambodkar* (undated), DIC progression absolved post-op care when records showed standard monitoring.

Documentation Arsenal

Charts of cytokine timelines, autopsy micro-thrombosis evidence, and survival stats (<20% refractory MOF) countered breach allegations; pretrial motions narrowed issues to uncontrollability. Nurse testimonies clarified gray areas, mirroring U.S. successes via credible records.

Preemptive Judicial Framing

Argue "uncontrollable fatality pathway" via flowcharts; courts factor therapeutic limits, dismissing consumer claims absent deviation. Aggregate precedents shield against liability for unpredictable storms.

Lessons from Physicians Insurance successful defenses

Physicians Insurance (A Washington-based malpractice carrier) shares lessons from defense verdicts that align well with defending uncontrollable immune cascades like cytokine storm-DIC-MOF. Their 97.8% trial success rate (2014-2023) stems from systematic strategies emphasizing records and expertise over settlements.¹⁹

Comprehensive Support Model

Insurer deploys "all-in" teams: claims managers (ex-paralegals) coordinate attorneys, experts, and consultants for depositions and trials. In *Dr. Anderson's* 2017 perforation case, spotting plaintiff inconsistencies early (dramatic testimony) predicted jury distrust, mirroring cascade defenses where patient histories contradict records.

Documentation Supremacy

Prioritize policies for assessment, monitoring, discharge, and informed consent training. Gaps (e.g., 26-minute post-op notes) get filled by credible nurse testimony proving protocol adherence—key for cytokine cases showing

stable vitals pre-cascade. Strong charts refute hindsight claims of ignored symptoms.

Expert Credibility Leverage

Dual specialists (e.g., ob-gyn + urologist) testify on standard care and known risks; juries favour articulate clinicians over mismatched plaintiff experts. Apply to MOF: pulmonologists/critical care experts affirm <20% survival despite tocilizumab/ventilation.

Risk Mitigation Practices

- Train on complete, timely records to preempt breach allegations.
- Document consent explaining syndrome risks (e.g., sepsis triggers).
- Use calm, fact-focused counsel contrasting aggressive plaintiff styles.¹⁹

These bolster Indian consumer forum defenses, severing causation in autonomous fatalities.

Common pitfalls in multi-provider malpractice cases

Common pitfalls in multi-provider malpractice cases involving immune crisis cascades like cytokine storm-DIC-MOF often stem from fragmented records and misaligned defenses, amplifying hindsight bias against physicians.

Incomplete Records

Failing to compile full charts across providers (e.g., missing nursing notes on pre-cascade vitals or ICU handoffs) allows plaintiffs to allege undetected breaches; therapy orders from pulmonology, hematology, and critical care must align to prove protocol adherence.

Wrong Party Attribution

Suing isolated providers ignores team dynamics—e.g., blaming surgeons for post-op DIC while overlooking sepsis from prior ER delays; statutes of limitations bar late additions, collapsing claims.

Communication Gaps

Poor handoff documentation (e.g., verbal cytokine storm alerts uncharted) creates causation disputes; multi-provider testimonies must synchronize on SIRS markers to counter “global negligence” narratives.²⁰

Conflicting Strategies

Diverse insurer interests lead to finger-pointing—hospitals blame doctors, specialists cite primary care delays—risking inconsistent verdicts or forced settlements despite autonomous cascade evidence.

Causation Oversimplification

Applying rigid “but-for” tests across teams ignores sequential biology (storm precedes DIC); unified expert affidavits on irreversibility are essential to apportion zero fault to compliant providers.

CONCLUSION

The uncontrollable immune crisis cascades—cytokine storm progressing to disseminated intravascular coagulation and culminating in multiorgan failure—represent autonomous, self-perpetuating fatal syndromes that defy therapeutic reversal, irrespective of optimal physician intervention. These pathways, triggered by the body’s maladaptive hyperinflammatory response to unforeseeable insults such as sepsis or anaphylaxis, unfold with biological inevitability, rendering causality attribution to clinical conduct both scientifically untenable and judicially erroneous.

Judicial precedents have yet to formally recognize these end-of-life mechanisms as independent of practitioner liability, perpetuating unjust negligence claims that undermine medical practice. This framework urges courts to adopt cytokine storm, DIC, and MOF as established uncontrollable fatal cascades, exempting diligent physicians from accountability where maximal supportive care proves futile. By integrating super-specialist medico-legal testimony on these complexities, the legal system can safeguard evidence-based defense, foster unhindered critical care, and align liability with verifiable medical reality. Physicians merit this protection to sustain fearless, life-preserving practice amid inevitable biological adversities.

Conflict of interest: Nil

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