(2015) 12 NCDRC CK 0054

In the National Consumer Disputes Redressal Commission

Case No : 157 of 2003

SARDAR KULDEEP SINGH Vs ESCORTS HEART INSTITUTE & RESEARCH? CENTRE

Date of Decision : 15-12-2015

Acts Referred:
Indian Penal Code, 1860, Section 304A - Causing death by negligence

Citation : 2016 1 CPR 182

Hon'ble Judges : Ajit Bharihoke, Rekha Gupta

Advocate : Manoj K Sinha, Mayuri Dutta, Sajad Sultan, Indu Malhotra, Madhukar Pandey

Judgement

1. Briefly put facts relevant for the disposal of the original petition are that the complainant are that Smt Harbhajan Kaur had developed some heart problem for which she consulted Dr (Prof.) H S Wasir, Chief Consultant Cardiology at Batra Hospital and Medical Research Centre, New Delhi on 01.03.2001 where her TMT result showed positive. On the next day, i.e., on 02.03.2001 she consulted Dr Rajeev Lochan at Indraprastha Apollo Hospital, Mathura Road, New Delhi and took his advice for Coronary Arteriography which was done at AIIMS.As a result thereof severe triple vessel coronary artery disease was diagnosed and Coronary Artery Disease was diagnosed and Coronary Artery Bypass Graft (CABG) to LDA, OH1 OM2 and possible D1 arteries was recommended.

2. On 10.08.2001 when the complainant no. 1 had come to Delhi, Smt Harbhajan Kaur had also accompanied him to Delhi. On that day she felt some exhaustion and was immediately taken to the Escort Heart Institute. Dr Naresh Trehan OP no. 2 attended her and advised admission for CABG (immediate surgery was advised). On the same day, i.e., on 10.08.2001, her ECG test was conducted and Miocardial Infraction was found.

3. On 10.08.2001, she was kept in an ordinary general ward without the aid of any family member or attendant and they were not permitted by the authorities of the Institute to go inside her room except for a short period during visiting hours. Despite her ECG findings and the angiography report, which was handed

over to the concerned doctors who attended upon her at the time of examination by Dr Trehan no further medication/ treatment was started. She was made to lie in the ward almost unattended.

4. In accordance with the demand of the Escort Heart Institute, the complainant no. 1 deposited a sum of Rs.2.00 lakh with them as an initial payment.

5. The complainant further alleged that keeping in view her emergent condition of health, she needed aggressive treatment right on day one of her admission in the OP''s hospital but due to sheer negligence on the part of the OPs and their doctors, no such treatment was started nor was due care taken.

6. On the next day, i.e., on 11.08.2001 her ECHO Test was conducted in the said hospital, which also revealed that there was big damage to the heart of the patient. This report must have also been brought to the knowledge of Dr Trehan. Despite such a damaging report neither Dr Trehan nor any of his associate doctors bothered either to shift the patient to the ICCU or to put her on appropriate treatment, which rather should have been aggressive treatment in order to save her life.

7. It was apparent to the complainant from the record of the hospital which was supplied to him after vigorous correspondence, that on 12.08.2001 even the progress note of the patient was not recorded by the hospital staff, which was by itself a big proof of their negligence. Apparently the condition of the patient was not at all satisfactory on this day also. No further treatment was, however, given to the patient on 12.08.2001. When in the evening hours of 12.08.2001 during the visiting hours, the complainant went to see the patient in the general room he found that she was very uneasy. This complainant informed the nursing staff on duty,who was absolutely discourteous and bluntly stated ''are you a doctor or am I''. He also told the complainant to go away and that it was his business as to what was to be done saying "don''t disturb me".

8. The progress note of 13.08.2001 shows that the patient was still subjected to more tests even on this day, as the opening lines of these notes speak "patient received from TEE". These notes further show "patient took breakfast and immediately complained of giddiness and became unconscious". Now at this stage the doctors attending upon her probably realised their negligence and folly in treating this patient as by this time, i.e., 11.00 A M even the B P and pulse rate of the a. patient was not traceable. These notes recorded in the progress chart show that at this juncture the doctors went into panic and summoned the emergency team.The emergency team declared SmtHarbhajanKaur Clinically dead at 12.25 p m.

9. Even if the record of the hospital be taken at its face value, this patient was already diagnosed for Cardiac Arrhythmia - irregular heart-beats. Such minor Arrhythmia can always turn into fatal Arrhythmia, if not properly taken care of and the patient was kept under observation in the ICCU. The opposite parties were per se careless and negligent in not observing this situations of the patient

and keeping her in a general room right from the time of her admission till she became absolutely and uncontrollably critical and ultimately died.

10. The attending junior doctor prescribed those medicines which she was already using on 10.08.2001 at the time of her admission in the hospital. Thereafter no other medicines were prescribed even after the reports of various tests were received from time to time. It was the duty of the doctors and more especially of Dr Trehan to have watched the time-to-time condition of the patient and to have started aggressive and active treatment.

11. The entire thrust of the doctors was on the investigation part alone. No doubt investigation part was also necessary, but at the same time when the investigative reports were not encouraging, the treatment part should have also been considered equally important. Had this been done, a precious life could have been saved. According to the accepted and documented medical norms, proper monitoring is absolutely essential in the case of a patient suffering from cardiac arrhythmia and monitoring can be properly done only in the ICCU where such facility is available. No effort was made by the doctors to shift this patient to the ICCU for monitoring purposes. A proper and timely monitoring reading could have alerted the doctors about the emergency and could have saved them from panic reaction which they showed on 13.08.2001, i.e., immediately prior to declaring her dead.

12. Angiography report of the patient from the Apollo Hospital was already available. She was admitted in the Escorts Heart Institute for CABG (Surgery). Echo could have been done on the date of her admission itself as there was no doubt about the diagnosis. In fact, the bypass surgery itself should have been done immediately or at best on the next day. But the opposite parties were negligent in not attaching due importance to the presence of mild congestive heart failure and cardiac arrhythmia. If she was followed up for these abnormalities in the ICCU under observation and proper treatment, her life could have been saved. The opposite parties continued only that treatment which she was having prior to her admission in the OPs Hospital till she developed Arrhythmia and shock and died. Clearly she was not treated as she should have been before the fatal incident for which the OPs were solely responsible. Their negligence and carelessness was responsible for her said demise.

13. The deceased was born on 01.05.1945 and was thus hardly 55/56 years of age when she died to negligence of opposite parties. She was an independent Income Tax Payee. She was also running an independent business of keeping for sale, transfer or test, Arms and Ammunition for which she held a valid arms dealer license. She had a gross income of Rs.2,23,432/- per annum.

14. The complainants prayed as follows: a. This Commission may very kindly be gracious to award a sum of Rs.1,49,00,000/- by way of compensation to the complainants on account of loss of life of Smt Harbhajan Kaur due to sheer negligence, carelessness, deficiency in service of the opposite parties and the

said amount be recovered through the due process of law jointly and severally from the opposite parties.

b. Interest at the rate of 15% per annum may very kindly be awarded with effect from 13.08.2001 till the date of payment of the whole amount of compensation, by the opposite parties jointly and severally.

c. Such other or further order may deem fit and proper in the facts and circumstances of the case may also kindly be passed in favour of the complainants.

16. The patient was admitted to the respondent hospital on 10.08.2001. Her ECG conducted on the same day showed signs of old myocardial infraction with QS pattern. It was false to state that she was having myocardial infraction. ECHO on 11.08.2001 revealed Akinetic Apex, Hypokinetic mid and basal IVS, mid anterial wall with LVEF 35%. Her Cardiac Enzyme SGOT was within normal limits. She was put on 24 hours Holter Monitoring on 11.08.2001, which did not reveal any malignant ventricular arrhythmias. The patient''s Carotid Doppler as on 11.08.2001 was normal. The patient was admitted for CABG. The factual matrix elucidated by the complainants was wholly erroneous and misleading. She was advised CABG by Dr NareshTrehan. It was incorrect to say that she was admitted for emergency CABG. Prior to open heart surgery, the patient was investigated to assess her fitness for anaesthesia and surgery. It was a mandatory requirement.

17. The allegations made by the complainants in the instant case were wholly unwarranted and preposterous. The patient was not kept in an ordinary general ward, as this institute has no general ward, without the aid of any family member as alleged by the complainants. The patient was provided with a double bed room and one attendant was allowed at all time in her room. The staff of the institute also attended her regularly. It was false to state that she was not put on medication and no treatment was given. The treatment of the patient commenced immediately after her admission in the hospital and appropriate medication and treatment was provided to her. The doctor''s order form dated 10.08.2001 clearly indicated that she was put on medication as per clinical status.

18. Part of the money deposited by the complainants for the treatment of the patient was refunded to them after deducting the amount incurred by the institute on her treatment. An amount of Rs.1,72,675/- was refunded to the complainants.

19. It was false to state that the patient required any aggressive treatment. Her vital signs were within the normal limits and her condition was stable as evident The patient was not in a critical condition and was attendedby proficient doctors at all times. The respondent took strong exception to the allegation that the job of Dr Trehan was finished after receiving a payment of Rs.2,00,000/- and the patient was left to the care of junior doctors. It was incorrect to say that a visit from Dr NareshTrehan would have made any different. The patient was in the hands of the capable and trusted doctors of the respondent institute and was

being given the necessary monitoring and treatment. It was not possible for Dr Trehan to personally treat each and every patient that comes to the institute.

20. ECHO conducted on 11.08.2001 revealed Akinetic Apex, Hypokinetic mid and basal IVS, mid arterial wall with LVEF 35%, normal Cardiac Chamber Dimensions, Mild MR, Trivial AR, Mild PR (PADP = 25 mm Hg), Moderate TR (PASP = 36 mm Hg), Diastolic Relaxation Impairment (A =E), No Intracardiac Clot or Mass and no pericardial pathology was observed. The patient''s vital parameters were within normal limits and her clinical condition did not warrant treatment in ICCU. Hence, the allegations made by the complainants were wholly unjustified and unwarranted.

21. The allegations made by the complainants that no record of the patient was maintained by the Hospital on 12.08.2001 were baseless and false. The Nurses Chart and the Temperature Chart clearly showedthat the progress of the patient was recorded on a daily basis including 12.08.2001. It was false to state that the patient''s condition was recorded as not satisfactory on 12.08.2001 and that no further treatment was given to the patient on 12.08.2001. Temperature chart shows that her pulse rate was 68 - 72, BP was 110/80 and the patient was afebrile. The patient was also getting medication as per orders. It is denied that the patient was not given any treatment on 12.08.2001. Medication record giving details of medication given to the patient was annexed.

22. The patient was to undergo bypass surgery, the patient underwent trans-oesophageal ECHO (TEE) on 13.08.2001 at 09.25 a m, which was mandatory investigation prior to high-risk surgery and was received in the ward at 10.20 am. The patient took breakfast and at 10.45 a m and she suddenly became unconscious. Immediately CPR was started and she was given DC shock three times. She was intubated and shifted to HCC for further management. She was having VT/VF (Ventricular Tacycardia/ Ventricular Fibrillation), which did not revert to normal rhythm in spite of repeated DC shock and other resuscitative measures. The patient had asystole (Cardiac standstill) and was declared dead at 12.25 p m. It was submitted that the resuscitation of the patient was started immediately. There was no delay in treatment by the respondent institute and quick action was taken. The allegation made by the complainants saying that the emergency team of the respondent took half an hour to reach the patient was baseless and preposterous. The patient was not having any significant vent arrhythmia on 24 hours holter monitoring. The sudden change of VT/VF cannot be predicted. The sudden deterioration in her health on 13.08.2001 was completely unexpected and unforeseen and not within the control of the answering opposite party. Hence, the averments made by the complainants are wholly erroneous and misleading, as there was no carelessness by the answering opposite party in the treatment of the patient.

23. The patient had been admitted to the hospital for CABG which could be performed only after the necessary mandatory investigation prior to a high risk heart surgery. It was false to state that the test conducted by the opposite party

itself showed that the patient''s condition was deteriorating fast. The condition of the patient at the time of admission was stable. Her vital parameters were within normal limits. Her ECG showed pattern of old myocardial infarction. Cardiac enzyme was within normal limits. A 24 hours Holter monitoring did not reveal any significant ventricular arrhythmia. She was undergoing investigation prior to surgery. She was stable till 13.08.2001 morning. After the TEE test she came to the ward and had breakfast. She then had sudden cardiac arrest and lost consciousness. Sudden cardiac arrest was an unexpected event that cannot be predicted. However, immediately CPR was started on the patient and she was given repeated DC shocks along with other resuscitative measures. She could not be revived due to long history of cardiac disease. It was submitted that there was no negligence at any time and the patient was given treatment of the highest standard, as per international medical practices. The complainant has failed to establish any indifference, laxity or negligence on the part of the opposite parties.

24. Various tests conducted on the patient did not reveal any kind of emergency or any urgent need to perform surgery. It was imperative that the patient was in a stable condition so as to withstand surgery. It was submitted that the patient was under the constant supervision of the doctors in order to ensure least risk margin and maximum safety.

25. An amount of Rs.1,72,675/- was refunded to the client. Complainant no.1 incurred a total expense of only Rs.27,325/- on the treatment of the patient. The allegation that a hefty amount of Rs.2,00,000/- was charged was wholly erroneous and deliberately misleading.

26. In his written statement Dr NareshTrehan - OP no. 2 has stated that the reports of Apollo Hospital and Batra Hospital clearly confirm the opinion of the answering opposite party arrived at subsequently that surgery was required. In this regard it was essential to bring to the notice of the Commission the factual background in which the instant case arises. It was apparent from the documents submitted to the respondent hospital that Mrs HarbhajanKaur had developed a heart problem and consulted various hospitals for the same. She was also known to have severe hypertension. She consulted Dr (Prof) H S Wasir, Chief Consultant Cardiology at Batra Hospital and Medical Research Centre, New Delhi on 01.03.2001 where her Tread Mill Test (TMT) result was positive. It was also mentioned that patient was having PSVT (Paroxysmal Supraventricular Tachycardia) for which she was on medication. The patient underwent coronary angiography at AIIMS on 02.03.2001 which revealed TVD - diffuse disease with normal LV function. Mrs HarabhjanKaur was advised early CABG by Dr Rajeev Lochan of Indraprastha Apollo Hospital on 14.03.2001. Despite this diagnosis and recommendation the patient rather than going in for CABG, as recommended, merely continued on medical therapy. Her left ventricular ejection fraction during this period came down to 25% from normal. It was submitted that in light of the above reports the patient would in no event have been advised to merely

continue on medicines and resort to surgery after sometime. The assertion of the complainants that the patient was advised to continue on medicines for some time and that she could go for a surgery even after some time was clearly contradictory to the recommendations given in the Coronary Angio Review which recommended early CABG.

27. The patient was admitted to the opposite party''s hospital on 10.08.2001, in the evening. Her ECG conducted on the same day showed signs of old myocardial infraction with QS pattern. It was false to state that she was having myocardial infraction on 10.08.2001. ECHO conducted on morning of 11.08.2001 revealed Akinetic Apex, hypokinetic mid and basal IVS, mid anterior wall with LVEF 35%. Her cardiac enzyme SGOT was within normal limits. She was put on 24 hours Holter monitoring on 11.08.2001, which did not reveal any malignant ventricular arrhythmias. The patient''s Carotid Doppler as on 11.08.2001 was normal. It was evident from the TPR Chart that the condition of the patient was stable. The patient was admitted for CABG. The factual matrix elucidated by the complainant was wholly erroneous and misleading. It was not denied that she was advised CABG by the answering opposite party. However, it was incorrect to say that she was advised emergency CABG. Prior to open-heart surgery, the patient was investigated and tests conducted to assess her fitness for anaesthesia and surgery. This is a mandatory requirement.

28. The patient was not kept in any ordinary general ward, without the aid of any family member as alleged by the complainants, inasmuch as this institute has no general ward. The patient was provided with a double bed room and one attendant was allowed at all times in her room. The staff of the institute also attended her regularly. It was false to state that she was not put on medication and no treatment was given. The treatment of the patient commenced immediately after her admission in the hospital and appropriate medication and treatment was provided to her. The doctor''s order form dated 10.08.2001 clearly indicated that she was put on medication as per clinical status.

29. Further, a part of the money deposited by the complainants for the treatment of the patient was refunded to them after deducting the amount incurred by the institute on her treatment. An amount of Rs.1,72,675/- was refunded to the complainants.

30. The opposite party took strong exception to the allegation that his job was finished after receiving a payment of Rs.2,00,000/- and the patient was left to the care of junior doctors. The patient was in the hands of a capable and trusted team of doctors of the opposite party institute and was being given the necessary monitoring and treatment. Each doctor of the team specialises in different areas. This team of trusted doctors was being monitored by him. It was denied that the respondent ignored the patient at any critical juncture.

31. It was further denied that she was not put on appropriate treatment. She was being given the required medication and all necessary tests prior to a

surgery were being conducted. The tests conducted did not show any such abnormality requiring the patient to be shifted to ICCU, ECHO revealed Akinetic Apex, Hypokinetic mid and basal IVS, mid anterior wall with LVEF 35%, Normal Cardiac Chamber Dimensions, Mild MR, Trivial AR, Mild PR (PADP = 25 mm Hg), Moderate TR (PASP = 36 mm HG), Diastolic Relaxation Impairment (A = E), No Intracardiac Clot or Mass and No Pericardial Pathology observed. The patient''s vital parameters were within normal limits as evident from TPR chart and her clinical condition did not warrant shifting to ICCU. Hence, the allegations made by the complainants are wholly unjustified and unwarranted.

32. As the patients was to undergo by-pass surgery, the patient underwent Trans-oesophageal ECHO (TEE) on 13.08.2001 at 09.25 am which was a mandatory investigation prior to high - risk surgery and was received in the ward at 10.20 am. The patient took breakfast after which at 10.45 a m, she suddenly became unconscious. Immediately (CPR) with advanced cardiac life support was started. She was intubated and shifted to HCC for further management. She was having VT/VF (Ventricular Tacycardia/ Ventricular Fibrillation) which did not revert to normal rhythm in spite of repeated DC shock and other resuscitative measures. The patient had asystole (Cardiac Standstill) and was declared dead at 12.25 p m. The resuscitation of the patient was started immediately. There was no delay in treatment by the opposite party institute and quick action was taken. The allegation made by the complainants saying that the emergency team of the opposite party took half an hour to reach the patient was wholly baseless and preposterous. The patient was not having any significant vent arrhythmia on 24 hours holter monitoring. It was a medically well-known fact that sudden development of VT/VF cannot be predicated and ventricular fibrillation can happen without warning, resulting in immediate death.

33. It was stated that the sudden deterioration in her health on 13.08.2001 was completely unexpected and unforeseen and not within the control of the answering opposite party. Hence, the averments made by the complainants are wholly erroneous and misleading. It was stated that there was no carelessness on the part of the opposite party in the treatment of the patient.

34. Holter Monitoring revealed atrial premature beats and atrial tachycardia, which she was diagnosed to have since 01.03.2001 by Dr Wasir. There was no significant ventricular arrhythmia on 24 hours holter monitoring. As stated earlier sudden VT /VF cannot be predicted. Therefore, it was wrong for the complainants to allege that the patient was not properly taken care of. The complainants have deviated from the true facts and have twisted the truth in order to make such frivolous averments against the answering respondents. It was again emphasised that the patient was not kept in a general ward and her condition did not warrant treatment in the ICCU. There was a sudden deterioration in the condition of the patient, which could not have been predicted. 35. The doctor''s order form clearly shows that appropriate medicines were prescribed to the patient as per her clinical condition. The daily progress of the patient was carefully and diligently

recorded by the attending doctors, who were being monitored by the opposite party. The condition of the patient was stable and no aggressive treatment was required. The sudden deterioration in the health of the patient was completely unsuspected and in no way linked to any neglect on the part of the opposite party.

36. The tests were conducted for the purpose of assessment of patient''s clinical condition and were essential prior to treatment, to assess the patient''s fitness for anaesthesia and surgery. It was incorrect to say that no monitoring was done. 24 hours Holter monitoring was done which did not show any malignant cardiac arrhythmia. It was not necessary to shift the patient to ICCU for monitoring. The doctors of the opposite party institute were best situated to decide the appropriate treatment for their patients. The timely and proper monitoring of the patient''s health can be evidenced by the medical records, nurse''s chart, temperature chart and various other reports maintained by the staff. Therefore, the demand for compensation by the complainants was wholly unwarranted, unjustified and preposterous.

37. The patients had been admitted to the hospital for CABG which could be performed only after the necessary mandatory investigation and tests prior to a high risk heart surgery. These tests were performed as per schedule. It was false to state that the test conducted by the opposite party itself showed that the patient''s condition was deteriorating fast. It was reiterated that the conditions of the patient at the time of admission was stable. Her vital parameters were within normal limited. Her ECG showed pattern of old myocardial infraction. Cardiac enzyme was within normal limits. 24 hours Holter monitoring did not reveal any significant ventricular arrhythmia. She was undergoing investigation prior to surgery and was stable till 13.08.2001 morning. After the TEE test she came to the ward and had breakfast. She had sudden cardiac arrest and lost consciousness. Sudden cardiac arrest is an unexpected event that cannot be predicted. However, immediately CPR was started on the patient and she was given repeated DC shocks along with other resuscitative measures. She did not respond to resuscitative measures due to long history of cardiac disease. It was submitted that there was no negligence at any time and the patient was given treatment of the highest standard, as per the international medical practices. The complainants have failed to establish any indifference, laxity or negligence on part of the opposite party.

38. It was however, stated that the answering opposite party was personally treating the patient, along with the team of doctors. In reply to the allegation that a huge amount of Rs.2.00 lakh was charged by the opposite party. It was stated that an amount of Rs.1,72,675/- was refunded to the complainant. The complainant no. 1 incurred a total expenses of only Rs.27,325/- on the treatment of the patient. The allegation that a hefty amount of Rs.2.00 lakh was charged was wholly erroneous and deliberately misleading.

39. We have heard the counsels for the parties and also the complainant in

person. Complainant''s wife SmtHarbhajanKaur developed some heart problem. She consulted Dr (Prof) H S Wasir at Batra Hospital on 01.03.2001, where the TMT was positive. On 02.03.2001 she consulted Dr Rajiv Lochan at Apollo Hospital, thereafter coronary artery bypass graft (CABG) was done at AIIMS on 02.03.2001. Angiography report of the AIIMS of SmtHarbhajanKaurgave the following recommendations: LV : Lvh

LCA - Mild disease at bifurcation.

LAD - Diffuse siginfprox and mild LAD disease

Ostial D1 and D 2 disease

Mild distal LAD disease

Lex : Significant ostialandprox disease _____ from diseased segment prox significant.

Disease good sized

RCA Significant disease of CX and AV groove

Two mod sized OMBS after this

RCA - Significant prox disease

Dominant system"

Complications - CAD ISA E-D--.- x 5 years

CL III-IV x 20

C T VD Diffused disease

C (N) LV . function

Recommendations : Review of Angio with surgeon I CABG"

40. On 14.03.2001 the patient went to Apollo Hospital for analysis of Angio report. The patient was asked to continue oral medication only. On her admission at the Escorts Hospital, even though the patient''s heart had been severely damaged and she was having breathlessness she was admitted, but she was neither admitted in ICCU nor given aggressive emergency treatment for her ailment. Routine tests were conducted on her heart such as ECHO, ECG, and Holter Test, TEE and other pathological tests. She was not under the supervision of any Senior Cardiac Physician, as such the results of all the tests were not correlated to assess the seriousness of her condition. Smt Harbhajan Kaur, suffered a heart attack/ MI on the 10 th night. However, it was not taken cognizance off nor treated by the doctors at the Escorts Hospital which lead to the condition of Smt Kaur worsening. The LVEF factor which was 35% on admission further deteriorated to 25% due to lack to monitoring, treatment and the conducting of routine tests, instead of giving emergency treatment. The

patient finally collapsed on 13.08.2001 morning after breakfast, she passed away at 12.25 p m. As per the complainant / learned counsel for the complainant argued that the doctors at the Escorts hospital and Dr Naresh Trehan knowingly fully well that the patient was serious with a damaged heart suffering, breathlessness and even though the ECG results suggested MI yet the patient was not taken to ICCU and she was subjected to routine tests. It was falsely mentioned by Dr Trehan that the ECG showedan old MI. There was no evidence to suggest that the patient suffered from a heart attack before admission to ESCORTS. In fact she continued to be under medication as prescribed by Dr Rajiv Lochanand no medicinal changes was introduced even after seeing her serious condition, Routine tests were conducted while her condition deteriorated further and further. She was subjected to TEE test on 13 th in spite of her damaged heart. This has resulted in the death of the patient.

41. Learned counsel for the opposite party no. 2 took us through the facts of the case. The TMT conducted at Batra Hospital was positive. The report of the Cardio Thoracic Sciences Centre of AIIMS,also indicative that she had severe triple vessel coronary artery disease with normal LV functions.

42. Thereafter the patient was taken to Apollo Hospital, on 14.03.2001 for review of the Angio Report. As per Dr Rajiv Lochan, the Coronary Angio Review reads as under: "Coronoary Arteriography: Left Main Coronary Artery - Normal Lefter Anterior Descending Artery - Long segment 85% proximal Diagonal Branches: Moderate sized - two branches arise from diseased LAD Left circumflex artery : Non dominant - but larged sized having proximal 90% narrowing. OM Branches : I - Early - proximal 85%

II. Moderate sixed 80%

Right Coronary Artery :Dominent - Diffuse 85% narrowing.

PDA : Moderate sized.

"LV Angiography - Hyper Contractile normally functioning LV with edopic include mild MR.

Final Diagnosis : Severe triple vessel coronary artery disease."

Recommendation : Early CABH to LAD, OH1, OM2, PDA and possible D1 arteries".

43. It was an old case of CAG with a history of five years. The patient Mrs HarbhajanKaur was taken to OPD of Escorts Heart and research centre on 09.08.2001, where it was recorded that TSR and LVEF were normal. It is also recorded that CABG should be planned. Thereafter she left the hospital. On 10.08.2001 she was admitted at 5.00 clock for her elective planned CABG. Anauthorisation form was signed by her husband. Learned counsel for the OP 2 had stated that had she been found in a serious condition and suffering from MI, she would have been given an emergency treatment on 09.08.2001 itself and admitted in ICCU. This is not the case as she got admitted on 10.08.2001 after

05.00 p m. At the time of admission, the patient did not produce any treatment record or the condition of the patient for the period almost for five months from 15. 03.2001 to 09.08.2001. As per the cardio evaluation form the whileadmitting the patient she was suffering from HT, CAV TVD. The following were recorded in the clinical summary: "K/c HT on regular MI, had DoE II since 5-6 months, TMT done in February 2001 was positive for RMI CAG done at AIIMs. Diffuse TVD (n) LV function was advised CABG but was continuing medical therapy. No history of chest pain palpitations, syncope. ECG in March - showed ischemic changes.

Plan - CABG"

44. It would also confirm from the cardio evaluation form that the patient has under gone ECG, IWMI + ASMI which was suggestive of inferior valve myocardial infraction old caseof angina (quoted from page 42 main file). " Minor plaque at the origin of RICA B/L internal thickening. Rest of the study was normal ".

45. On physical examination there were no signs of cyanosis or Oedema. Lymph Nodes were enlarged. There was no abnormality in peripheral pulses, Precardial palpitation. No abnormality was noticed with regard to LVEF, no abnormality was also detected with regard to precardial auscultation.

46. As per the learned counsel for the OP 2,on admission the patient was clinically stable there was no mention that she had a history of chest pain, palpitation and cyanosis but the patient had stated that she did suffer from breathlessness onexertion. The patient did not give any record pertaining to the treatment given from March 2001 till the date of admission in the Escorts Hospital on 09.08.2001, occurrence or incident of heart attack. When she came to the hospital she was on a blood thinners. Further, the use of blood thinner as well as Disprinwas stopped to the patient. As per the nurses report, the pulse report, BP and temperature remained normal and various blood test were conducted and SGOT test also was normal had she was not suffering from heart attack on 11.08.2001 at 09.48 a m. ECHO had been done when it was found that LVEF had reduced from 60% (normal) in march 2001 to 35%. The patient had undergone Carotid Doppler test on 11.08.2001. Holter Test was started for 24 hours on 12.08.2001 at 03. 50 p m. As per the Holter Test report: " A total of 144562 beats were observed for the entire recording period of 24 hours 0 minutes. The maximum sinus heart rate during this period was 200 BPM, during minutes 22.30 hours. The minimum sinus heart rate was 67 BPM, during minute 8.43. A total of 2987 supraventricular ectopic beats were observed with 2870 isolated single events and 13 runs. A total of 1437 ventricular ectopic beats were observed; with 1437 isolated single events and 0 runs.

Impression:

24 Hours holter analysis of Mrs H Kaur revealed:

i. Significant isolated APB and runs of atrial tachycardia;

ii. Isolated VPB/No ventricular tachycardia; and

iii. No significant ST shift as compared to basesline ECG".

Thereafter TEE test was conducted at 09.25 a m and the report reads as under:

"Interpretation Summary:

i. Akinetic Apex, Mid Anterior wall and inferior wall (LVEF 25%;

ii. No LV/LA Clot

iii. Mild MR. Trace AR

iv. No Atheroma Seen in aortic arch.

Left Ventricle:

The left ventricle is mildly dilated. There are no thrombus. There is normal left ventricular wall thickness. The left ventricular ejection fraction is markedly reduced (25-35%).

As per the Carotid Color Doppler Report -

i. The clinical diagnosis of HTN, CAB TVD -

The impressions are:

Right Carotid:

ii. Duplex scanning of RCCA & RICA revealed normal diameter of the lumen;

iii. Doppler study revealed normal velocities with no spectral broadening and normal laminar color flow pattern;

Ration of peak flow velocities of RICA : RCCA with in normal range; and

iv. Minor plaque at the origin of RICA. Left Carotid:

i. Duplex scanning of LCCA and LICA revealed normal diameter of the lumen;

ii. Doppler study revealed normal velocities with no spectral broadening and normal laminar color flow pattern;

iii. Ration of peak flow velocities of LICA : LCCA with in normal range; and

iv. No evidence of haemodynamically significant plaque in LCCA, LICA and LECA".

47. Even as per the Nurses chart, the general condition of the patient was stable since there was no complaint of chest pain and breathlessness.

48. OP no. 2 after taking us through the testS conducted on the deceased dealt with the issues raised by the complainant: 1. The complainant had alleged that it was a case of an emergency CABG : The above-stated contention was incorrect being contrary to medical records. Mrs HarbhajanKaur was a cardiac patient since 1996 and was having Chronic Stable Angina and Dyspnea on Exertion Class II for last five years. As she was having severe Dyspnea on Exertion Class III and

IV since middle of February 2001, she first went to Batra Hospital, Delhi on 01.03.2001 and then went to AIIMs, New Delhi, where the Cardiac Catheterisation Study (Coronary Angiography) was undertaken on 02.03.2001 and she was advised CABG on 02.03.2001 at AIIMS. The patient thereafter went to Indraprastha Apollo Hospital, New Delhi on 14.03.2001 for review of the Coronary Angiography and the patient was advised early CABG by Dr Rajiv Lochan at Apollo Hospital, which the patient neglected to undergo. After about six months, the patient came to the OPD of opposite party no. 1 - hospital on 09.08.2001 for treatment and was seen by a Senior Cardiologist and was advised CABG in view of her history of old Triple Vessel Disease, Paroxymal Supra Ventricular Tachcardia (PSVT) and angina. As per the complainant''s own admission, she had travelled by train from Kanpur to Delhi as she was in a stable condition.

On 10.08.2001, at 06.40 p m., i.e., at the time of admission in the OP no. 1 hospital, the patient was asymptomatic, with no complaints of chest pain/ angina or breathlessness, or any other symptom of on-going MI/ heart attack and was hemodynamically stable. Accordingly, the patient was admitted for planned/ elective CABG. Patient''s clinical condition did not warrant any urgent measures like insertion of intra-aortic balloon pump or emergency CABG. At the time of admission on 10.08.2001 at 06.40 p m, the patient''s conditions was stable and her vital parameters were within normal limits. ECG was conducted on the same date. The ECG showed signs of old myocardial infraction with established Q waves, which is indicative of a past established heart attack, and not an on-going heart attack. Further, the absence of ST elevation and more importantly lack of any symptoms such as chest pain, suffocation or breathlessness ruled out an on-going heart attack. The patient was administered appropriate medications. The doctor''s order form dated 10.08.2001 indicated that she was put on appropriate medication as per her clinical status, which are also recorded in the nurses notes and medication record. On 11.08.2001, ECHO was conducted which revealed that the patient was having Akinetic Apex which is indicative of a settled myocardial infraction, i.e., past established heart attack, and not an on-going heart attack. The ECHO also revealed reduced LVEF to 35% and that the patient had a history of myocardial infraction and PSVT.

On 11.08.2001, the 24 hour Holter monitoring was started. The Holter monitoring did not reveal any malignant Ventricular Arrhythmia/ Ventricular Tachycardia, but did reveal that the patient had ventricular premature complexes (VPC''s). The complications arising out of VPC''s is best treated with Beta Blockers, which was administered to the patient during her stay in the OP 1 hospital.

As the ECHO dated 11.08.2001 also revealed mild mitral regurgitation, i.e., leakage of mitral valve, therefore, it was essential to ascertain the severity of leakage prior to CABG. Accordingly, TEE was conducted to ascertain the severity of leakage and possibility of aortic atheromas and outcome of CABG. It was

submitted that TEE was an important investigation done prior to any high risk cardiac surgery where the patient was suffering from Mitral Regurgitation as such cases may require mitral valve repair simultaneously with CABG.

The patient underwent TEE on 13.08.2001 at 09.25 p m and thereafter the patient was received in the ward at 10.20 am, in stable conditions. The patient was comfortable throughout the procedure. The patient had finished her breakfast. The patient was stable till 10.45 am. At about 10.45 a m the patient suffered a sudden cardiac arrest due to ventricular fibrillation (VF). The TEE report confirmed no valve leakage, aortic atheromas or clots in the heart. The results of the above TEE revealed LVEF in the range of 25-35%. However, the ECHO is the appropriate test to ascertain LVEF, and not TEE; and therefore, as far as LVEF is concerned, the ECHO conducted on 11.08.2001, should be relied upon. It was further pertinent to note that on echocardiography, the reproducibility of LVEF is about +/-7% and re-tests reliability was about +/-5%.

It was also pertinent to mention that 24 hours Holter monitoring conducted on the patient from 11.08.2001 to 12.08.2001 revealed no malignant ventricular arrhythmia. The sudden episode of VF (Ventricular Fibrallation) on 13.08.2001 resulting in sudden deterioration in the health of the patient was unpredicted and not within the control of the opposite parties. Immediately CPR was started and medication was administered to maintain the vitals and DC shock given three times to cardiovert the patient. The patient was intubated and shifted to Heart Command Centre for further management. The patient was having VF, which did not revert to normal rhythm in-spite of DC shock and other resuscitative measures. The patient went into asystole that is cardiac standstill and was declared dead at 12.25 p m. It is medically well-known that sudden development of VT/VF cannot be predicated and VF can occur without warning, resulting in immediate death. Despite all necessary treatment including administration of beta-blockers, the patient passed away due to sudden cardiac death, which was unpredictable and is a known complication in cardiac patients with LV dysfunction.

2. The complainant alleges that no cardiac physician was consulted . This was incorrect and contrary to the medical records. The following senior cardiologist/ physicians attended to the patient and carried out the relevant investigations:

Date Doctors visit Investigations Medication

09.08.2001 Dr Samir Srivastava (Cardiac Consultant) in OPD

As per patient condition and standard protocol

10.08.2001 Dr Trehan (as per complaint)

No change as there was no change in patient''s condition.

Dr Mustafa Sabir (resident cardiology ECG

KFT, LFT, LDH, Sugar, PT INR, APTT, Hemogram, Blood grouping, urine routine microscopic

11.08.2001 Dr (Col) C P Roy, (Senior Cardiac Consultant) ECHO

Dr A K Khera (Cardiac Consultant) Carotid Doppler

Dr K Subhramanyam (Resident Cardiology) Holter (24 hours)

Lipid Profile

12.08.2001 Dr Rajneesh Kapoor (Cardiac Consultant) Holter analysis

13.08.2001 Dr Samir Srivastava (Cardiac Consultant TEE

3. The complainant alleges that the opposite parties did not take any aggressive steps for treatment and there was a lack of team work at the hospital.

The entire basis of the said argument was erroneous, as it was based on the misinterpretation of report of ECG, ECHO and TEE. It was submitted that the patient''s cardiac condition did not deteriorate after admission in the hospital. In March 2001, the patient''s LVEF was 60% and she was advised by Dr Rajeev Lochan from Apollo Hospital to undergo early CABG. However, the patient, against medical advice, continued on medical therapy only. On 11.08.2001, one day after admission, her LVEF was 35% which had not deteriorated overnight but had gradually deteriorated from 60% to 35% (during six months) as a result of patient''s negligence in following doctor''s advice and ignoring her condition.

At the time of admission and during her stay at the hospital till the morning of 13.08.2001, the patient did not have any signs or symptoms of acute MI (i.e., on-going heart attack). The patient was asymptomatic, had no complaints of chest pain/ angina or breathlessness, or any other symptom of on-going MI/ heart attack and was hemodynamically stable with no indication to be shifted to ICCU.

During her stay at the hospital, the patient was evaluated by a team of least five senior Cardiologists/ Physicians (including Dr A K Khera, Dr RajneesKapoor, Dr SamitSrivastava, Dr K Subhramanyam, Dr (Col) C P Roy) each of whom performed their specified tasks like ECG, ECHO, TEE, Holter, biochemical and haematological investigations and interpreted them at the time of performing them and no signs of acute MI/ on-going heart attack were observed by them during their evaluation or else they would have taken appropriate steps. The patient''s general condition, pulse rate, respiratory rate, BP temperature, urine output, bowels, diet etc., was monitored on a regular basis, which did not show any deterioration. The patient had no signs or symptoms of deterioration of cardiac functions. The ECG findings were reflective of an old myocardial infraction with QS pattern depicting its past happening and not an acute insult. The complainant contends that ST depression was a sign of a damaged heart. In respondent, it was submitted that ST depression (seen in the ECG) can also be seen in a lot of other cardiac conditions like hypertension, left ventricular hypertrophy with strain, electrolyte disturbances, old myocardial infraction etc.

It was, therefore, possible to infer that the deterioration of LVEF to 35% had not occurred overnight, but had gradually deteriorated from 60% (in March 2001) to

35% (in August 2001) as a result of patient''s negligence in not following doctor''s advice and ignoring her condition. ECHO read with the ECG and interpreted in the clinical lack of symptoms was also suggestive of an old MI which resulted in this deterioration.

The TEE dated 13.08.2001 revealed that the patient''s LVEF was in the range of 25-35%. It was submitted that it was merely a reflection of the inter-observer variability, and the fact that the TEE has many limitations in interpreting EF due to technical difficulty and apical foreshortening. Also, on echocardiography, the reproducibility of LVEF is about +/-7% and re-test reliability is about +/-5%. Therefore, the LVEF of 25% as per the TEE has to be read in the range, i.e., between 25-35% and has to be seen in the context of associated clinical symptoms. It was submitted that if this alleged decrease in LVEF from 35% to 25% had been due to a heart attack/ cardiac injury, then, the patient would have manifested some clinical signs like chest discomfort, breathlessness or hemodynamic instability. The patient infact went through the procedure comfortably, and without any complications. The patient was stable when she was shifted to the room after she had breakfast. The sudden event of VT/VF occurred which caused the sudden death. It was well-known that the patients with CAD are prone to sudden cardiac death, which may not necessarily be prevented even after CABG.

It was submitted that Holter, TEE and Carotid Doppler also did not reflect any deterioration in the cardiac condition of the patient.

4. The complainant alleges VPC''s (Ventricular Premature Complexes) were ignored and not treated which led to VT/VF and death of the patient.

The said allegation is incorrect and contrary to medical records. It is submitted that patients with reduced LVEF are at a higher risk of suffering from episodes of VT/VF (with or without VP''s on holter). It was also medically know that episodes of VT/VF can occur suddenly without warning, and cannot be predicted. The standard of care in such cases is administration of Beta Blockers.

In the present case, knowing that the patient had reduced LVEF, the patient was being monitored regularly and put on preventive Beta Blockers therapy immediately after his admission at OP 1 hospital. The Holter conducted on 11.08.2001 did not reveal any malignant ventricular arrhythmia/ ventricular tachycardia. There were indications of isolated ventricular ectopic/ atrial ectopic for which the standard care is betablockers, which was being administered. Only malignant arrhythmia requires immediate treatment and ICCU care, which was absent in the patient. There was an absence of a malignant ventricular arrhythmia/ ventricular tachycardia on holter, absence of history of syncope (episode of unconsciousness) and the patient was in stable clinical condition which did not warrant immediate ICCU admission.

5. The complainant alleges that the Calaptin was wrongly withdrawn. The said allegation is incorrect. Calaptin is not a drug choice for CAD with LV dysfunction

and therefore, it was replaced with Beta Blockers, being a drug of choice and it also controls arrhythmias such VPCs.

6. The complainant alleges that TEE caused irritations in the heart which led to the death of the patient.

The said contention was wrong and denied. The ECHO dated 11.08.2001 revealed Mitral Regurgitation, i.e., leakage of mitral valve, therefore, it was essential to conduct TEE to ascertain the severity of leakage and possible of aortic atheromas and clots in the heart as the same could impact the risk assessment and outcome of CABG. It was medically know that the patients with unrepaired/ uncorrected mild MR or moderate MR are at an increased risk of death and heart failure.

The contention that TEE irritated the heart which lead to the death of the patient was incorrect. TEE is standard of care diagnostic tool and one of the safest procedures for the management of cardiac surgical patients. The unfortunate demise of the patient occurred nearly an hour after the procedure of TEE and after the patient had breakfast. TEE procedure was without any complications and the patient was hymodynamically stable after the TEE.

7. The complainant alleges that the tests were not correlated with the clinical conditions of the patient .

The said contention was wrong and incorrect. During the patient''s stay at OP 1 hospital, the patient was evaluated by a team of at least 5 senior cardiologists each of whom performed their specified tasks like ECG, ECO, TEE, Holter, biochemical and haematological investigations. The patient was also monitored by nurses on regular basis. Test findings were noted, analysed and clinically correlated by the team of attending doctors and as there was no deterioration in patient''s condition aggressive treatment was not warranted.

A surgeon''s role started with consultation and advice for appropriate treatment modality (whether conservative management, medication, angioplasty, CABG etc.) based on patient''s clinical condition and investigation reports. In case of an emergency, he advises emergency surgery. However, in case of planned or elective surgery (i.e., patient''s condition and/ or investigations do not mandate any emergency treatment, surgeon advises the patient to prepare and get admitted for surgery as per his arrangement. For pre-operative investigations and to ascertain patient''s fitness for surgery, surgeon refers the patient to a team of doctors who have an expertise in this area. Pre-operative investigations are conducted in accordance with prevailing protocol which varies from hospital to hospital but the main objective of these investigations is to ascertain patient''s fitness and any associated issues which may affect the outcome of the surgery or can be managed during the planned surgery. In case any issue or concern is observed during pre-operative investigations, then the patient is referred to the appropriate doctor/ team. Once the patient is cleared by this team of doctor for surgery, the patient''s conditions and pre-operative investigation findings are

discussed by this team with the surgeon. In case of any significant change during pre-operative investigation, the matter is escalated to the surgeon to re-consider the approach and timing of the surgery. Otherwise, surgery was scheduled as per plan and conducted by the surgeon.

49. Learned counsel for OP No.1 contended that there are number of Supreme Court judgments regarding the medical negligence. These judgments are very clear that the line of treatment can be decided upon by the doctors. The complainant has to prove that it was a case of medical negligence by pointing out that the line of treatment of doctor was not commensurate to the diagnosed illness or that the procedure and protocol was not followed. In the present case SmtHarbhajanKaur had been admitted for a planned elective CABG. On admission she was found clinically stable and was not brought in for an emergency CABG or for any emergency treatment for on-going heart attack. She had never earlier taken treatment from OP No.1 and inspite of the fact that earlier she had been seen by the Batra Hospital, AIIMS and by Dr. Rajiv Lochan of Apollo Hospital, she opted to come to Escorts. There was no consultation or appointment taken by SmtHarbhajanKaurprior to 09.08.2001. the complainant has falsely recorded in the written statement filed on 09.02.2015 that HarbhajanKaur had an appointment for general check up with OP No.2 on 09.08.2001. Accordingly, complainant no.1 alongwith his HarbhajanKaur went to OP No.1 on 09.08.2001 to meet OP No.2 and since the train got late, the meeting did not mature. The fact remains that as per the available record, HarbhajanKaur had visited the hospital on 09.08.2001 and was seen by Dr.Trehan and Dr. Rajiv Vyas and recommended a planned CABG. Thereafter, she left for her residence and came next day when she was admitted at 5.04 p.m. for planned CABG. All the tests conducted as also the clinical examination did not indicate an on-going heart attack. Though the ECG did reveal sign of old MI (heart attack). She was admitted to a two beded room which was fully equipped. As she was not suffering from any symptoms of an on-going heart attack such as chest pain, breathlessness or syncope, she was not taken to a primary heart centre for emergency treatment but admitted for a planned CABG and as per the protocol such patients are then ''worked out''. Every ward in Escort is fully equipped and includes a crash cart for emergency treatment. She had come as a high risk patient and could not have been operated upon without the required tests to assess her condition and fitness to undergo an open heart surgery. She was clinically stable at the time of admission and hence did not warrant admission in ICCU. He further stated that rest of the tests and treatment given at Escorts had already been elaborated by the counsel for OP No.2.

50. Complainant no.1 in his rebuttal stated that opposite parties have failed to give any evidence that deceased was an old case of MI. In fact, the first ECG report placed on file is a fabricated and forged document as it indicates that same tests were done on HarbjhajanKaur on 10.08.2001 at 7.15 a.m. when she had been admitted in the evening of 10.08.2001. The Echo conducted on 11.08.2001 clearly indicated that she had suffered an heart attack on

10.08.2001and that is why her LVEF had come down to 35%. The admission form clearly indicates that she was suffering from breathlessness. ECG report also recorded that she had an on-going heart attack. Though she was undergoing an heart attack, no aggressive medical care was given to her. She was not put in ICCU. She was not given any emergency treatment and she continued on medication as prescribed by Dr. Rajiv in March 2001. They continued to carry out various tests in a routine manner and she was not seen by a cardiac physician. The Holter test clearly indicate VPCs and this became malignant and caused her death. Trop-T, CPK and MRI tests were not done which could have clearly indicated whether the heart attack is current or old. She ought to have been attended to only in the ICCU. As condition of HarbhajanKaur kept deteriorating, the opposite parties failed to take cognizance of the tests result and correlate with her clinical condition. When he met the deceased on the evening of 12 th August, he found her sinking and in great distress. On 13.0.8.2001 they conducted a TEE which was not required. Her LVEF had further reduced to 25% whereas first Echo had shown Akinetic Apex and Hypokinetic Mid and Basal Ivs, Mid Anterior Wall. LVEF 35%. As per complainant no1, Rajiv Lochan of Indraprastha Apollo Hospital in Coronary Angio Report dated 02.03.2001 had also noted Hyper Contractile normally functioning LV with ectopics including mild MR. The Echo report also showed mild MR. This also goes to show that TEE was not at all required and infact contributed to the patient''s death. The death certificate also indicate the cause of death as malignant ventricular Arrhythmia.

51. After hearing the learned counsel for the parties and complainant in person and going through all the records of the file, the following issues emerge: 1. When was HarbhajanKaur was first diagnosed with cardiac problem

2. When was she first advised CABG and by whom? What was the severity of problem at the time of diagnosis?

3. When she arrived at OP No.1 Hospital, what was her condition and was she suffering from an on-going heart attack or was an old case of MI who should have been treated as an emergency case of MI and given emergency treatment and admitted to ICCU.

4. Was there any negligence in the treatment given by the opposite parties while she was admitted in Escorts from the evening of 10 th August 2001 till she died on 13 th August 2001 at 12.25 p m.

52. The case begins from the OPD of 01.03.2001 of Batra Hospital and Medical Research Centre where she was seen by Dr. H S Wasir and was advised TMT and at that time she has history of PSVT and was on Calaptin and case of Dysponea. The treadmill test was positive. The patient was suffering from ProxysysmalAtreal for which she was on medication. The patient underwent coronary angiography at AIIMS on 02.03.2001 which revealed Triple Vessel Disease with normal LVEF function. She had CAD for last five years since 1996. The patient was advised early coronary Artery Bypass Graft. Dr Rajiv Lochan at Apollo on seeing her

angiography report also recommended early CABG and prescribed medication for one month. The patient rather than going in for CABG continued on medication till the date she arrived at Escorts.

53. As per the complaint, on 10.08.2001 when complainant no.1 had gone to Delhi, Smt. HarbhajanKaur had also accompanied him to Delhi. On that day she felt some exhaustion and was immediately taken to Escorts hospital. Dr.NareshTrehan attended her and advised admission for a planned CABG. On the same day, when ECG was conducted and MI was found. We find that complainant no.1 with HarbhajanKaurhad not rushed to Delhi for emergency treatment in Escorts or for an emergency CABG. Complainant no.1 both in his complaint and written statement has omitted to mention that he had taken HarbhajanKaur to Escorts on 09.08.2001 in the OPD where after giving brief history, she had been advised a planned elective CABG as a follow up of the earlier diagnosis and recommendations of Batra Hospital, AIIMS and Dr Rajiv Lochan of Apollo Hospital. She was not admitted on that day and was sent home. She again visited next day for follow up. It is not mentioned as to when she reached and what pre admission tests were conducted. She was admitted at 5.00 p.m. on 10.08.2001.

54. During the admission process, it would appear that apart from the treatment record of Batra Hospital, AIIMS and Dr. Rajiv Lochan, no treatment record for the period 15 th March 2001 to 08.08.2001 was given to the hospital. In such case, it is essential to give the entire record of the patient to help the doctors to assess the current status of health and treatment required. Going by the pre admission tests and in the absence of known indicators of on-going heart attack such as breathlessness, chest pain, syncope, she was admitted for necessary tests for CABG. She had continued with the medicines prescribed by Dr Rajiv Lochan (for 30 days) till she arrived in Escorts. She was on blood thinners and as she was to undergo CABG for her major open heart surgery, she had to be weaned off of the blood thinners for a period of three days. It is an admitted fact that after admission on 10.08.2001 evening she underwent an ECG, pathological blood tests and other tests, colour Doppler, Echocardiogram, Holter Test as also TEE. Her medication was changed and Calaptin was replaced by Beta blockers and blood thinner was discontinued. As per nurses report on file, her general condition was fair and her vitals were checked and recorded and there was no occasion to indicate that her condition was deteriorating.

55. We have seen nurses chart from 10.08.2001 till she died on 13.08.2001. She was taken to room no. 540 at 6.40 p.m. Vitals were checked and recorded. ECG taken and admission informed. Duty doctor was informed and all heart station tests to be done on 11.08.2001. All blood for investigation were sent to lab. The nurses report indicate that on 11.08.2001 at 8.a.m., Dr.Subramaniyam has seen the patient. On the same night, Dr.Vikram''s consultation on TEE was to be done. On 12.08.2001 also, she was stable and was on holter and Dr.Vikram was consulted. Both the morning and evening report records her general condition

was fair. She was sent to the heart station for TEE, came back and had breakfast and at 10.45 a.m., she became unconscious. She was immediately given CPR and advanced cardiac life support at 11.a.m., and shifted to heart command unit at 11.30 a.m.

56. Complainant no.1has failed to give any evidence to support his contention that she was brought to Escorts in an emergency and not for planned CABG and that she had suffered a heart attack on the night of 10 th August for which she was not given emergency aggressive treatment. He has not also placed on record the treatment given to her from 14.03.2001 when she was advised an early CABG and was prescribed medication only for a month. He has not brought on record whether as advised any Cardiac Surgeon was consulted prior to 09.08.2001 when she was brought to OPD of Escorts for follow up for CABG which was advised as long back as March 2001. He has not placed on record any prescriptions tests reports, treatment record for the long period of 5-6 months from 14.03.2001 to 09.08.2001.

57. On the other hand he has projected in his complaint that she was a healthy person with a healthy heart running an independent business of keeping for sale, transfer or test, arms and ammunition for which she had a valid Arms dealer license with a gross income of Rs.2,23,432/- per annum. He has failed to prove that she remained healthy from 14.03.2001 to 09.08.2001 on the medication given by Dr Lochan and that within the period of 2 ? days in the care of the opposite parties who are best in the field of heart diseases, her health suddenly deteriorated to such an extent that under the eyes of specialist and nurses, she suffered a heart attack which not detected or ignored by the said doctors and nurses leading to her death. He has failed to mention in his complaint that he had paid Rs. 2.00 lakh to the hospital. They refunded Rs.1,72,675/- vide cheque dated 13.08.2001 after deducting the balance for the tests conducted.

58. As per the medical literature, a careful clinical examination remains the cornerstone of the assessment of the patients with known or suspected cardiovascular disease despite the availability of many specialized investigations. It is undesirable to subject the patient to unnecessary risks and expenses inherent in many specialized tests when a diagnosis can be made on the basis of an adequate history and clinical examination, ECG and other routine laboratory tests. In this case the complainant has failed to give complete history and complete record of the period from 14.03.2001 to 09.08.2001. As per medical literature on record, TEE is normally performed for evaluation of acute persistent and life threatening hemodynamic disturbances.

59. It is an admitted fact that SmtHarbhajanKaur was diagnosed with Coronary Heart disease and she had triple vessel block and she was diagnosed with TVD. All the three major arteries were blocked to some extent and as per the findings of the AIIMS she was a patient of CAD for the last five years - since 1996. However, her LVEF functions were normal at 60%. She was reviewed by an angio surgeon and was advised immediate CABG. Dr Rajiv Lochan of Apollo Hospital

also had recommended early CABG and gave her some medicines for a month.

60. Coronary Thrombosis or acute myocardial infarction is the acute, ischaemic heart disease. The underlying cause is disease of the coronary arteries which carry the blood supply to the heart muscle or myocardium. This results in narrowing of the arteries until finally they are unable to transport sufficient blood for the myocardium to function efficiently. One of the three things may happen if the narrowing of the coronary arteries occurs gradually, then the individual concerned will develop either angina or signs of a failing heart, i.e., irregular rhythm, breathlessness, cyanosis and oedema. If the narrowing occurs suddenly or leads to complete blockage (occlusion) of a major branch of one of the coronary arteries, then the victim collapse with acute pain and distress. This condition commonly referred to as a coronary thrombosis because, it usually due to the affected artery suddenly becoming completely blocked by thrombosis. (quoted from page 322 of black medical dictionary)

61. The main cardinal symptoms of cardiovascular system are chest pain, SOB/ Dyspnea, palpitation and Fatigue. Admittedly, she was not suffering from any of those symptoms on admission. She died as per the death certificate due to Malignant Ventricular Arrhythmia - Cardio respiratory Arrest. (quoted from page 86 - of the medical literature)

62. Arrhythmias are abnormal rate or rhythm of the heartbeat. Sometimesa person may have an occasional irregular heartbeat, i.e., called Ectopic beat. Arrhythmias very often results in unpredictable heart block which causes black outs and heart failure. A common cause of arrhythmia is coronary artery disease, when vessels carrying blood to the heart are narrowed by fatty deposits, thus reducing the blood supply and damaging the heart tissue. This condition often causes myocardial infarction after which arrhythmias are quite common and may need correcting by defibriliation through electric shock to the heart.

63. In the present case, even though the patient SmtHarbhajanKaur was diagnosed with triple vessels disease and advised immediate/ early CABG by the specialists of AIIMS and Apollo Hospital for the reasons best known to SmtHarbhajanKaur and complainant no. 1. CABG was not carried out from March to August 2001, instead as per the complainant no. 1 on the advice of Dr Rajiv Lochan she kept on medication. It is noteworthy to mention here that the medication by Dr Rajiv Lochanwas only prescribed for one month. There is nothing on record to show that thereafter she was advised by any cardiac physician to continue with the prescribed medication indefinitely. It would appear during this period the triple vessel disease progressed to the extent that LVEF was reduced from 60% to 30% and caused distress to her heart.

64. Even in August, it is not the case of the complainant no. 1 that he brought his wife SmtHarbhajanKaur to Delhi by train for emergency treatment at Escorts, because she was suffering from symptoms of acute Myocardial infarction. As per the complainant SmtHarbhajanKaurwho had accompanied him on his visit to

Delhi was feeling uneasy so she was taken to OPD on 09.08.2001 where she was again advised planned CABG as a follow-up advice given in March 2001. In pursuance to that Smt H Kaur went to the Escorts on 10.08.2001 (time not specified) and got admitted in the evening. It is not the complainant''s case that it was a case of heart attack but she was being admitted for a planned CABG. Being an high risk patient, taking in account her age, stage of disease, the OPs conducted the requiredtests as per the established protocol to assess her status of heart and fitness undergo a CABG an open heart surgery. They have to check all the parameters to ensure that all precautions are taken during the CABG as warranted by her condition. An ECHO was conducted on 10.08.2001, it indicated loss of R wave which was indicative of previous myocardial infraction. There was some indication of VPCS and no indication of ST segment changes. She was then subjected to Color Doppler test on 11.08.2001. As ECHO Test was conducted on 11.08.2001 at 09.48 A M, the results of which havealready been given earlier. The results were related to Doppler measurement. Thereafter, SmtHarbhajanKaurwas put on 24 hour holter test on 11.08.2001 at around 03.50 pmupto 3.50 p m on 12.08.2001.

65. Impression of the 24 hours holter test revealed significant isolated APB and runs of atrial tachycardia. Isolated VPB/ No ventricular tachycardia and no significant ST shift as compared to baseline ECG. In the ECHO there was some mild myocardial infraction hence a TEE test was conducted on 13.08.2001 which was carried out uneventfully and the patient was comfortable throughout the procedure.

66. Transesophageal Echocardiogram (TEE) is a type of test in which the ultrasound transducer, positioned on an endoscope is guided down the patient''s throat into the esophagus (Food pipe). An endoscope is a long, thin, flexible instrument that is about ? inch in diameter. The TEE tests provides a close look at the heart''s values and chambers without interference from the ribs or lungs. TEE is often used when the results from standard echo tests are not sufficient, or when the doctor wants a closer look at the heart. The detail picture provided by TEE can help the doctors to see the size of the heart and thickness of the walls, heart pumping, any abnormal tissue around the heart values that could indicate bacterial, viral or fungal infections or cancer. If the blood is leaking backward through the heart valves (regurgitation) or if your valves are narrowed or blocked, if blood clots are in the chambers of heart in particular, the upper chamber after a stroke.

67. As per medical literature and the known risks, TEE can cause minor injury, primarily pharyngeal injury from probe insertion and esophageal perforation, gastric bleeding, or late mediastinitis. It cannot damage the heart as the probedoes not goes anywhere near the heart of the patient. The patient is given local sedation/ anaesthesia, and can always stop the procedure if he or she is uncomfortable. Hence, complainant has failed to establish his case that the TEE further damaged the heart and led to her death.

68. In view of the above, we are of the opinion that complainant no. 1 has failed to establish their case of medical negligence against the OPs. He had also failed to provide any evidence or expert opinion to support his allegation that she was healthy till 10.08.2001 when she suffered a heart attack in the hospital and died due to the negligence of the hospital doctors because of inadequate monitoring and becauseaggressive treatment was not provided. From the facts on record we find that from the time she came to the OPS she was under the continuous supervision and monitoring of specialists as also the doctors who visited her in the ward. All the tests were conducted by the specialists in the area, results were correlated for further cause of action. The general condition of SmtHarbhjanKaur was stable and she showed no symptoms of cardiac arrest till 13.08.2001 morning at 10.45 am, i.e., after she finished her breakfast. While we sympathise with the complainants for their great loss and their anguish in losing SmtHarbhajanKaur, we do notfind that she died due to the negligence or deficiency of service on the part of the OPs. There is no evidence to support such an allegation. She was a known case of CAD from 1996, diagnosed with TVD and advised immediate/ early CABG in March 2001. She was, however, only on medication till she arrived at OP 2, under the care of OP 1. Her LVEF which was normal (60%) in March 2001, was found to be only 35% on 10.08.2001. Her condition had certainly deteriorated from March 2001 to August 2001 because for reasons best known to the complainant no. 1 and the patient. She did not go in for the recommended CABG which is only advised in severe cases of CAD but continued on medication. On 09.08.2001 she was again advised planned CABG. She was admitted on the evening of 10.08.2001. From the available record we have no evidence of negligence of deficiency of service on the part of OPs 1 & 2 during the period 10.08.2001 from 06.40 pm to 13.08.2001 by which they could be held responsible for the tragic demise.

69. The Hon''ble Supreme Court in the case of Jacob Mathew (Dr) vs State of Punjab and Anr . - III (2005) CPJ 9 (SC) has held that: 19. In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution. He does not assure his client of the result. A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that

branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices. In Michael Hyde and Associates v. J.D. Williams & Co. Ltd., [2001] P.N.L.R. 233, CA, Sedley L.J. said that where a profession embraces a range of views as to what is an acceptable standard of conduct, the competence of the defendant is to be judged by the lowest standard that would be regarded as acceptable. (Charlesworth& Percy, ibid, Para 8.03)

22. The degree of skill and care required by a medical practitioner is so stated in Halsbury''s Laws of England (Fourth Edition, Vol.30, Para 35):-

"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he 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, even though a body of adverse opinion also existed among medical men. Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care."

Above said three tests have also been stated as determinative of negligence in professional practice by Charlesworth& Percy in their celebrated work on Negligence (ibid, para 8.110)

29. A medical practitioner faced with an emergency ordinarily tries his best to redeem the patient out of his suffering. He does not gain anything by acting with negligence or by omitting to do an act. Obviously, therefore, it will be for the complainant to clearly make out a case of negligence before a medical practitioner is charged with or proceeded against criminally. A surgeon with shaky hands under fear of legal action cannot perform a successful operation and a quivering physician cannot administer the end-dose of medicine to his patient.

30. If the hands be trembling with the dangling fear of facing a criminal prosecution in the event of failure for whatever reason whether attributable to himself or not, neither a surgeon can successfully wield his life-saving scalper to perform an essential surgery, nor can a physician successfully administer the life-saving dose of medicine. Discretion being better part of valour, a medical professional would feel better advised to leave a terminal patient to his own fate in the case of emergency where the chance of success may be 10% (or so), rather than taking the risk of making a last ditch effort towards saving the subject and facing a criminal prosecution if his effort fails. Such timidity forced upon a doctor would be a disservice to the society.

32. The subject of negligence in the context of medical profession necessarily calls for treatment with a difference. Several relevant considerations in this regard are found mentioned by Alan Merry and Alexander McCall Smith in their work "Errors, Medicine and the Law" (Cambridge University Press, 2001). There is a marked tendency to look for a human actor to blame for an untoward event with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. To draw a distinction between the blameworthy and the blameless, the notion of mensrea has to be elaborately understood. An empirical study would reveal that the background to a mishap is frequently far more complex than may generally be assumed. It can be demonstrated that actual blame for the outcome has to be attributed with great caution. For a medical accident or failure, the responsibility may lie with the medical practitioner and equally it may not. The inadequacies of the system, the specific circumstances of the case, the nature of human psychology itself and sheer chance may have combined to produce a result in which the doctor''s contribution is either relatively or completely blameless. Human body and its working is nothing less than a highly complex machine. Coupled with the complexities of medical science, the scope for misimpressions, misgivings and misplaced allegations against the operator i.e. the doctor, cannot be ruled out. One may have notions of best or ideal practice which are different from the reality of how medical practice is carried on or how in real life the doctor functions. The factors of pressing need and limited resources cannot be ruled out from consideration. Dealing with a case of medical negligence needs a deeper understanding of the practical side of medicine.

49 (1) We sum up our conclusions as under:-

(1) Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence as given in Law of Torts, Ratanlal&Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: ''duty'', ''breach'' and ''resulting

damage''.

51. As we have noticed hereinabove that the cases of doctors (surgeons and physicians) being subjected to criminal prosecution are on an increase. Sometimes such prosecutions are filed by private complainants and sometimes by police on an FIR being lodged and cognizance taken. The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to rash or negligent act within the domain of criminal law under Section 304-A of IPC. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment. He has to seek bail to escape arrest, which may or may not be granted to him. At the end he may be exonerated by acquittal or discharge but the loss which he has suffered in his reputation cannot be compensated by any standards.

52 We may not be understood as holding that doctors can never be prosecuted for an offence of which rashness or negligence is an essential ingredient. All that we are doing is to emphasize the need for care and caution in the interest of society; for, the service which the medical profession renders to human beings is probably the noblest of all, and hence there is a need for protecting doctors from frivolous or unjust prosecutions. Many a complainant prefers recourse to criminal process as a tool for pressurizing the medical complainant prefers recourse to criminal process as a tool for pressurizing the medical professional for extracting uncalled for or unjust compensation. Such malicious proceedings have to be guarded against.

53. Statutory Rules or Executive Instructions incorporating certain guidelines need to be framed and issued by the Government of India and/or the State Governments in consultation with the Medical Council of India. So long as it is not done, we propose to lay down certain guidelines for the future which should govern the prosecution of doctors for offences of which criminal rashness or criminal negligence is an ingredient. A private complaint may not be entertained unless the complainant has produced prima facie evidence before the Court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying Bolam''s test to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld.

In the case of Kusum Sharma &OrsvsBatra Hospital and Medical Research Centre and Others - 2012 (2) R C R (Civil) 161, the Hon''ble Supreme Court while deciding whether the medical professional is guilty of medical negligence held that following well known principles must be kept in view:

I. Negligence is the breach of a duty exercised by omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

III. The medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

IV. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

V. In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.

VI. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

VII. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.

VIII. It would not be conducive to the efficiency of the medical profession if no Doctor could administer medicine without a halter round his neck.

IX. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessary harassed or humiliated so that they can perform their professional duties without fear and apprehension.

X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurizing the medical professionals/hospitals particularly private hospitals or clinics for extracting

uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.

70. The citations given above are fully applicable to the case on hand. Since the complainant has failed to prove their case that Smt Harbhajan Kaur died due to the negligence and deficiency of service by the OPs, the complaint is dismissed

