(2014) 07 NCDRC CK 0017

In the National Consumer Disputes Redressal Commission

Manjeet Chawla — APPELLANT

Vs

ESCORTS HEART INSTITUTE AND RESEARCH CENTRE — RESPONDENT

Date of Decision : 17-07-2014

Acts Referred:

Citation : 2014 4 CPJ 81

Hon'ble Judges : S.M.Kantikar J.

Judgement

1. P class="subparagraph">"Overconfidence precedes carelessness and blurs out the risk. Inferiority magnifies it. Overconfidence is a common factor in errors. Unfortunately, most of us are poor at assessing the gaps in our knowledge, tending to overestimate both how much we know and how reliably we know it,"

Concern about quality arises from fear and anecdote than from facts; there is little systemic evidence about quality of health care in India. We have no mandatory any local or national system to track quality of care delivered to the patients here. Whereas it is most unfortunate that, in our country, more information is available on quality of airlines, restaurants, cars and electronic gadgets than quality of health care...!!

The Compliant:

2. THIS complaint was filed on 26 July 2001, by Mrs. Manjeet Chawla and her two sons alleging medical negligence in treatment and deficiency in services by the doctors at ESCORTS Heart Institute & Research Centre, New Delhi causing death of Mr. Pritpal Singh Chawla (the husband of the complainant No. 1) Mr. Pritpal Singh Chawla then aged about 52 years, at the time of filing of this complaint in the year 2001, (hereafter referred to as ''the Patient/deceased'') had undergone Tread Mill Test (TMT) on 13/02/2001 which was reported as ''positive'' for Reversible Myocardial Infarction (RMI) and Ischemia. Thereafter, on the next day i.e. 14/2/2001, he approached ESCORTS Heart Institute & Research Centre, the OP (in short ''EHIRC''), with a complaint of "Palpitation" and "Angina on Exertion (AOE)". As an OPD patient (Reg. No: 149609) he consulted Dr. T.S.

Kleir, a Cardiologist at OP hospital. The patient showed Dr. Kleir his TMT report and previous medical records, such as, prescriptions of the treatment, ECG, blood test reports, etc. The patient also informed Dr. Kleir about his diabetic status, since July 1984; and that he was taking insulin twice a day; (20 units in the morning before breakfast and 15 units before dinner). After examination, Dr. Kleir advised the deceased to undergo immediately, coronary angiography test (CART) and told that, it should be done as early as on the following day i.e. 15th February 2001. Hence, the patient (deceased) accepted his advice and underwent certain more blood tests and chest x -ray, as per instructions of Dr. Kleir, on the same day i.e. 14/02/2001, at the OP hospital itself.

3. AS instructed by Dr. Kleir, the patient took normal breakfast and medicines on the morning of 15/2/2001, and went to the hospital at 2:00 p.m., and got admitted to Cath Lab. The patient deposited Rs. 14,000/ - towards the fees of the procedure for the angiography. The deceased was made to sign on some forms, including "informed consent form", without explaining the unforeseen complications during conduct of CART. The deceased was taken on the table for CART at 6.35 p.m. and the procedure was over within 35 minutes i.e. by 7.10 p.m. While the deceased was still in recovery room, he suffered an attack of Cardiogenic Pulmonary Edema. Then at about 7.20 p.m., he was administered Lasix and some other medicines. He was shifted to ICU by 7.30 p.m. and connected to monitor. The OP had not administered oxygen concentrate to the deceased, there was no alert issued for senior doctors, further the patient suffered brain death. The complainant alleges that, to avoid brain death, OP should have administered oxygen. It was seen from Nursing notes which clearly mentioned that (a) the deceased was in fully unconscious state and apnea" (unable to draw breath), (b) he was repeatedly given DC shocks, amboo and cardiac massage, for a pretty long time (c) BP was not recordable, pulse was feeble, (d) The patient was connected to monitor in ICU.

4. IT was further alleged that, at 9.55 p.m. Dr. Kleir interpolated a remark in the noting of some other doctor which reads as follows: "the Pt. was discussed with Surgeon (Dr. Meharwal) for urgent CABG. He felt the condition of patient was not stable for CABG". As per complainant, this interpolation must have been made on 16th February 2001 and not at 9.55 p.m. of 15th February 2001. The interpolation raises eye brows and questions on the integrity of OP. The complainant was under confusion that, • Why, the note was interpolated?

• Why, Dr. Meharwal did not himself come and see the patient?

• Why, Dr. Meharwal did not come and see the deceased in Cath Lab between 7.10 and 7.20 p.m. to conduct CABG?

• Why, Dr. Trehan did not come and see the deceased in Cath Lab. Both these doctors are stated to be in the hospital?

• What is the system of "ALERT" calls for surgeons, seniors and specialists in the hospital?

• At what time did Dr. Kleir discuss the condition of the deceased with Dr. Meharwal, when he himself had gone to Cath Lab to attend to other patients, waiting for angiography?

As per record, on the same day, Dr. Kleir conducted five more angiography tests, after the angiography of Late Sh. P.S. Chawla, the patient and each angiography procedure consumes at least 30 minutes. Complainant also alleged that the medical records showed several cuttings and over writings on the Nursing notes. On 16th February 2001, OP observed bluish marks on the legs of the patient and apprehending occurrence of Gangrene, conducted embolectomy. Patient''s kidneys got damaged because allergy test of the contrast media had not been done. On 17th February 2001, the deceased had to be taken for Dialysis, subsequently; the patient expired due to renal failure and hypoglycemia on 24th February 2001 at 1.30 p.m. in the hospital. In the death summary issued by OP, the cause of death was shown as "Multiple organ failure". The OP did not recommend or conduct ''Autopsy'' to know the actual cause of the death. Hence, the entire suffering of patient was due to negligence of Dr. Kleir and the main allegation was, that prior to Angiography, OP failed to do important investigations like Echocardiography, Holter studies and the Contrast media testing. The complainants have filed a detailed considered opinion of an expert, Dr. Davis Greshan from UK, who opined that death of patient was due to non -handling of post angiography emergency situation properly, which resulted in brain death. Hence, alleging the medical negligence by the doctors at OP hospital in treating the patient without proper and reasonable care during and after angiography; and that the hospital also lacks infrastructure to handle such emergencies and complications, the complainants filed this complaint and prayed for total compensation of Rs. 9,66,47,090/ - for the financial loss, mental agony for the sudden death of the deceased, loss of support, love and affection.

The Complainant filed her affidavit and affidavit -evidence of Dr. Greshan K. Davis, the Expert from U.K. The OP filed the affidavit -evidences of the Medical Superintendent, Major Gen. Tarsem Kumar and that of the consultant Cardiologist Dr. T.S. Kleir.

Defense:

The OP filed a written version and evidence by the way of affidavits of concerned doctors, in this case. It is submitted that the Patient consulted doctors in the OPD of EHIRC on 14th February 2001 with a TMT test report done on 13/2/2001, at another institute. Over last few weeks before 14/02/2001, the Patient complained of palpitations and angina after some exertion. In view of his complaints & positive report for RMI (reversible myocardial ischemia) the patient was advised to undergo a day -Cath angiography (CART) on the next day and asked to report at 2 p.m. at Cath lab. The angiography was advised in order to get a correct assessment of blockages in the arteries and to take further decision either regarding Angioplasty or bypass surgery. The procedure, risks and benefits, were explained to the patient. It is also admitted that, Dr. Kleir handed

over a pamphlet to the patient on guidelines for angiography patients which clearly state that there is approximately 1% risk of serious complications including deterioration of renal function or cardiac condition, especially in cases where there is substantial existing blockage. Prior to the angiography, the Patient was also advised to undergo various tests, such as ECG, X -rays, blood sugar, etc. The Angiography revealed triple vessel disease; all three arteries were severely blocked as is evident from the angiography report. It also revealed left ventricular dysfunction (LVEF was only 40%). Angiography Report is marked as Exhibit DW -IV.

5. THAT , shortly after angiography, the patient suddenly developed florid pulmonary edema and hypotension. The patient was immediately managed and was treated in ICU. He was given appropriate medication. He was put on the ventilator immediately and an Intra -Aortic Balloon Pump (IAPB) was inserted. This is the best possible management of acute pulmonary edema in any good institute of the world. It is stated that pulmonary edema is one of the known complications in a patient with severe blockages of the coronary arteries. It could happen during angiography, after or even, without coronary angiography, at any stage. The patient was immediately, thereafter, shifted to the CCU. Literature which shows that pulmonary edema is a known complication of angiography and that Angiography can even result in death is marked as Exhibit DW -V ''Colly''. Shortly thereafter, the patient also had Ventricular Arrhythmia (VT) post angiography. He was given a cardiac massage and was cardioverted. Nurses Chart for 15 -02 -2001 at 7.30 p.m. recorded that patient was seen by Dr. Kleir, Dr. Dhar Anesthetist and Dr. Apara and Dr. Vanitha, Cardiologists. DC shock was given. However, the patient''s pulse was feeble and he continued to be hemodynamically unstable.

6. PATIENT ''s urine output was being monitored regularly. Till midnight of 17th February 2001, the urine output and serum Creatinine was normal, hence there was no need for dialysis. It is stated that only at 1 a.m. on 18th February 2001, his urine output was found to be abnormally low and immediately, Inj. Lasix 10 mg stat was given and it was again repeated at 4 a.m. The patient did not respond, hence, peritoneal dialysis was started. Thereafter, since the patient did not respond, a Nephrologist was called for, at 6 a.m. As Serum Creatinine was high at 4.4. mg %, peritoneal dialysis was advised and it was started by Dr. Ashwini Goel, the Nephrologist at about 12 noon, on 18th February 2001, and he was under observation, till 23rd February 2001. The patient was being monitored by a competent team of doctors, during each and every stage of post -angiography complications, without any delay. Hence, there was no negligence by doctors at OP hospital. Op further submitted that Dr. K.S. Chawla, the brother of the patient, who had come from United Kingdom, approached Dr. Kleir on 24th February 2001, to stand as a witness to the affixation of thumb impression of the patient, on a Will, prepared by Dr. Chawla. But, Dr. Kleir refused for such illegal and unethical act, because the patient was on a ventilator and was in a critical state and was not fit to read the will. Due to severe persistence, Dr. Chawla was

sent to meet the then Medical Superintendent, who also expressed his disapproval of such an illegal act and did not cooperate with him. Thereafter, on account of their refusal, Dr. Chawla threatened to take action against the Op institute, by filing a complaint, alleging negligence in the treatment of the patient. Hence, the present complaint has been filed with the above mentioned circumstances, which is wholly mischievous, malafide and devoid of any merit, whatsoever. Also, the demand for compensation and punitive damages of Rs. 9.60 crores is completely misconceived, baseless and unsubstantiated, in as much as the present complaint fails to establish any negligence or deficiency in service, on the part of the opposite party.

Arguments:

7. WE have considered the rival contentions and affidavits of the parties. Counsel for the complainant, Shri. Wadhavani argued for 4 hours, he has produced several medical literatures/texts from books on cardiology and Internal Medicine. His main argument was centered on the point that the Cardiologist did not follow the standard of practice, while performing the Angiography of the patient; that prior to angiography Dr. Kleir has not performed i) Echocardiography ii) The Holter Study and the Contrast media (dye) sensitivity test on the patient. The counsel drew our attention towards the opinion of an expert Dr. Davis Greshan, who has also opined that, if OP had been careful by getting echo and HMT done before venturing upon the conduct of the procedure, the complications could have been avoided. He further argued that, OP became panicky, during post - CART complications, and realized his negligence. The patient was taken off from the Cath lab table at 07.10 p.m., and within 10 minutes, inj. Lasix was administered. Thereafter shifted to ICU at 7.30 p.m. instead of calling Dr. Meharwal, Senior Cardiac Surgeon for a decision of possible CABG. The mode of shifting of patient was also doubtful, as the Cath Lab was on the first floor and the ICU was on the fifth floor. The complainant is unaware of it, whether shifting was done on stretcher or in sitting posture, on wheel -chair. Dr. Meharwal, the cardiac surgeon, who had to perform the surgery, was available in the hospital; there is no explanation as to why Dr. Meharwal did not personally come to see the patient. It is also doubtful that Dr. Kleir had discussed the case with Dr. Meharwal. The nursing notes on his being brought from Cath Lab to ICU show the following: - (i) the deceased was unconscious

(ii) and apnea (this word has been struck out)

(iii) was given cardiac massage and DC shocks and amboo given innumerable times

(iv) Blood pressure (BP) not readable,

(v) The pulse was feeble; the deceased was on monitor which showed VT (ventricular tachycardia).

The counsel further argued that entire nursing staff and doctors were in panic

which is evident from a number of corrections made by it, in the nursing notes of 15 -02 -2001. These notes are clearly indicative of brain death in the patient.

8. THE counsel for OP, Shri Sajad Sultan, vehemently argued and denied the truth into the allegations made by the complainant. He has admitted that OP had not conducted noninvasive tests, such as ECHO, HMT and allergy tests, before angiography, but however, OP had recorded RMI on 14th February 2001. Further, he submitted that, the patient had pulmonary edema, which is a known complication of any patient with severe blockages of coronary arteries and could occur at any time, irrespective of angiography. The patient''s treatment was started in Cath lab itself and subsequently, he was shifted to CCU immediately. Doctors were available at all times to treat the patient. It is stated that the CABG could not be conducted due to the unstable condition of the patient, as per the advice of the surgeon and not due to non -availability of a surgeon, as alleged. That, Peritoneal Dialysis was not delayed but was started, as and when, advised by the Nephrologist. It is also stated that an embolectomy had to be done to the thrombosed artery, where IABP was inserted, which is also a known complication of IABP insertion. The patient continued to be in critical condition and his condition was intimated to the relatives regularly. Patient''s blood sugar and potassium levels were monitored regularly, every few hours and he was given medication for it, as and when required. With respect to the allegation, that on 24th, the blood sugar of the deceased was just 25 mgm, which led to collapse of the deceased, the blood sugar result taken on 24 -02 -2001 of 25 mgm, was sent for rechecking. On rechecking, blood sugar was observed, as under:

It is further stated that the patient did not die due to hypoglycemia. Patient was regularly seen in the CCU, including in the morning of 23rd February 2001 and 24th February 2001. The allegation that there was no monitoring by doctors on 23rd February 2001, is false. As per Nurse''s Chart on 23rd February 2001, the patient was seen by several doctors, including Dr. Kleir.

The counsel further submitted that the death of the patient occurred due to Multi Organ Failure i.e. Coronary artery disease, Triple vessel disease, Left Ventricular Dysfunction, Acute Myocardial Infraction, Acute renal failure, Hyperkalemia (i.e. high levels of potassium) and Ventricular Arrhythmia. It is stated that inspite of the best medical attention and care rendered by Dr. Kleir and other doctors at the Institute, unfortunately, could not save the patient. Therefore, there was no negligence in the treatment of the patient by OP. Counsel further argued that, the Medical opinion given by Dr. Davis is bias and wrong, and not as per the practices available at the time when the patient was treated. It mentions that the treatment was as per contemporary practices, instead of giving any reference to practices prevailing at the time of treatment.

Counsel reiterated that the complaint was filed with malafide intentions and prayed for the dismissal of complaint

Findings and Discussion:

We have perused the entire medical records like case papers, nursing notes, the lab tests reports, angiography reports placed on file and the medical literature on concerned subject.

9. MEDICAL Literature: To substantiate medical negligence, the Counsel for the complainant drew our attention to literature from medical books, the guidelines of American College of Cardiology.

• From "Harrisons Principles of Internal Medicine" Volume I, which is reproduced as:

While most patients with coronary artery disease or valvular disease can be managed using only clinical and non -invasive test data, more than 1.5 million cardiac catheterization and angiographic procedures are performed each year for diagnostic or interventional purposes or both." "Given the expense and small but real risks of cardiac catheterization, it is not performed routinely whenever cardiac disease is diagnosed or suspected. Instead, cardiac catheterization is recommended only when there is need to confirm the presence of a clinically suspected condition, define its anatomic and physiologic severity and determine whether important associated conditions are present This need most commonly arises when a patient is experiencing limiting or escalating symptoms of cardiac dysfunction or myocardial ischemia or when objective measures such as exercise testing or echocardiography suggest that the patient has high risk of progressing to rapid functional deterioration, myocardial infarction or other adverse events.

The first goal in the evaluation of patients with palpitations is to exclude the possibility of life threatening arrhythmias. The risk for such arrhythmias is highest in patients with coronary artery disease, congestive heart failure or other structural cardiac abnormalities.....The most common first test, after the initial evaluation of palpitation is continuous electrocardiographic (Holter) Monitoring.

• We have perused the ACC/AHA guidelines (American College of Cardiology/ American Heart Association):

(a) On page 1759 of it''s ''Guidelines for coronary angiography stated:

The procedure (CART) is associated with small but definable risks and is relatively expensive. As such, the physician must make a reasoned decision on its use, based on the anticipated clinical benefit versus risks and cost of procedure". It is further stated " CART is principally used in three clinically situations: first, to determine the presence and extent of obstructive CAD in a setting, in which the diagnosis is uncertain and CAD cannot be excluded by non - invasive testing; second, to assess feasibility and appropriate forms of therapy such as revascularization by percutaneous or surgical intervention and finally, as a research tool for assessment of treatment results and progression and regression of coronary atherosclerosis".

• The OP did not perform allergy test for the contrast medium used in angiography procedure. We have referred to medical literature and research

articles on cardiovascular interventional radiology to know about Contrast -induced nephropathy. The article titled as: Clinical Pharmacology, Uses and Adverse Reaction of Iodinated Contrast Agents: A Primer for the Non -radiologist" Mayo Clin Proc. April 2012; 87(4):390 -402 The relevant text is reproduced below:

Contrast -induced nephropathy refers to a reduction in renal function after the administration of an ICA. The standard diagnostic criteria for contrast -induced nephropathy is a greater than 25% increase in baseline serum creatinine concentration within 3 days of receiving an ICA after other possible causes have been ruled out. Serum creatinine will usually peak within 3 to 7 days and return to baseline (or a new baseline) within 14 days. In many patients, the course is usually benign; however, the development of contrast -induced nephropathy can prolong hospital stay, increases the need for dialysis, and increases overall mortality.

Other patient factors include age, systemic diseases that predispose patients to renal dysfunction (example diabetes mellitus and hypertension), and factors that contribute to a reduction in cardiac output (example severe hemodynamic instability, dehydration, congestive heart failure, and myocardial infarction within 24 hours of receiving an ICA). Furthermore, physicians responsible for ordering imaging tests that require the use of ICAs should consider addressing risks, benefits, and alternatives with their patients given the potential for adverse outcomes associated with this class of drugs. Equipment and drugs used to treat severe and life threatening reactions should be readily available in all clinical locations where ICAs are administered.

10. RELEVANCE of medical opinion of Dr. Greshan K. Davis: We have perused the evidence on record and medical opinion given by Dr. Greshan K. Davis and answers to the interrogatories posed to him by the OP. Some of the relevant interrogatories and the answers are reproduced as below:

• (e) Are you qualified to give an opinion on the medical issue at hand? What is your total experience?

I am highly qualified to give an opinion on the issue at hand. I am a Consultant Cardiologist and Director of a Cardiac Catheterization laboratory in a United Kingdom Teaching Hospital for eight years. I have done over 5000 diagnostic cardiac catheterization procedures over a period of 16 years. I have worked in Cardiac Catheterization laboratories in the United Kingdom, New Zealand and the United States. I am a Fellow of the American College of Cardiology as well as the European Society of Cardiology, Royal College of Physicians of the United Kingdom and the Royal Australasian College of Physicians. I publish in this area and regularly provide this service for UK Courts in cases of possible clinical negligence.

• (f) I put it to you, that severity of positivity will not have much implication in our case. Can you show of how much importance is "severity of positivity of

TMT" in a diabetic symptomatic patient?

Severity of positivity of a TMT is very important and should be noted by any cardiac catheterization operator, prior to performing the procedure. It suggests that the patient is likely to have serious underlying coronary artery disease including possibly a left main stem narrowing. This would suggest special caution be undertaken when using the diagnostic left coronary catheter during the procedure.

• (J) I put it to you that since patient''s ECG taken prior to angiography had shown no evidence of prior myocardial infarction or LV dysfunction; hence it is not absolutely necessary to do echocardiography prior to angiography. Would doing an ECHO prior to angiography have made any difference in the outcome of the patient?

The symptom of shortness of breath in a patient with suspected underlying ischemic heart disease raises the possibility of significant impairment of left ventricular function. An ECG does not provide any direct assessment of a patient''s left ventricular function. For example, the ECG could show evidence of old myocardial infarction and the ECHO show good overall LV function as in cases of cardiomyopathy. ECHO is the investigation of choice to determine LV function and would also have given other information in the deceased.

Yes, doing an ECHO prior to angiography or even after angiography without doing left ventriculography would, on the balance of probabilities have made a difference in the outcome of the patient. ECHO affects patient management in that ventriculography would not have been needed.

• (k) I further put to you that you have said in conclusion no. 5 that patient had high left ventricular end diastolic pressure (LVEDP) and LV angiography should not have been done. Even though, ECG was not suggestive of significant LV dysfunction, and there are known conditions where patients can have high LVEDP without significant LV dysfunction, and there are known conditions where patients can have high LVEDP without significant LV dysfunction please refer to ".....Heart Disease: A Textbook of Cardiovascular Medicine, 8th Edition" (annexed herewith the interrogatories as Reference 1) would you like to deny what has been mentioned therein with respect to LV dysfunction.

It would be putting the patient''s life at risk to assume that the raised LVEDP was due to another cause other than systolic LV dysfunction as the coronary artery blockages were already found. Echo would detect the causes of LV dysfunction including LV systolic dysfunction, diastolic dysfunction, aortic regurgitation, etc. This makes it is an important investigations.

• (L) I put it to you, that with current techniques, it is a rare patient who cannot undergo LV angiography safely. In this regard please refer to "Grossman Textbook of Intervention Cardiology" (annexed herewith the interrogatories as Reference 2), would you like to deny it? Considering the background and ECG

(prior to the Angiography) don''t you think the LV angiography was safe?

The risks of cardiac catheterization are well documented with a risk of serious complication affecting approximately 1 in 1000. The fact remains that there are patients (such as in this case) in whom ventriculography should not be performed in current cardiological practice as this information is available safely by ECHO and there is no need to put patients at risk. ECHO in some patients, for example, may reveal a clot in the ventricle and the patient could then have a fatal stroke, if left ventriculography is performed. Angiography could still be carried out to get the information about the coronary arteries, but the ventriculography omitted resulting in a shorter and safer procedure. The clinical background and ECG did not rule out ventriculography but the information obtained in the Cath lab using the pigtail catheter before injecting contrast into the ventricle (LVEDP) should have been interpreted as ''UNSAFE'' to inject and the procedure terminated at this stage and an ECHO could safely be performed in the recovery area.

• (s) Isn''t MD, MRCP coupled with vast experience sufficient for attending doctor (Dr. T.S. Kleir) to understand the complications of the patient?

The complications were understood when it occurred and the management instituted but unfortunately they were unsuccessful. The case related to how they could and should have been avoided.

After perusal of entire medical record on file, the medical literature and the report of Dr. Davis our observations and discussion as; The OP has filed annexure DW V with its own affidavit of evidence wherein it is written: "The risk of major complications is It was an admitted fact that, Dr. Kleir proceeded for angiogram without echocardiography study (in short ECHO). The medical case papers show that ECHO was done a day after, post CART. The findings show that "LVEF" was 30% against the normal range of 60 to 62%. Thus, the report was very clearly suggestive of (i) left ventricular dysfunction, (ii) "ischemia", (iii) silent MI; (iv) de -compensated heart failure and congestive heart failure. We are of considered view that these findings were not consequential to the TMT findings of previous day. Therefore, if, ECHO had been done prior to CART, Dr. Kleir would not have recommended CART because contraindications would have been known to him, beforehand.

11. ALL ''non -invasive'' tests -the (Echo) is conducted to ascertain the exact detailed condition of the heart, HMT is continued electrographic monitoring of various heart beats to study arrhythmia; allergy tests, particularly of contrast media and anesthetic drug to be used during the procedure help, to foresee possible reactions. Also, additional blood tests should also have been made. These studies help the doctor to study the condition of heart and assess the possibilities of encountering any complications, while doing CART. It necessarily follows that before taking decision and recommending CART to a patient, the doctor must find out, whether, there exists, any contradictions. The existence of

contradiction can only be determined by conducting all non -invasive investigations like, pathological blood tests as lipid profile, KFT (Kidney function test) and LFT (Liver functioning test), the allergy test for contrast media and the Echocardiography, Holter Meter Test. By not getting pathological and other tests, is an omission in duty, which is not a Standard of Practice. Such omission by the OP exposed the patient to the known and avoidable risks and made him a victim, thereof.

12. THEREFORE , we are of considered view that the OP recommended and conducted CART, as a routine procedure, without proper care and caution. OP ignored the risks of CART, because overall percentage of the patients encountering the risks is small; but, failed to appreciate that the risks were real and as high as fatal in individual cases. Also, OP had not kept the arrangements ready to meet with emergent conditions; which is clear from the decision of OP to shift the deceased to ICU, instead of conducting CABG; even the surgeon did not come to examine the condition of the deceased at 07.20 pm, i.e. immediately after the incident. It is also, clear from the Biochemical Investigation chart Annexure G notes and in evidence filed by OP Dr. Major Gen. Tarsem Kumar that, the patient''s blood sugar level was 25 mg/dl on 24.02.2001 at 00 hrs. It was a severe hypoglycemic condition. There is no explanation why this had occurred despite, 24x7 observation and services available in ICU. The OP sent the blood sugar for rechecking, there is no such evidence on record. Therefore, we are of considered opinion that the ICU staff was not vigilant and had not properly monitored the patient. Also the patient developed renal failure, along with severe hypoglycemia which led to the death of patient. We found the nursing notes and doctor''s notes show many corrections and overwriting at several places. We see no documents about the recheck of blood sugar. The biochemical report chart did not show periodic blood sugar estimation done by OP.

13. THE allergy test for the contrast was not done prior to CART which was a necessary one. As per the research articles on Cardiovascular interventional radiology (supra para 12) in recent years, various contrast media have been developed for use in coronary angiography. These contrast media may be divided into ionic contrast media of high osmolality, those of low osmolality, and non - ionic contrast materials. Iodinated contrast agents are commonly used to perform coronary angiography and coronary angioplasty, and are generally well tolerated and usually excreted harmlessly in the urine or faeces. However, complications can occur; contrast nephropathy and allergic reactions are most frequently reported. Contrast agents can also cause kidney problems in people taking metformin, a common treatment for diabetes. The patient herein was a known diabetic from 1984 and on medication. The diabetics are at more risk for contrast nephropathy. The post angiography, on 2/3rd day, patient''s blood investigations showed Serum Creatinine was high 4.4 mg/dl, it clearly indicates nephropathy. Therefore, Dr. Kleir while ordering the imaging test by of ICAs should have addressed the risks, benefits, and alternatives to the patient. Thus, collectively (with ref to para 16, 17 and 18) it is a deficiency in service and

negligence on the part of OP. Relevant references to decisions on Medical Negligence:

We have put reliance upon several judgments on Medical Negligence delivered by Hon''ble Supreme Court of India and the courts in UK which have commented upon the reasonable care and the standard of medical practice.

14. IN Sidaway vs. Governers of Bethlem Royal Hospital, (1985) AC 871, The House of Lords (UK) has held: a practitioner who specializes in any particular area of medicine must be judged by the standard of skill and care of that Speciality

As per Lord Bridge: Broadly, a doctor''s professional functions may be divided into three phases: diagnosis, advice & treatment. In performing his functions of diagnosis and treatment, the standard by which English Law measures the doctor''s duty of care to his patient is not open to doubt. In the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men... The true test for establishing negligence in diagnosis or treatment on the part of a doctor or ordinary skill would be guilty of if not acting with ordinary care....

15. IN "Malay Kumar Ganguly vs. Sukumar Mukherjee & Ors. with Dr. Kunal Saha Vs. Dr. Sukumar Mukherjee & Ors. : [AIR 2010 Supreme Court 1162]." We may hold a medical practitioner liable to indemnify the complainant only where his conduct falls below the standard of a reasonably competent professional in his field. The medical professional is expected to exercise reasonable degree of skill, a reasonable degree of care and should possess knowledge of an expert in the field which is comparable with a standard medical practitioner. Neither the very highest nor a very low degree of competence is contemplated.

16. IN "Kishori Lal Vs. E.S.I. Corporation" [II, (2007) CPJ 25 (SC)], the Supreme Court has observed that: the claimant has to satisfy the court on the evidence that three ingredients of negligence, namely, (a) existence of duty to take care; (b) failure to attain that standard of care; and (c) damage suffered on account of breach of duty, are present for the defendant to be held liable for negligence. We are of the opinion that the complainant herein could not establish failure of the appellants to attain the required standard of care in the given situation. It will be too simplistic inference to say that because of alleged complaint of pains, the appellant no. 2 ought to have abandoned the Angiography procedure in the midway or that due to aortic dissection during the procedure his negligence was the only deducible conclusion.

In Poonam Verma Vs. Ashwin Patel & Ors, : (1996) 4 SCC 332, the Apex Court held that negligence, as a tort, is the breach of a duty caused by omission to do something which a reasonable man would do, or doing something, which a prudent and reasonable man would not do.

17. THEREFORE , the whole concept is about performing or not performing an act which a prudent and reasonable man would perform or not perform. The decision in Bolam vs. Frien Hospital Management Committee, 2 All ER 181, which we have referred to hereinafter. A doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art.

18. WE have also referred to the decision in Laxman Balkrishna Joshi (Dr.) Vs. Dr. Triambak Bapu Godbole, : AIR 1969 SC 128 and held that a doctor when consulted by a patient owes him certain duties, namely, (a) A duty of care in deciding whether to undertake the case;

(b) A duty of care in deciding what treatment to give; and

(c) A duty of care in the administration of the treatment.

A breach of any of these duties, gives a cause of action for negligence to the patient. His summing up to the jury in the action of Hatcher v. Black and others, (1954) Times, 2nd July, the trail judge said:

In the case of an accident on the road, there ought not to be any accident if everyone used proper care and the same applies in a factory; but in a hospital, when a person goes in, who is ill and is going to be treated, no matter what care you use, there is always some risk. Every surgical operation involves risks. It would be wrong, and indeed bad law, to say that simply because a misadventure or mishap occurred, thereby the hospital and the doctors are liable. Indeed it would be disastrous to the community, if it were so. It would mean that a doctor examining a patient or a surgeon operating at a table, instead of getting on with his work, would, for ever be looking over his shoulder to see if someone were coming up with a dagger. For an action for negligence against a doctor is, for him, like unto a dagger. His professional reputation is as dear to him, as his body, perhaps more so, and an action for negligence can wound his reputation as severely as a dagger can his body. You must not, therefore, find him negligent simply because something happens to go wrong, as for instance, if one of the risks inherent in an operation actually takes place or because some complications ensue which lessen or take away the benefits that were hoped for, or because, in a matter of opinion, he makes an error of judgment. "You should only find him guilty of negligence when he falls short of the standard of a reasonably skilful/ medical man. In short, when he deserves of censure - for negligence in a medical man is deserving of censure.

In the case of Roe and Woolley v. The Ministry of Health and An Anaesthetist,, (1954) 2 All ER 131, which went to the Court of Appeal, it was held that neither the Anaesthetist nor any other member of the hospital staff had been guilty of negligence and when delivering his judgment Lord Justice Denning said:

Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks.

Doctors, like the rest of us, have to learn by experience; and experience often teaches, in a hard way.

Finally, it is observed that vital question is always, whether, the practitioner exercised reasonable skill and care, in the circumstances? The circumstances inevitably vary from case to case.

In Bolam v. Frien Hospital Management Committee,, (1957) 2 All ER 118 the Court was required to deal with a case where plaintiff was suffering from mental illness and the consultant advised to undergo electro - convulsive therapy. There was evidence that in such therapy, there was a risk of fracture. That may be small, namely, one in thousands. On second occasion, when treatment was given, the Plaintiff sustained fractures. No relaxant drugs or manual control were used, but a male nurse stood on each side of the treatment couch, throughout the treatment. It was admitted that use of relaxant drugs would have excluded the risk of fracture. Proceedings were initiated for damages.

19. IN the said case, it was observed that, the medical evidence shows that competent doctors held different views on desirability of using relaxant drugs and restraining the patient''s body by manual control and also on the question of warning a patient of the risk of electro conversant therapy. Justice M.C. Nair observed that in the case of medical man, negligence means: - In the case of a medical man, negligence means, failure to act in accordance with the standards of reasonably competent medical men at the time. This is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms to one of those proper standards then he is not negligent. Counsel for the plaintiff was also right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defense, unless that belief is based on reasonable grounds. That again is unexceptionable.

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

The Court in Laxman Balkrishna Joshi (Dr.) v. Dr. Triambak Bapu Godbole : (AIR 1969 SC 128 : (1969) 1 SCR 206) has held as under:

A person who holds himself out ready to give medical advice and treatment, impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment.

The aforesaid principles are reiterated by Apex Court in A.S. Mittal v. State of U.P.,, (1983) 3 SCC 223.

20. IN Indian Medical Assn. v V.P. Shantha, : (1995) 6 SCC 651, Hon''ble Supreme Court approved the following passage from Jackson and Powell on

Professional Negligence (SCC p. 666, para 22) The approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client, a duty in tort, as well as in contract, to exercise reasonable care in giving advice or performing services.

Therefore, on the basis of evidence, medical literature and the medical opinion of Dr. Davis on file, we are of considered view that, the OP owed a duty to take care of the deceased. OP had miserably failed to discharge its duty, whether; it was in anxiety not to lose a patient and/or out of over confidence or both? It was a wrong decision and advise for the patient to undergo immediate angiography - CART. It was not an emergency, thus OP had sufficient time to have planned CART. The angiography was conducted without baseline ECHO and other investigations. The doctors at OP ought to have studied the condition of the deceased, whether he was fit to undergo CART and could have anticipated the probability of occurrence of the known complications. Hence, it was not a Standard of practice, OP ought to have conducted Allergy test for contrast medium. The Acute Cardiac Failure which could be consequence of raised LVDEP (para 13 K & L), it could have been avoided by the Cardiologist by terminating the angiography procedure. It further led to Multi Organ Failure, including Acute Nephropathy, which was further potentiated by the Contrast Medium. The OP, also failed to manage the Post -angiography complications as per standards of medical practice. The hospital is a corporate hospital, but lacks infrastructure of Cardiac Alert System or Rapid Response Team. The ICU staff was careless and negligently monitored the patient, who suffered prolonged severe hypoglycemia and unfortunate death on the same day. OP is also guilty of overwriting and making corrections in the medical records. A doctor or a hospital is expected to take reasonable care in administration of the treatment.

21. MEDICAL negligence is an act of commission or an act of omission which a prudent doctor of average skill, knowledge and experience would not do. It leads to three kinds of errors or decision failure: slips, lapses, and mistakes. Slips or lapses occur when the actions associated with a decision, do not proceed as planned. Errors may occur when ''good'' rules are used inappropriately or when ''bad'' rules are used to make a decision. Thus, OP is responsible for negligence; inaction and passivity, accordingly the OP hospital liable for the negligence and deficiency in service, in treating the patient with slips, lapses and mistakes. Thus, the complainant has proved on the evidence that three ingredients of negligence, namely, (a) existence of duty to take care; (b) failure to attain that standard of care; and (c) damage suffered on account of breach of duty,

22. TO fix the liability, we have to consider many aspects. It is true that, Doctors'' decisions about diagnosis and treatment are often made rapidly in difficult circumstances, but mistakes might result more from biases and short - cuts than, time pressures. If we were to impose severe liability on hospitals and

doctors, for everything that happens to go wrong, it will lead to depriving of the services to the people or community at large, Doctors would tend to think more of their own safety, than of the goodness of their patients. Initiative would be stifled and confidence shaken. Thus, we insist on due care of the patient at every point, but we must not condemn negligence that which is only a misadventure. Therefore, on the basis of foregoing discussion, we order that, The OP hospital is directed to pay compensation of Rs. 25,00,000/ - with interest @ 9% pa from the time of death of the patient and Rs. 2,00,000/ - as costs of litigation, within 90 days, to the complainant, otherwise it will carry interest @ 9% p.a., till its realisation.

