Date of pronouncement:-07.09.2026

IN THE NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION NEW DELHI

FIRST APPEAL NO. 216 OF 2020

(Against the Order dated 20.12.2019 in CC No.58 of 2014 of the Andhra Pradesh State Consumer Disputes Redressal Commission, Vijayawada)

WITH

IA/1877/2020 (STAY)

1. Guntur City Hospital
   Mukku Pichi Reddy Towers,
   Old Club Road, Kothapet,
   Guntur-522001

2. Dr. M. Nagendra Prasad, MD (Gen),
   Guntur City Hospital
   Mukku Pichi Reddy Towers,
   Old Club Road, Kothapet,
   Guntur-522001

3. Dr. Srikanth,
   Consultant Cardiologist,
   Guntur City Hospital
   Mukku Pichi Reddy Towers,
   Old Club Road, Kothapet,
   Guntur-522001 ..... Appellants

Versus

1. Mrs. Shubhada Dhawde,
   W/o Late Dhananjaya Shankar Dhawde,
   Advocate,
   R/o B-5, Medhavi, Cross Road No.2,
   Swami Samardh Nagar, Lokhandwala Complex,
   Andheri West, Mumbai-400053

2. Ms. Sakshi Dhawde,
   D/o Late Dhananjaya Shankar Dhawde,
   R/o B-5, Medhavi, Cross Road No.2,
   Swami Samardh Nagar, Lokhandwala Complex,
   Andheri West, Mumbai-400053 .....Respondents

BEFORE:
HON'BLE MS. JUSTICE SAROJ YADAV, PRESIDING MEMBER
HON'BLE MR. JUSTICE ANOOP KUMAR MENDIRATTA, MEMBER

Appearance at the time of arguments:-
For the Appellants : Ms. Kanika Agnihotri, Sr. Advocate,
Ms. Subhashini Arani, Advocate,
Dr. Srikanth, OP-3 in person,
Ms. Shivani Patil, Advocate.
For the Respondents : Dr. Divakar Babu, Professor (VC).

JUSTICE ANOOP KUMAR MENDIRATTA, MEMBER

ORDER

1. A complaint was preferred on behalf of respondents herein i.e. complainants before Andhra Pradesh State Consumer Disputes Redressal Commission, Vijaywada **(hereinafter referred to as "State Commission")**, alleging negligence in treatment of deceased Dhananjay Shankar Dhawde by the OPs. Complainants further claimed compensation for Rs.50,00,000/- with litigation cost, which was allowed by learned State Commission *vide* impugned Order dated 20.12.2019 as under:-

> *"51) It is summarized that the complainants are entitled to the following amounts under different heads:*
>
> | | | |
> |---|---|---|
> | *I.* | *Loss of contribution and dependency* | *: Rs.37,25,953-00* |
> | *II.* | *Loss of Consortium to the 1st complainant* | *: Rs. 25,000-00* |
> | *III.* | *Towards mental agony* | *: Rs. 75,000-00* |
> | | | *Rs.38,25,953-00* |

Thus, a total amount under the different heads comes to Rs.38,25,953/- and the opposite parties 1 to 3 are jointly and severally liable to pay the said amount with interest @ 9% per annum from the date of complaint, i.e., 03.03.2014.

52) In the result, the complaint is allowed in part directing the opposite parties 1 to 3 jointly and severally to pay a sum of Rs.38,25,953/- (Rupees thirty eight lakhs twenty five thousand nine hundred and fifty three only) with interest @ 9% per annum from the date of complaint; i.e., 03.03.2014 till the date of realization to the complainants. The complainants are entitled for Rs.25,000/- towards litigation expenses. The opposite parties are directed to pay the said amounts within eight weeks from the date of receipt of the copy of the order."

Appellants and respondents are hereinafter referred to as OP-1 to 3 and complainants respectively, as appearing in the complaint, for sake of convenience.

2. Aggrieved against the Order passed by the learned State Commission, OPs have preferred present FA No.216 of 2020 *i.e.* Guntur City Hospitals (OP-1); Dr. M. Nagendra Prasad, MD (OP-2) and Dr. Srikanth, Consultant Cardiologist (OP-3).

3. In brief, Dhananjaya Shankar Dhawde (deceased), aged about 54 years was admitted at OP-1 hospital on 24.04.2012 about 10:00 PM with complaint of difficulty in breathing, dyspepsia and constipation. Patient was attended to by the Duty Doctor and was admitted in ICU for treatment and observation. Dhananjay Shankar Dhawde was also seen

by Dr. M. Nagendra Prasad, MD (General Physician/OP-2) and referred for examination by a Cardiologist for ascertaining any heart related issues. Thereupon, patient was examined by Dr. Srikanth (OP-3), a visiting Cardiologist and Assistant Professor in Government General Hospital, Guntur on 25.04.2012 at OP-1 hospital.

4. As per the complainants, Dr. Srikanth, Cardiologist (OP-3) clinically examined the patient and advised to undergo Echocardiography, upon which ECG and Ultrasound were undertaken. It is further the case of the complainants that OP-3 opined that heart of the patient was functioning normally without any abnormality. Further, the patient was shifted to a room in a couple of hours from ICU. Later, the patient was discharged from the hospital on 26.04.2012 after prescribing certain antacids. In the discharge summary, patient had been diagnosed to be suffering from GERD (Gastroesophageal Reflux Disease) with URTI (Upper Respiratory Tract Infection). It is the specific case of the complainants that Dhananjaya Shankar Dhawde never exhibited GERD and was wrongly diagnosed. Also, the signs and symptoms indicated in ECG were ignored by OPs.

5. Thereafter, on 27.04.2012, Dhananjaya Shankar Dhawde resumed his duties in the Bank wherein he was working as Chief Manager. However, on 28.04.2012 after reaching the Bank, he experienced

sweating, restlessness and breathlessness and visited the clinic of OP-2, wherein he was attended to by a junior doctor as OP-2 was attending the second death anniversary of his mother.

6. Complainants allege that patient was not properly treated and evaluated despite being informed that they planned to travel to Pithapuram for darshans at temple. Complainants, thereafter, reached Rajahmundry on 28.04.2012 but next morning about 10:00 am, Dhananjaya Shankar Dhawde expired after developing severe breathlessness, giddiness and profuse sweating in the hotel. The grievance of the complainants is that OPs failed in exercising reasonable degree of professional care and diligence which resulted in the death of Dhananjaya Shankar Dhawde and amounted to deficiency in service.

7. Complaint was accordingly preferred by the complainants against OPs alleging negligence before the learned State Commission.

8. In order to appreciate the stand of the complainants, the case set up on behalf of OPs in the written version filed on record may be noticed.

OP-1 submitted that as soon as the patient reported in OP-1 hospital, he was promptly attended to by the Duty Doctor. Also, OP-2 Dr. M. Nagendra Prasad, MD was requested to see the patient. After going through the history of the patient, vitals recorded in the case-sheet

and investigations done, OP-2 suspected that patient may have some cardiac issue and, as such, referred for opinion by a Cardiologist. Thereafter, Dr. Srikanthh, DM (Consultant Cardiologist) working as Assistant Professor in Government General Hospital, Guntur was requested to examine the patient, who opined that patient may have some lungs related problem and prescribed the investigations by way of X-Ray Chest PA view and CT Scan chest. However, without undergoing the investigations recommended by OP-3, the patient got discharged from OP-1 hospital on 26.04.2012 and later on did not visit the hospital. Any negligence on the part of the OPs was denied.

9. OP-2 (Dr. M. Nagendra Prasad) took stand on similar lines and stated that on account of failure on the part of patient to undergo investigations prescribed by OP-3 (Consultant Cardiologist) and further failure to subsequently get himself examined after the reports, the final conclusion regarding the nature of ailments could not have been ascertained and given. As such, no negligence could be attributed to OPs as there was no omission on the part of OP-1 to 3 in treating the patient and evaluating as case of GERD with URTI, based upon the symptoms evaluated in the hospital. The allegations relating to informing the junior doctor with reference to travel plans to Rajahmundry were denied.

10. OP-3 took a specific stand that on 25.04.2012, he had examined the patient and advised 2D Echo, X-Ray Chest PA view and CT Scan chest, having suspected some lung related problem which may have been affecting the heart. The patient, thereafter, failed to undergo the CT Scan and in view of good response to the treatment given, the patient wanted to get discharged. Further, OP-3 was of the *prima-facie* opinion that patient was not suffering from ischaemic heart disease since he was non-hypersensitive, non-diabetic and non-smoker. The patient was in a stable condition at the time of discharge on 26.04.2012 and even attended to his duties in the Bank on 27.04.2012 without any episode. The patient is further stated to have requested for discharge in order to get the reimbursement as he was working as Chief Manager with the Union Bank of India. It was pointed out that the death of deceased on account of cardiac arrest cannot be confirmed as no *post-morterm* was conducted.

11. <u>Findings by learned State Commission in brief</u>

Learned State Commission referred to the principle laid down by the Hon'ble Apex Court in ***Dr. S.K. Jhunjhunwala v. Dhanwanti Kumar and Another,*** **AIR 2018 SC 4625** that a medical practitioner cannot be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one

reasonable course of treatment in preference to another and, thereafter, posed for consideration, whether the tests conducted were analysed and deceased was correctly evaluated by OPs.

Learned State Commission observed that Ex.A3, A4 and A6 disclosed that WPC Liver Function Test, Blood Urea, Serum Creatinine, Electrolytes, HIV, HVSAG, HCV tests had been advised to the patient and to aforesaid extent OP-1 & 2 correctly followed the protocol in conducting the relevant tests. However, the defence raised on behalf of the OPs was discredited, on the ground that the patient had not been advised CT Scan by Dr. Srikanth (OP-3) as relied by the OPs and the said document was subsequently introduced in evidence, since the progress sheet pertaining to examination by Dr. Srikanth (OP-3) was not filed along with the written version by OPs. The authenticity of the document was also doubted on the ground that it did not contain the name of the patient as well as the date and time of examination. Reference was made to deposition of RW-1, who was examined on behalf of OP-1 hospital, and stated that Duty Doctor had prescribed X-Ray chest PA view along with other tests. Learned State Commission inferred that since the tests had been prescribed on 24.04.2012 by Duty Doctor, the question of prescribing the same again by OP-3 did not arise.

12. Learned State Commission further placing reliance on Ex.A-4 (i.e. ECG report) observed that sinus tachycardia as observed therein accompanying 'myocardial infarction' may be indicative of cardiogenic shock. It was noticed that since ECG report referred to 'left axis deviation' and the borderline T abnormality of ECG should have been given special attention by OP-3. Learned State Commission in support of its findings further observed that dilated cardiomyopathy (DCM) leads to shortness of breath and fatigue and referred to final impression/findings in Ex.A-7 (echocardiography report dated 25.04.2012) as under:-

1. *LV (left ventricle) dilated (enlarged)*
2. *TR mild (mild tricuspid regurgitation)*
3. *RV free wall hypokinesis indicating pulmonary hypertension i.e. increased blood pressure in lungs system*

13. For purpose of concluding that OP-2 & 3 had been negligent in assessing the condition of deceased Dhananjay Shankar Dhawde, learned State Commission also did not accept the expert opinion given by Dr. Y.V. Subba Reddy, Head of Department (Cardiology), Osmania General Hospital, Hyderabad, which was obtained by learned State Commission at the request of OPs. Learned State Commission held that the expert witness was made to state his final observation based on

Ex.B-1 to the effect that “if other investigations were done, the same might have helped the final diagnosis and better treatment of the patient”. It may be reiterated that Ex.B-1 is the progress sheet containing prescription by OP-3 whereby deceased was advised 2D Echo, X-Ray Chest PA View and CT Chest, to rule out ILD, COPD and has been discredited by the learned State Commission on account of being subsequently introduced by the OPs in evidence.

14. <u>Contentions on behalf of the Appellants/OPs</u>

Learned counsel for the appellants having referred to the factual position, vehemently contends that learned State Commission proceeded only on assumptions that the unfortunate death of the deceased was on account of incorrect diagnosis and treatment provided to the deceased. She urges that the cause of death as heart attack is only presumptive, based upon the information given on behalf of the complainants at the time of cremation, without the same being corroborated by medical opinion. Learned counsel further submits that neither any FIR was registered after the death of deceased, nor the deceased could be provided with any medical aid. As such, the possibility of death for any other reason cannot be ruled out. She argues that on the basis of history revealed on examination of the patient on 24.04.2012 and symptoms exhibited, the case was treated for

GERD with URTI and the medications were accordingly prescribed. Further, the patient was referred for examination and opinion by a Cardiologist to rule out any cardiac issue. The patient was accordingly examined by Dr. Srikanth, Cardiologist (OP-3), who after examining the ECG, advised for 2D Echo, CT Scan Chest and X-Ray Chest PA view to rule out COPD/ILD. She submits that the observations of learned State Commission discarding the prescription by OP-3 (Dr. Srikanth) as per progress sheet on 25.04.2012, is misplaced as a categorical stand had been taken in the written version regarding examination and advice tendered by Dr. Srikanth.

Learned counsel further vehemently contends that the patient had been independently examined by OP-3 after being referred by OP-2 and as such was bound to record the necessary tests which according to him were required to be undertaken by the patient. She emphasizes that the parameters of the patient were stable at the time of discharge on 26.04.2012 and, thereafter, patient had attended his duties on 27.04.2012 without any episode. She explains that OP-2 Dr. M. Nagendra Prasad did not examine the patient on 28.04.2012 on account of death ceremony of his mother and no adverse inference can be drawn against the doctors since the patient had never been examined by them after discharge on 26.04.2012. The patient is thereafter stated to have

proceeded on his own to Rajahmundry, wherein he unfortunately expired on 29.04.2012.

Learned counsel also argues that the opinion of the expert, which had been obtained by the learned State Commission has been wrongly discarded. She points out that though the patient had not suffered 'myocardial infarction', the same has been referred to support the findings by the learned State Commission. She submits that professional doctors might be held for negligence, if they do not possess the requisite skills that they claim to have. However, no doctor can predict the ailments, which may not be clinically co-related or foreseeable. She claims that OPs performed their duties to the best of their ability with due care and caution in accordance with medical standards. In support of the contentions, reliance is further placed upon ***Mark Stevan Christianson & Anr. v. M/s Fortis Hospitals Ltd. & Ors., CC No.15 of 2014*** decided by this Commission on 23.07.2026; ***Mandar Jadhav v. Dr. Riya & Ors.,* CC No.109 of 2011** decided by this Commission on 15.02.2017; ***C.P. Sreekumar (Dr.), MS (Ortho) v. S. Ramanujam,* (2009) 7 SCC 130** and ***Neeraj Sud and Anr. v. Jaswinder Singh (Minor) and Anr., Civil Appeal No.5526 of 2012*** decided by Hon'ble Supreme Court of India on 25.10.2024.

15. <u>Contentions on behalf of Respondents/Complainants</u>

On the other hand, learned counsel for the complainants/respondents supports the findings of the learned State Commission and submits that OPs indulged in suppression and misrepresentation of pivotal facts. Reference is made by him to the ECG and Echocardiography reports and submits that OP-2 & 3 negligently overlooked the symptoms and failed to correctly diagnose the ailment suffered by the deceased. He further relies upon the cross-examination of the witnesses, which has been also referred to by the learned State Commission in support of the findings. The OPs are stated to have adopted a callous, casual and lackadaisical attitude with utter lack of requisite competence, skill and diligence warranted of a concerned speciality in the field. He submits that diagnosis of GERD with URTI was not correctly diagnosed by OPs and ECG/2D Echo report clearly reflected that deceased suffered from a heart ailment but was not treated for the same.

He further contends that CT Scan was never prescribed by OP-3 and the said document had been subsequently introduced. He points out that even the name of patient is not reflected on the said progress sheet whereby OP-3 claims to have examined and suggested tests by way of “2D Echo, CXR PA View and CT Chest to rule out ILD, COPD”. It

is also urged that OP-1 hospital ought to have carried the CT Scan since it claims to be a modern hospital with all essential paraphernalia. He accordingly prays for dismissing the appeal.

16. <u>Analysis</u>

We have given considered thought to the contentions raised and perused the record carefully.

17. The principle governing 'negligence' by a professional doctor has been settled in leading case of ***Bolam v. Friern Hospital Management Committee,*** **1957 (2) ALL ER 118 QBD** and it lays down that a man need not possess the highest expert skill; it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. The said principle of law is followed by the Indian Courts and has been extensively referred to in ***Jacob Mathew v. State of Punjab,*** **(2005) 6 SCC 1** and is a touchstone to test the plea of medical negligence.

Conclusions drawn by Hon'ble Apex Court in ***Jacob Mathew v. State of Punjab and Another*** (supra) in para 48 of the judgment may be beneficially reproduced :-

> *"48. We sum up our conclusions as under:*
>
> *(IX) 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".

(2) Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. ***A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional.*** *So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed.* ***When it comes to the failure of taking precautions, what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence.*** *So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.*

(3) A professional may be held liable for negligence on one of the 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 possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.

*(4) The test for determining medical negligence as laid down in Bolam case [(1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)] , WLR at p. 586 [[**Ed.**: Also at All ER p. 121 D-F and set out in para 19, p. 19 herein.]] holds good in its applicability in India.*

(5) The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

(6) The word "gross" has not been used in Section 304-A IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be "gross". The expression "rash or negligent act" as occurring in Section 304-A IPC has to be read as qualified by the word "grossly".

(7) To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do

something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent. (8) Res ipsa loquitur is only a rule of evidence and operates in the domain of civil law, specially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining per se the liability for negligence within the domain of criminal law. Res ipsa loquitur has, if at all, a limited application in trial on a charge of criminal negligence."

18. Thus, the proposition is authoritatively settled that a doctor is not negligent, if he is acting in accordance with acceptable norms of practice unless there is evidence of medical body of skilled persons in the concerned specialty opining that the accepted principles/procedures were not followed. Accordingly, medical professional can be held liable for negligence only if he fails to exercise reasonable skill which he possesses in giving the treatment or in case he does not possess the requisite qualification or skill.

The observations of the Hon'ble Apex Court in ***S. K. Jhunjhunwala v. Dhanwanti Kaur and Another,*** **(2019) 2 SCC 282** in para 22 and 23 may also be beneficially reproduced for reference:-

"22. *It was held in* ***Jacob Mathew case [Jacob Mathew v. State of Punjab, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369]*** *that 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 what the entire 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 not possess.

23. *It was further observed in Jacob Mathew case [Jacob Mathew v. State of Punjab, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369] that the fact that a defendant charged with negligence who acted in accord with the general and approved practice is enough to clear him of the charge. It was held that the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident and not at the date of trial. It was held that 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 possible for every professional to possess the highest level of expertise or skills in that branch which he practises. His Lordship quoted with approval the subtle observations of Lord Denning made in Hucks v. Cole [Hucks v. Cole, (1968) 118 New LJ 469], namely,*

> *"a medical practitioner was not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference of another. A medical practitioner would be held liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field".*

(emphasis supplied)"

19. Following ***Jacob Mathew v. State of Punjab*** (supra)**,** Hon'ble Apex Court in ***Kusum Sharma v. Batra Hospital,*** **(2010) 3 SCC 480** laid down the principles to be considered while determining the charge

of medical negligence, which stand reiterated in ***M.A. Biviji v. Sunita, (2024) 2 SCC 242*** as under:-

> *"89. … (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.*
>
> *(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 another 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.

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

20. Reverting back to the facts of the case, the findings by the learned State Commission need to be evaluated in the light of pleadings and evidence on record, to ascertain if OP-2 & 3 exhibited lack of such degree of standard of skill as any other ordinary competent practitioner exercising skill in the concerned speciality, on admission of Dhananjaya Shankar Dhawde prior to his death from 24.04.2012 to 26.04.2012.

21. We may notice that as per the discharge slip, all the vital parameters of the patient were stable and the final diagnosis was made of GERD with URTI i.e. *"gastro esophageal reflux disease with upper respiratory tract infection*". As per the course of treatment, deceased was admitted on 24.04.2012 with clinical features of difficulty in breathing, dyspepsia and constipation and was managed with fluids, nebulization and other supportive care.

22. It is pertinent to notice that after going through the case-sheet and report of ECG, OP-3 (Dr. Srikanth) advised 2D Echo with X-Ray Chest PA view and CT Scan Chest. At the time of examination on 25.04.2012, all other parameters of patient were found in normal range with pulse

rate at 80pm, BP-130/90 mmHg and no abnormality was detected with reference to CVS and lungs. The patient was also observed to be non-diabetic, non-smoker and non-alcoholic with no history of 'orthopnea' and PND. The patient had been referred to OP-3 for evaluation of SOB mild as reflected in the prescription. In the aforesaid background, the prescription to undertake X-Ray Chest PA view along with CT Scan Chest to rule out ILD, COPD appears to be correct course of action to ascertain the exact ailment. Merely on the basis of Echocardiography report dated 25.04.2012, it would have been pre-emptory to finally diagnose that patient had cardiac episode, when all other parameters were in normal range.

23. At this stage, it may also be appropriate to refer to the expert opinion given by Dr. Y.V. Subba Reddy, Professor & HOD, Department of Cardiology, Osmania General Hospital, Hyderabad based upon Ex.A1 to A12 and Ex.B1 forwarded to him along with records with reference to treatment provided to deceased at OP-1 hospital after admission on 24.04.2012.

> ***"Opinion of Dr. Y.V.Subba Reddy Proff. & H.O.D. Department of Cardiology, Osmania General Hospital, Hyderabad.***
>
> *I am giving my opinion based on the records given to me by the court, such as complaint copy Exhibits A1 TO A12 and Exhibit B1.*
>
> *Patient by name D.S.Dhawade male 54 years was admitted on 24-04-2012 at 10.P.M. and discharged on 26-04-2012, time of*

discharge not mentioned. The chief complaints of the patient were difficulty in breathing, dyspepsia, constipation. They have made provisional diagnosis as GERD respiratory infections and they have administered the treatment for the above complaint. They have conducted blood investigation like WBC, Platelet count, serum N.A., serum K and floride and they have the patient in ICCU and they have given nebulization, the vital parameters are within normal limits, like pulse rate, B.P. temperature, SPO2 were within normal limits. Later he was examined by General Physician, he suspected that patient may be having some cardiac problem, hence he called cardiologist to see the patient and give his opinion. Then consultant cardiologist of the hospital Srikanthh examined the patient and found that patient is having mild breathlessness, B.P. and pulse were within normal limits. Then he conducted 2D Echocardiography and found the impression dialated R.A. (Right Artrium) Right ertical mild Tricuspide regurgititation, R.V. free wall Hypokinesia, good L.V. function. After this examination he advised Xray chest, P.A. View, C.T. Scan chest for further opinion and also was advised to undergo ultra sound abdomen and other investigations done in the hospital. E.C.G. revealed synustachycardio, non specific S.T.T. changes and patient did not give history of diabetes, hypertension and smoking. The patient was discharged on 26-04-2012 and the top of page 25-04-2012 mentioned on Exh. A1 discharge summery. During the hospital stay, patient vital parameters within normal limits. The advise of the cardiologist to undergo the further investigations not done, which might have helped the final diagnosis and better treatment of the patient.

In my opinion the doctor who attended the patient admitted to the hospital and they took the expert opinion of physician and cardiologist and patient was discharged without evaluation. His vital parameters were within normal limits, such as B.P. pulse temp. SPO2 and the cardiologist was never called again to review the investigations which he ordered to undergo by the patient. ***The***

hospital stay was very short, the consultants have taken reasonable care and exercised their knowledge for the diagnosis.

Clarifications sought by the counsel for the complainant Mr. Gowri Shankar Rao. In the final diagnosis column of Exh. A1 discharge summery nothing was mentioned about the condition of the heart of the patient. It was clarified that no medicine were prescribed for cardio problem. It is a known fact that all the patients of heart attack need not have chest pain.

Sd. *Sd/-*

Advocate Commissioner. *Expert Doctor*
(Dr. Y.V. Subba Reddy)"

The opinion categorically notices that the patient was advised by OP-3 to undergo X-Ray Chest PA View, CT Scan Chest after conducting the 2D Echocardiography for further opinion. Further, patient was also advised to undergo Ultrasound Abdomen apart from other investigations done in the hospital. The patient admittedly did not give any history of diabetes, hypertension and smoking and his vital parameters were within normal limits during hospital stay. He further observed that the advice of the Cardiologist to undergo further investigations might have helped the final diagnosis and better treatment of the patient. It is pertinent to note that the Cardiologist was never called again to review the investigation which the patient was advised to undergo and the Consultants had taken reasonable care and exercised their knowledge for the diagnosis.

24. We are of the considered opinion that expert opinion by Dr. Y.V. Subba Reddy, Professor & HOD, Department of Cardiology, in absence of any evidence to contrary, categorically establishes that the course of evaluation adopted by OP-3 for purpose of further diagnosis and treatment, taking into consideration the clinical symptoms, was possibly a correct course of action. It may further be noticed that the patient was having all vital parameters in normal limits at the time of his discharge on 26.04.2012 and had even attended to his duties without any episode on 27.04.2012. There does not appear to be any reason to discredit the aforesaid opinion of expert, which reflects that the treatment advised by OP-3 was a correct course of action which a prudent and reasonable practitioner in the concerned speciality would have adopted. A simple lack of care or an error of judgment to foresee a subsequent complication which was not clinically co-related, is not a proof of negligence on the part of the medical professional. Shri Dhananjaya Shankar Dhawde admittedly expired on 29.04.2012 and OP-2 & 3 did not have any opportunity to review the patient after discharge on 26.04.2012. It is well settled that negligence is a 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 something which a prudent and reasonable man would not

do. The diagnosis and treatment provided by OP-2 & 3 in the OP-1 hospital in the facts and circumstances, does not establish any negligence on their part.

25. We may further observe that the aforesaid expert opinion given by Dr. Y.V. Subba Reddy has not been accepted by the learned State Commission on the ground that the document containing prescription of OP-3 (Dr. Srikanth) opining various tests had been subsequently introduced/fabricated by OPs. The inference drawn by the learned State Commission regarding subsequent introduction of said prescription/progress sheet with reference to 25.04.2012 is on the ground that the tests ought not have been re-prescribed by OP-3 as the same were prescribed earlier by the doctor on duty and for aforesaid purpose reference is made to cross-examination of RW-1 Dr. Chinta Rama Krishna, DM (Nephrology), an Authorised Signatory on behalf of the hospital.

26. It may be observed that RW-1 was examined on behalf of OP-1 hospital and had not personally examined the patient. He merely deposed on the basis of hospital records. During cross-examination, he responded that the Duty Doctor in ICU prescribed various investigations i.e. blood group as well as X-Rays and also prescribed X-Ray Chest PA View, ECG and Serum Electrolytes. We may notice that the documents

whereby the tests had been prescribed by the Duty Doctor have not been brought to our notice. Even otherwise, it does not appear to reason that the specialist (OP-3) who independently examined the patient is precluded from prescribing the tests, merely because the Duty Doctor on admission may have prescribed the same. Any specialist in the field independently examines and assesses the patient and prescribes the tests, deemed appropriate. He is not bound to follow any prescription by a Duty Doctor or another specialist. No adverse finding could have been given against OP-3 for prescribing the aforesaid tests as drawn by the learned State Commission.

We may further observe that CT Scan was admittedly not undertaken by the deceased prior to his discharge from OP-1 hospital as the said facility is not available therein, as revealed in the evidence of RW-1 Dr. Chinta Rama Krishna. The deceased, after discharge on 26.04.202 never visited OP-1 hospital again after suffering breathlessness on 28.04.2012 but had visited the Clinic of OP-2, wherein he was unavailable in person. We are of the considered view that merely because the CT Scan facility is not available in a hospital, it cannot amount to negligence in imparting necessary treatment and care on the part of OP-1. The outsourcing of CT Scan facility by several

Nursing Homes and Hospitals is an admitted fact depending upon the available space and finances of the Hospital.

27. The fabrication of prescription by OP-3 advising the tests has been consistently denied by RW-1, RW-2 as well as RW-3. A stand was categorically taken regarding prescribing of tests by OP-3 in para 79 of the written version filed on record on behalf of OP-2 (Dr. M. Nagendra Prasad) as well as in para 10 of the written version filed on behalf of OP-3. The existence of the document cannot be disbelieved merely because the same had been filed along with the evidence and not along with the written version. It cannot be ignored that OP-3 was merely a visiting Consultant and made his notes/prescription provided in the progress sheet of the patient in the hospital. As the progress sheet happens to be in continuation, merely because the name, date and time is not reflected, does not *per se* make the document fabricated at later stage. Normally, the maintenance of record is by the Administrative/Nursing staff and the visiting consultants generally prescribe the course of treatment further needed by the patient on progress sheet while visiting the indoor patient as a Consultant. In view of above, the findings arrived at by the learned State Commission holding that the said prescription had been subsequently introduced by OPs, does not appeal to reason.

28. We may further observe that since the condition of the patient was stable on the date of discharge on 26.04.2012 with all parameters within normal limits and CT Scan was yet to be conducted, OP-2 & 3 did not finally diagnose the patient for further treatment of heart ailment. Thereafter, the patient was never personally examined by OP-2 & 3 prior to his death on 29.04.2012. Any specialist or doctor may not be in a position to predict and forecast any fatal episode or complication at a later point of time after discharge of a patient in a stable condition from the hospital. It may be emphasized that the cause of death has not been brought on record as the patient was never taken to a hospital on developing complications prior to his death on 29.04.2012 at Rajahmundry.

In the facts and circumstances, it cannot be said that OP-2 & 3 were remiss in diagnosing or discharging the deceased on 26.04.2012. The doctors provided the treatment and evaluated the patient as per acceptable medical standards and cannot be held liable for negligence merely because a further observational stay at the hospital could have provided a better insight into the prognosis of case. It cannot be ignored that onus of proving medical negligence lies on the complainant and mere averment in the complaint is not proof of negligence. The

obligation is on the complainant to provide the *facta probanda* as well as *facta probantia.*

29. Further, it is pertinent to notice that except for the 'cremation receipt' reflecting cause of death as "heart attack", there is no other medical document on record to ascertain the exact cause of death of deceased. The same is only based upon information furnished at the cremation ground by the family members. Admittedly, neither any complaint was lodged with the police, nor any *post-mortem* was conducted to ascertain the exact cause of death of deceased. Presuming that cause of death is related to the earlier symptoms, which were exhibited on admission in the hospital on 24.04.2012, as inferred by the learned State Commission may be preposterous.

30. For aforesaid reasons, we are unable to conclude that conduct of OP-2 & 3 was palpably erroneous or unacceptable to term it as a case of professional negligence. In our considered opinion, learned State Commission erred in holding the OPs negligent in the facts and circumstances of the case, on the premise that the treatment or diagnosis of the condition of deceased by OPs fell below that of the standard of a reasonably competent practitioner in the field. The Order passed by the learned State Commission is accordingly set aside. Appeal is allowed. Pending applications, if any, stand disposed of. No

order as to costs. Amount, if any deposited, by the appellants be released to them after a period of thirty days of passing of this Order.

A copy of this Order be forwarded to the learned State Commission as well as the concerned parties by the Registry, for information.

Sd/

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(SAROJ YADAV, J)
PRESIDING MEMBER

Sd/

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(ANOOP KUMAR MENDIRATTA, J)
MEMBER

sd/B-5/reserved matter