Maharaja Agrasen Hospital . vs Master Rishabh Sharma . on 16 December, 2019

Equivalent citations: AIRONLINE 2019 SC 1757, (2020) 1 GUJ LH 220, (2020) 1 SCALE 221, (2020) 1 TAC 364

Author: Indu Malhotra

Bench: Indu Malhotra, Uday Umesh Lalit

REPORTABLE

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION
Civil Appeal No. 6619 Of 2016

MAHARAJA AGRASEN
HOSPITAL & ORS. …APPELLANTS

Versus

MASTER RISHABH SHARMA & ORS. …RESPONDENTS

WITH
Civil Appeal No. 9461 Of 2019
(Arising out of Diary No. 15393 of 2019)

POOJA SHARMA & ORS. …APPELLANTS

Versus

MAHARAJA AGRASEN
HOSPITAL & ORS. …RESPONDENTS

JUDGMENT

INDU MALHOTRA, J.

1. The present Civil Appeals arise out of a complaint of medical negligence made by Respondent Nos. 1 to 3 – the Complainants against the Appellant No.1 – Hospital and Appellant Nos. 2 to 4 – the Paediatricians and Ophthalmologist Doctors working with the Appellant No.1- Hospital, and Respondent No.4- the Gynaecologist, before the National Consumer Disputes Redressal Commission (hereinafter referred to as the "National Commission").

2. The National Commission vide Judgment and Order dated 10.05.2016 ("impugned Judgment") allowed the consumer complaint, and held the Appellant No.1 – Hospital, and Appellant Nos. 2 to 4 – Doctors guilty of medical negligence, since they failed to carry out the mandatory check up of

Retinopathy of Prematurity ("ROP") on Respondent No.1- Master Rishabh, who was a pre-term baby, which led to his total blindness. In so far as Respondent No.4- Dr. Rama Sharma, the Gynaecologist is concerned, who had delivered the baby, she was exonerated by the National Commission, and has not been pressed before this Court.

3. Aggrieved by the impugned Judgment passed by the National Commission, the Appellant No.1- Maharaja Agrasen Hospital, a super speciality hospital, Appellant No.2

-Dr. G.S. Kochhar and Appellant No.3- Dr. Naveen Jain, the Consultant Paediatricians working for the Appellant No.1 – Hospital, and Appellant No.4-Dr. S.N. Jha, the Senior Consultant Ophthalmologist working for the Appellant No.1- Hospital have filed Civil Appeal No. 6619 of 2016.

4. Respondent No.1-Master Rishab Sharma, is the child-

patient, who was Complainant No.1 before the National Commission, and was represented by his widowed mother Pooja Sharma – Respondent No.2/the Complainant No.2. Respondent No.3 is the elder brother of Respondent No.1.

The Complainants have filed Civil Appeal No. 9461 of 2019 (Diary No. 15393 of 2019) before this Court for further enhancement of the compensation awarded by the National Commission.

5. The background facts in which the present Civil Appeals have been filed are as under:-

> 5.1 Respondent No.2-Pooja Sharma – the Complainant No.2 was under the ante-natal care of Respondent No.4-Dr. Rama Sharma at Sharma Medical Centre since September 2005.
>
> 5.2 On 02.04.2005, at about 5.30 p.m., the Respondent No.2 had to undergo a caesarean section in view of the condition of Placenta Previa. The baby-Respondent No.1 was born pre-term at 32 weeks' gestation, with a weight of 1.49 kg at the time of birth.
>
> 5.3 On the same day, at about 8:30 p.m., Respondent No.4- Dr. Rama Sharma, the Gynaecologist referred the case for intensive care to Maharaja Agrasen Hospital-Appellant No.1.

At the time of admission, the general condition of the baby was poor, and was diagnosed as "32 weeks pre-term AGA with HMD". The baby was treated in the Neo-natal ICU of the Paediatrics Unit and was put on ventilatory support, and Surfactant injections were administered gradually.

5.4 The Respondent No.1-baby stayed in the Appellant No.1-Hospital for almost 4 weeks, and was discharged on 29.04.2005, which was 27 days after birth.

The Discharge Slip issued by the Appellant No.1- Hospital to the Complainants reads as follows:

" Maharaja Agrasen Hospital Punjabi Bagh, New Delhi-110026, Ph. 25106645 to 54 DISCHARGE SLIP Hospital No. 505404. Ward: NICU Deptt./Unit: Paed-III. Name: B/O. Pooja Sharma Age/Sex NB/M. Date of Admission: 02.04.2005 at 8.30 p.m. Date of Discharge: 29.04.2005 Diagnosis: PT (32) with HMD with Neonatal Hyperbil with B/L Pneumothorax Fungal Septicemia.

Condition at time of discharge: Satisfactory. Consultants: Dr. G.S.Kochar /Dr. N. Jain DOB: 02.04.2005.

Sex: Male.

Birth weight: 1.49 kg.

Weight at discharge: 1.56 kg.

Mode: Emergency LSCS for placenta previa.

FOLLOW UP ADVICE:

• Syp. Taxim O 1 ml BD x 5 d.

• Syp. Osteocalcium TDS.

• Drops Visyneral Z 0.3 ml OD.

• Drop Vitcofol 5 drops OD.

• Drop Evion 5 drops OD • To review in Pead. OPD on Wed / Sat 4 p.m. • Refer back to Rama Nursing Home (Sharma Medical Centre) _____ _____-sd-_____ Consultant Medical Officer " 5.5 There is no advice to the Complainants to have the ROP test carried out on the baby, who was born prematurely, in the Discharge Slip. Post discharge, the Respondent No.2-Complainant brought the baby for a follow up check-up on 04.05.2005 to the Paediatrics Unit of the General OPD of the Appellant No.1-

Hospital, when the baby was 4 weeks and 4 days old.

The baby was examined by the Consultant Paediatricians - Dr. G.S. Kochhar and Dr. Naveen Jain/ Appellants No. 2 and 3.

As per the medical records, the Respondent No.1- baby was found to be stable, and Respondent No.2- Complainant was advised to continue breast feeding along with supplements.

It is pertinent to note that there was no advice or recommendation for ROP check-up on this date in the Medical Records produced by the Appellant No.1 – Hospital.

5.6 On 13.07.2005, the Respondent No.2-Complainant brought the baby for a 2nd follow-up visit when he was over 3 months old to the Paediatrics Unit of the General OPD of the Appellant No.1-Hospital. The Respondent No.1-baby was examined by Dr. Manoj on behalf of Dr. G.S. Kochhar. Dr. Manoj advised the Complainants for the BERA scan/test to be conducted.

It is pertinent to note that there was no advice for ROP check-up given even on this visit.

5.7 Respondent No.2-Complainant submits that sometime in November 2005, she noticed abnormal visual responses in the Respondent No.1 – baby. The Complainant asked for the medical records of the baby to have his follow up treatment done.

The medical records were, however, not made available by Appellant No.1-Hospital.

5.8 On 23.11.2005, Respondent No.2 – Complainant took the baby to Nayantara Eye Clinic, Delhi where an ultrasound (B. Scan) was conducted. It was advised that eye-ointment and eye-drops be administered to the baby.

5.9 On 03.12.2005, the baby was taken by Respondent No.2- Complainant to Shroff Charity Eye Hospital, Delhi for further examination where the ultrasound (B. Scan) was conducted. The Shroff Charity Eye Hospital diagnosed that the baby had ROP Stage 5 in both eyes, which is a case of total retinal detachment. 5.10 Respondent No.2-Complainant approached Respondent No.4- Dr Rama Sharma, the Gynaecologist of Sharma Medical Centre to explain how the medical condition of Respondent No.1-baby had remained un- diagnosed. Dr. Rama Sharma shifted the blame to the Appellants.

5.11 On 07.12.2005, Respondent No.2-Complainant took the baby to the Appellant No.1-Hospital in the Private OPD Consultation. Dr. Sanjay Bhavan, Ophthalmologist examined Respondent No.1-baby. The case was referred to Dr. Lingam Gopal of Shankara Netralaya at Chennai for an urgent appointment. 5.12 On 07.01.2006, the Respondent No.1-baby was taken by his mother-Respondent No.2-Complainant to Dr. Rajendra Prasad Centre for Ophthalmic Sciences at AIIMS, New Delhi for OPD Consultation. After examination, it was confirmed that it was a case of ROP Stage 5.

5.13 On 24.02.2007, the Respondent No.2-Complainant was constrained to issue a legal notice to the Appellant No.1-Hospital to provide the entire in-patient medical records of the baby in compliance with Regulation 1.3.2 of the Indian Medical Council (Professional Conduct, Etiquettes and Ethics) Regulations, 2002 (“IMC Regulations”).

5.14 The Appellant Nos. 1 to 3 failed to provide the in- patient medical records to the Complainant despite the issuance of legal notice.

5.15 The Respondent No.2-Complainant then filed a complaint with the Delhi Medical Council for a direction to the Appellant No.1-Hospital to provide the complete in-patient medical records pertaining to the baby.

5.16 Eventually, the Appellant No.1-Hospital provided a copy of the medical records of the baby alongwith the Case Summary on 14.06.2007 after more than 2 years of discharge from the Appellant No.1-Hospital. 5.17 The Respondent No.2-Complainant contends that when she received these records, she was shocked to find that the medical records mentioned an alleged ROP check-up was conducted on 26.04.2005 by Appellant No.4-Dr. S.N. Jha. The Respondent No.2- Complainant contends that no ROP examination was conducted by Appellant No.4-Dr. S.N. Jha. 5.18 On 04.08.2007, the Respondent No.2-Complainant addressed a letter to the Medical Superintendent of Appellant No.1- Hospital. The relevant extract of the said letter is reproduced hereinbelow for ready reference:

> "Under the above enclosure we have received photocopies of some Medical Record (uncertified) along with a case summary dated 13- 06-2007.
>
> The said summary states that on 26-04-2007 ROP examination on our baby was conducted in the Ophthalmological unit of your hospital and review examination after two weeks was also advised.
>
> We are rather intrigued by this observation as it does not find mention anywhere in the Discharge Summary nor is there any follow up advise.
>
> Since both of us do not recollect any such examination conducted in our presence or review advise and the said medical record is also totally silent about it, kindly provide us with the entire record of the Ophthalmological unit, name of the Paediatric Ophthalmologist who had conducted the ROP examination and his written report dated 26-04-2006." [emphasis supplied] 5.19 Appellant No.1- Hospital replied to the letter on 24.08.2007, wherein it was stated that:
>
> "As per standard neonatal protocol, ophthalmological check-up was requested on 25-04-2005 to rule out ROP.
>
> The ophthalmological examination was done in the Nursery on 26- 04-2005 morning by Dr. S. N. Jha, Senior Consultant Ophthalmologist. The written report of the Ophthalmological unit is stated on page no.102 of the case record." [emphasis supplied] 5.20 On 19.11.2007, Respondent Nos. 1 to 3 filed a Consumer Complaint under Section 21 (a)(i) of the Consumer Protection Act, 1986 before the National Commission [Consumer Case No. 119 Of 2007] claiming compensation of Rs. 1,30,25,000/- alleging medical negligence and deficiency in service on the part of Appellant Nos. 1 to 4, and Respondent No.4-

the Gynaecologist, for compensation for the permanent physical disability, mental agony, and social stigma, deprivation of normal human life, companionship, torture and harassment etc. 5.21 The Delhi Medical Council vide order dated 14.12.2007 issued a warning to the Appellant No.1-Hospital for the delay in supplying the medical records of the Respondent No.1-baby to the Complainant. 5.22 The National Commission vide Order dated 29.02.2012 directed the Medical Board, AIIMS to give an expert opinion in the matter.

5.23 The Medical Board of AIIMS submitted its Report dated 11.05.2012 to the National Commission. The Report states that as per standard guidelines (National Neonatology Forum), new born babies who are born at 32 weeks' gestation or less, should have their eyes examined at 3-4 weeks of age and more frequent check-ups to be done thereafter. Appellant No.4- Dr. S.N. Jha examined the baby at 24 days of age in accordance with established protocol. If ROP screening does not reveal any ROP, then repeat examination should be performed after 2 weeks. The Report goes on to say that after discharge, the baby was brought twice to the General OPD of the Appellant No.1-Hospital. There is no record to show that the baby was brought after 2 weeks of discharge to the Paediatrics OPD clinic when subsequent progression could been assessed and treated on time.

6. The National Commission vide its Judgment and Order dated 10.05.2016 (bench comprising of Presiding Member J.M. Malik J. and Dr. S.M. Kantikar, a qualified doctor) held as under:

> 6.1 The National Commission was not convinced that the ROP screening was done by O.P. No.5/Appellant No.4 on Respondent No.1-baby. The progress sheet was devoid of any details about the ROP examination, the method and instruments used, drugs (midrates/tropicamide)/ anaesthesia used during ROP testing. The Ophthalmologist has not mentioned any details of the dilation of the pupils, and the findings by indirect ophthalmoscope, and the intra-ocular or extra retinal findings. The standard ROP screening protocol was not followed.

The Nurses' Daily Records from 25.04.2005 to 27.04.2005 does not show that any ROP examination was done by O.P. No. 5/Appellant No.

4. 6.2 The AIIMS Report did not comment about the details of the ROP screening and the follow-up findings. 6.3 The National Commission held that the sequence of events leading to ROP usually takes about 4 to 5 weeks, except in a small sub-set of premature infants who develop rush disease in 2 to 3 weeks. The routine screenings should begin at no later than 4 weeks after birth, and possibly even earlier for infants at higher risk (2 to 3 weeks). It is strongly recommended that one session of retinal screening be carried before Day 30 of the life of any premature baby. The examination should be done with the dilation of the pupil with Tropicamide 0.5% to 1% with Phenylapinephrine 2.5%.

6.4 The National Commission came to the conclusion that O.P. No.5/Appellant No.4 did not conduct the ROP screening on the baby. ROP screening is a team-work of the Paediatrician, Opthalmologist and the NICU nurse. There is no medical documentation of the ROP screening procedural details. The O.P. No. 5 should have performed the retinal examination with binocular indirect opthalmoscope on dilation of the pupil with scleral depression to ascertain avascular zone at

the periphery of the retina. The National Commission found that nothing was forthcoming from Page 102 of the medical records. It appears to be a bare visual examination done by O.P. No. 5 in haste to cover up the case.

The National Commission was of the considered view that neither the ROP screening was performed, nor was any advice for follow up of ROP given to the Respondent No.2-Complainant/mother. 6.5 The National Commission held that the Respondent No.1-Master Rishabh had been rendered blind for life, which could never really be compensated in monetary terms. The baby had lost his father during the pendency of proceedings in 2013. The Respondent No.2-Complainant had been pursuing the consumer complaint single-handedly for almost a decade.

6.6 The National Commission awarded an amount of Rs.

53,00,000/- to the Respondent No.1-baby by applying the average inflationary principle at a conservative rate of 1% p.a., keeping in mind the fluctuations over the next 59 years. The National Commission awarded an amount of Rs. 10,00,000/- to the Respondent No.2-Complainant/mother who would have to take care of the blind child throughout her life. A further amount of Rs. 1,00,000/- was awarded towards costs of litigation. The National Commission held O.P. Nos. 2 to 5/ Appellant Nos. 1 to 4 to be jointly and severally liable to pay the total amount of Rs. 64,00,000/- within 2 months of the Order. The entire amount would carry interest at the rate of 9% p.a. Out of the total compensation awarded, Rs.

50,00,000/- would be kept in a Fixed Deposit with a nationalised bank till Respondent No.1 attained the age of majority. The periodic interest on the deposit would be paid to the Respondent No.2- Complainant/ mother till the child attained the age of majority. The remaining amount of Rs.

14,00,000/- would be released to the Respondent No.2-Complainant.

7. Aggrieved by the impugned Judgment passed by the National Commission, C.A. No. 6619 of 2016 was filed by the Hospital and the Doctors before this Court. The Complainants have filed Civil Appeal No. 9461 of 2019 (Diary No. 15393 of 2019) before this Court for enhancement of compensation.

This Court vide interim Order dated 29.07.2016 ordered stay of the operation of the impugned Judgment, subject to the Appellant No.1-Hospital depositing 50% of the amount awarded by the National Commission in this Court within 6 weeks.

On 07.09.2016, the Appellant No.1-Hospital deposited an amount of Rs. 32,00,000/- in this Court. This Court vide Order dated 7.11.2016, directed the amount to be kept in a Fixed Deposit with UCO Bank, which was renewed from time to time. The fixed deposit is due to mature on 17.02.2020.

8. We have heard the learned Counsel for all the parties and perused the original Medical Records, pleadings and written submissions filed by the parties.

9. The learned counsel for the Appellants viz. the Hospital and Doctors inter alia submitted that:

> 9.1 Respondent No.1-baby was pre-term (32 weeks) with signs of HMD, and was admitted in Appellant No.1-

Hospital on 02.04.2005 in a critical condition with little chance of survival. The baby was admitted in the neo-natal ICU, and had to be immediately placed on ventilatory support for 10 days. As per standard protocol, regular investigations and Arterial Blood Gas (ABG) analysis were performed. Blood component therapy was given. The critical condition of the baby and possible neuro-development, visual and hearing sequel was informed to the parents. The baby was given utmost care and attention by the Doctors of the Appellant No.1-Hospital.

9.2 As per protocol, ophthalmological examination was advised on 25.04.2005 to rule out ROP, as recorded at Page 100 of the medical records. Appellant No.4-Dr. S.N. Jha, the Senior Ophthalmologist conducted the ROP test on 26.04.2005, who found no ROP in Respondent No.1-baby, as recorded by Appellant No.4 in his handwriting at page 102 of the medical records. It was submitted that the Appellant No.4 had advised a further review/check-up after 2 weeks in the speciality OPD on Wednesay/Saturday between 4 p.m. to 6 p.m. The parents of Respondent No.1-baby were explained all the problems which may develop in a premature baby.

9.3 As per the Discharge Summary at Page 109 of the medical records, the Complainants were advised to bring the Respondent No.1-baby for a ROP and BERA check-up to the speciality OPD on Wednesday/Saturday at 4 pm. 9.4 The Respondent No.2-Complainant brought the baby to the General OPD of Appellant No.1- Hospital on 04.05.2005 after 8 days of the first ROP check-up, and not after 2 weeks as advised. Thereafter, the baby was brought on 13.07.2005, which was after 2 months again to the General OPD.

9.5 The Appellants relied on the Report of the Medical Board constituted by AIIMS, which had vide their Report dated 11.05.2012 held that the baby was not brought to the Paediatrics OPD Clinic on Wednesdays or Saturdays at 4 P.M. after two weeks of discharge, when subsequent progression of ROP could have been assessed and treated on time.

9.6 The Appellant No.4/O.P. No.5 - Dr. S.N. Jha, a Senior Ophthalmologist was engaged with the Appellant No.1- Hospital from 1997 to 2010. It was submitted on his behalf that on 25.04.2005, the Paediatrics Dept. of the Appellant No.1-Hospital had requisitioned him to perform the ROP examination. The Appellant No.4 submits that the ROP was duly conducted by him on 26.04.2005. His finding is recorded at Page 102 of the medical records, wherein he has recorded that he did not find any evidence of ROP at that stage. It was further submitted that it was not required to record the method of dilation of the pupil and use of indirect ophthalmoscope. The standard medical literature establishes that ROP manifests itself after 4 weeks of post-natal age. In view thereof, the finding of Appellant No.4, who examined the baby only on 26.04.2005 i.e. when the baby was 24 days old, there was no evidence of ROP, cannot be faulted.

9.7 It was further submitted that the only requirement for conducting an ROP examination is a chemical solution of Tropicamide and Phenylephrine to dilate the eyes, which was available in the nursery, and an indirect ophthalmoscope, which is available with all ophthalmologists. who have specialised in the care of retina, and are competent to carry ROP examination. It was submitted that the Appellant No.4 was not required to record the procedure for conducting the ROP examination, which is merely the retinal examination of the baby by use of an indirect ophthalmoscope after dilation of the pupils. 9.8 Appellant No.4 - Dr. S.N. Jha was not consulted on the two subsequent visits by the Respondent No.2- Complainant with the baby on 04.05.2005 and 13.07.2005 in the Ophthalmology department, even though he would have been available in the speciality OPD on Wednesdays/Saturdays at 4 P.M.

10. The learned counsel for the Complainants – Respondent Nos. 1 to 3 (Appellant Nos. 1 to 3 in Civil Appeal No. 9461 of 2019/Diary No. 15393 of 2019), inter alia submitted that the Respondent No.1-baby has become permanently blind on account of the gross medical negligence by the Hospital, and the three specialist doctors i.e two consultant Paediatricians, and the Ophthalmologist, for the following reasons:

> 10.1 The Appellant Nos.1 to 4 did not at any stage conduct the ROP examination of the baby, who was a premature baby, nor was the family ever informed about the high risk of ROP in a premature baby, and the necessity for regular check-ups.
>
> 10.2 The Appellant No.1-Hospital had deliberately withheld the medical records for over two years after discharge.

At the time of discharge on 29.04.2005, the Complainants were provided with a Discharge Slip, which did not disclose any instructions advising that the infant be brought for ROP examination (the Discharge Slip in Para 5.4 above).

In this Discharge Slip, there is no advice of ROP having been conducted, or follow-up of ROP, nor was the risk of ROP explained by the Appellant Nos. 2 and 3 to the Respondent No.2-Complainant.

10.3 The Complainants have strongly contended that parts of the medical records, which were provided after 2 years in 2007, had been fabricated and interpolated as an afterthought to escape liability.

It was submitted that a bare perusal of the noting dated 26.04.2005 made in the medical record by Appellant No.4- the Ophthalmologist, shows that is merely a scribble, and is illegible. The Complainants have strongly refuted the case of the Appellants that the ROP was conducted by Appellant No.4 on 26.04.2005.

The Complainants have supported their submission on the basis of :(i) the progress sheets, which contain no details of the ROP examination; (ii) there is no mention of the ROP examination in the Nurses' Daily Record; (iii) ROP exam is conducted with the help of dilation by using Cyclopentolate (0.5%) and Phenylephrine (2.5%) drops to be applied 2 to 3 times, about 10-15 minutes apart. There

is no record with respect to the administration of the these medicines to the baby; (iv) there is no mention of the ROP test in the Discharge Slip of 29.04.2005;

10.4 The Complainants contended that if the standard protocol had been carried out by the Doctors, the ROP would have been detected at an early stage, and could have been cured, since it is medically known to be reversible at the early stages.

On account of the negligence of the Appellant Nos. 1 to 4, the ROP was discovered only at Stage 5, by the Shroff Charity Eye Hospital, when the baby was 8 months old. By this time, the ROP became irreversible, and resulted in total blindness of the Respondent No.1- baby.

10.5 It was further urged that the quantum of compensation awarded by the National Commission was grossly inadequate and insufficient. The National Commission failed to take into account variables such as the additional educational expenses in special schools, transportation costs, costs of purchasing, maintaining and upgrading Visual Aid/Assistive Devices, costs of permanent nursing/attendant care and miscellaneous medical expenses. It was further contended that the average rate of inflation taken by the National Commission i.e. a conservative rate of 1 % per annum for the next 59 years, was grossly undervalued. The Complainants sought enhancement of the compensation to the extent of Rs. 9,87,84,000/-.

11. Discussion and Analysis 11.1 Inordinate Delay in Supply of Medical Records We find that there was an inordinate delay of over 2 years in making the Medical Records of Respondent No.1- Master Rishabh available to the Respondent No.2- Complainant. Regulation 1.3.2 of the IMC Regulations casts a statutory obligation upon every doctor/hospital to provide medical records within 72 hours of the request being made by the patient.

11.1.1 The Medical Council of India has framed the IMC Regulations with the previous approval of the Central Government, in exercise of the powers conferred by Section 20A read with Section 33(m) of the Indian Medical Council Act, 1956. The IMC Regulations came into force on their publication in the Gazette of India on 06.04.2002, and have statutory force.

11.1.2 Regulation 1.3.2 of the Indian Medical Council (Professional Conduct, Etiquettes and Ethics) Regulations, 2002 provides as under:

> “1.3 Maintenance of medical records:
>
> 1.3.1 Every physician shall maintain the medical records pertaining to his /her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3.
>
> 1.3.2. If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

1.3.3 A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.

1.3.4 Efforts shall be made to computerize medical records for quick retrieval.

[emphasis supplied] As per Regulation 7, if the doctor refuses or fails to provide the medical records within 72 hours when the patient or his/her authorised representative makes a request as per the Regulation 1.3.2, the said act of commission or omission would constitute professional misconduct rendering him/her liable for disciplinary action and punishment under Regulation 8.

Regulations 7 and 8 provide as follows:

"7. MISCONDUCT The following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action 7.1 Violation of the Regulations: If he/she commits any violation of these Regulations.

7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of three years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it as per the regulation 1.3.2.

8. PUNISHMENT AND DISCIPLINARY ACTION 8.1 It must be clearly understood that the instances of offences and of Professional misconduct which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which calls for disciplinary action, and that by issuing this notice the Medical Council of India and or State Medical Councils are in no way precluded from considering and dealing with any other form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances as in all others, the Medical Council of India and/or State Medical Councils have to consider and decide upon the facts brought before the Medical Council of India and/or State Medical Councils.

8.2 It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for Disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of

committing professional misconduct, the appropriate Medical Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register of the name of the delinquent registered practitioner. Deletion from the Register shall be widely publicized in local press as well as in the publications of different Medical Associations/ Societies/Bodies.

8.3 In case the punishment of removal from the register is for a limited period, the appropriate Council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed.

8.4 Decision on complaint against delinquent physician shall be taken within a time limit of 6 months.

8.5 During the pendency of the complaint the appropriate Council may restrain the physician from performing the procedure or practice which is under scrutiny.

8.6 Professional incompetence shall be judged by peer group as per guidelines prescribed by Medical Council of India." 11.1.3 The IMC Regulations framed by the Medical Council of India are binding on all medical professionals, who are under a statutory obligation to provide medical records to the patients or their attendants. All hospitals, whether Government or private are liable to maintain the medical records, and provide the same to patient or their attendants within 72 hours of the request.

11.1.4 The Delhi Medical Council vide Circular No. DMC/DHS/F.5/2/2009 dated 15.05.2009 casts a statutory obligation on all registered medical practitioners and hospitals/nursing homes to strictly adhere to Regulation 1.3.2 of the IMC Regulations. The failure to comply with the same would constitute professional misconduct and entail disciplinary action.

11.1.5 This Court in Federation of Obstetrics & Gynaecological Societies of India v. Union of India1 held that "considering the nature of services rendered by medical professionals, proper maintenance of records is an integral part of the medical services." 1 (2019) 6 SCC 283 11.1.6 The Respondent No.2-Complainant submitted that she had made several requests for being provided the in-

patient records for further evaluation/examination of the baby, which was not made available to her for over 2 years after his discharge in April 2005 from the Appellant No.1- Hospital. Respondent No.2-Complainant had to run from one hospital to another so as to ascertain why her son had abnormal visual responses. Despite repeated requests, the Medical Records were withheld by the Hospital. The Respondent No.2-Complainant had a legal notice issued on 24.02.2007 to the Appellant No.1- Hospital requesting for the entire in-patient medical record of her child, and made a complaint to the Delhi Medical Council. The Appellant No.1 -Hospital eventually provided the medical record on 14.06.2007. 11.1.7 The Delhi Medical Council vide Order dated 14.12.2007 issued

a warning to the Appellant No.1- Hospital for the delay in supplying the medical records of Respondent No.1 to the Complainant.

We find that withholding the medical records of Respondent No.1, who was a premature baby, for a period of over 2 years, would constitute grave professional misconduct under Regulation 7, apart from being a gross deficiency in service on the part of the Appellant No.1-Hospital and its management. 11.2 Failure to diagnose Retinopathy of Prematurity (ROP) Retinopathy of Prematurity (ROP) is one of the major emerging causes of childhood blindness. A premature baby is not born with ROP. At the time of birth, particularly in the case of premature babies, the retina is immature, which is natural at this stage. It is the post-natal developments in the retinal vessels which could lead to ROP.

11.2.1 As per medical literature, all infants with a birth weight of less than 1500 grams, or gestational age of less than 32 weeks, are required to be mandatorily screened for ROP, which usually takes about 4 to 5 weeks to be diagnosed. The routine screening should begin no later than 4 weeks after birth, and possibly even earlier for infants at higher risk (2 to 3 weeks). The standard of care is to be judged in the light of the protocols and standard procedures prevailing on the date of birth, and not on the date of trial. 2 11.2.2 In Programme Planning and Screening Strategy in Retinopathy of Prematurity3, published in March 2003 co-authored by Drs. Subhadra Jalali, MS; Raj Anand, MS; Harsh Kumar, MD; Mangat R Dogra, MS;

Rajvardhan Azad, MD,FRCS (Ed); Lingam Gopal, MS have opined that:

> "There are several compelling reasons to have a screening programme for ROP. Firstly, the premature child is not born with ROP and retinal disease is not present at birth. Each prematurely born child has a potential for normal vision, even if the retina is immature at birth. Screening for ROP aims to identify those infants who have reached or have the potential to reach threshold ROP, which if untreated, may cause blindness or visual impairment. This has medico-legal implications. There are indefensible legal repercussions should an infant develop ROP and retinal detachment, but had not received eye examination. Secondly, the grief and the personal tragedy for the family is tremendous, besides the economic burden of such childhood blindness. The aim of screening premature babies for ROP is to detect all treatable 2 Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka, (2009) 6 SCC 1; Jacob Mathew v. State of Punjab (2005) 6 SCC 1 : 2005 SCC (Cri) 1369 3 Subhadra Jalali, MS; Raj Anand, MS; Harsh Kumar, MD; Mangat R Dogra, MS;

Rajvardhan Azad, MD,FRCS (Ed); Lingam Gopal, MS, Programme Planning and Screening Strategy in Retinopathy of Prematurity, Indian J Ophthalmol 2003 (March 2003), Vol. 51, Pages 89-99 neonates, with minimal expense of time and resources.

This also aims at not screening those babies who are unlikely to get a severe form of ROP. Early recognition of ROP by screening provides an opportunity for effective treatment.... The criteria for screening babies are based on two critical factors – the birth weight and the gestational age."

[emphasis supplied] A well organised screening strategy and timely intervention can to a large extent prevent blindness due to ROP. Extensive clinical trials and publications4 have established that among other factors, gestation period and low birth weight are critical in the pathophysiology of ROP. If detected early and treated with peripheral retinal cryopexy or laser, ROP blindness can be prevented to some extent.5 Once the 4 Palmer EA, Flynn JT, Hardy RJ, Phleps DL, Phillips CL, Schaffer DB, Incidence and early course of retinopathy of prematurity. Ophthalmology 1991;98:1628-40; Fielder AR, Shaw DF, Robinson J, Ng YK, Natural history of retinopathy of prematurity: A prospective study. Eye 1992;6:233-42; STOP-ROP Multicentre Study Group. Supplemental therapeutic oxygen for prethreshold retinopathy of prematurity (STOP-ROP), a randomised controlled trial: Primary outcomes. Paediatrics 2000;150:295-10. Cryotherapy for Retinopathy of Prematurity Cooperative Group. Multicentre trial of cryotherapy for retinopathy of prematurity-Three-month outcome. Arch Ophthalmol 1990;108:195-40. 5 Cryotherapy for Retinopathy of Prematurity Cooperative Group. Multicentre trial of cryotherapy for retinopathy of prematurity-Three-month outcome, Arch Ophthalmol 1990;108:195-40 ; Cryotherapy for Retinopathy of Prematurity Cooperative Group. Multicentre trial of cryotherapy for retinopathy of prematurity-3¹ □□years outcome for both structure and function, Arch Ophthalmol 1993;111:339-44. Tsisis T, Tasman W, Mcnamara JA, Brown G, Vander J. Diode laser photocoagulation for retinopathy of prematurity, Trans Am Ophthal Soc 1997;95:231-36.; Despande DA, Chaturvedi M, Gopal L, Ramachandram S, Shanmugasundaram R. Treatment of threshold retinopathy of prematurity, Indian J Ophthalmol 1998;46:15 19.

case crosses Stage 3, in very few cases can the sight be saved even by extensive vitreoretinal surgery.6 11.2.3 This Court considered this issue in a similar case in V. Krishnakumar v. State of Tamil Nadu7. In that case, a premature female baby was born in the 29th week of pregnancy. The infant weighed only 1.25 kgs at birth. The doctors failed to examine the baby for ROP, or advise the parents that the baby was required to be seen by a paediatric ophthalmologist since there was a possibility of occurrence of ROP, so as to avert permanent blindness. The discharge summary neither disclosed a warning to the infant's parents of the possibility that the infant might develop ROP for which certain precautions must be taken, nor any signs that the doctors were themselves cautious of the dangers of development of ROP. The doctors attempted to cover up their gross negligence of not having examined the infant for the onset of ROP, which is a standard precaution for a well-known condition in such a case. 6 Cherry TA, Lambert SR, Capone-A Jr. Electroretinographic findings in stage V retinopathy of prematurity after retinal reattachment, Retina 1995;15:21-24; Noorily SW, Small K, Juan E de, Machemar R. Scleral bucking surgery for stage 4B retinopathy of prematurity, Ophthalmology 1992;99:263-68.

7 (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546 This Court after reviewing and analysing the medical literature on ROP, observed that the problem occurs in infants who are prematurely born, and who have been administered oxygen and blood transfusion upon birth. If detected during early stages, it can be prevented. In para 4 of the judgment, this Court held that:

> "4. ....It is said that prematurity is one of the most common causes of blindness and is caused by an initial constriction and then rapid growth of blood vessels in the retina. When the blood vessels leak, they cause scarring. These scars can later shrink and

> pull on the retina, sometimes detaching it. The disease advances in severity through five stages — 1, 2, 3, 4 and 5 (5 being the terminal stage). Medical literature suggests that Stage 3 can be treated by Laser or Cryotherapy treatment in order to eliminate the abnormal vessels. Even in Stage 4, in some cases, the central retina or macula remains intact thereby keeping intact the central vision. When the disease is allowed to progress to Stage 5, there is a total detachment and the retina becomes funnel shaped leading to blindness. There is ample medical literature on the subject.

It is, however, not necessary to refer all of it. Some material relevant to the need for check-up for ROP for an infant is:

> "All infants with a birth weight less than 1500 gm or gestational age less than 32 weeks are required to be screened for ROP." [AIIMS Report dated 21-8-2007]
>
> 5. It is undisputed that the relationship of birth weight and gestational age to ROP as reproduced in NCDRC's order is as follows:
>
> "Most ROP is seen in very low birth weight infants, and the incidence is inversely related to birth weight and gestational age. About 70-80% of infants with birth weight less than 1000 gm show acute changes, whereas above 1500 gm birth weight the frequency falls to less than 10%."
>
> 6. .... It is further observed that ROP is a visually devastative disease that often can be treated successfully if it is diagnosed in time." [emphasis supplied] This Court relied upon a Report dated 21.08.2007 of the All India Institute of Medical Sciences, New Delhi comprising of five members, of which, four were ophthalmological specialists. The Board opined as under:
>
> "A premature infant is not born with Retinopathy of Prematurity (ROP), the retina though immature is normal for this age. The ROP usually starts developing 2-4 weeks after birth when it is mandatory to do the first screening of the child. The current guidelines are to examine and screen the babies with birth weight<1500 gm and <32 weeks gestational age, starting at 31 weeks post-conceptional age (PCA) or 4 weeks after birth, whichever is later. Around a decade ago, the guidelines in general were the same and the premature babies were first examined at 31- 33 weeks post-conceptional age or 2-6 weeks after birth.

There is a general agreement on these above guidelines on a national and international level. The attached annexure explains some authoritative resources and guidelines published in national and international literature especially over the last decade.

However, in spite of ongoing interest world over in screening and management of ROP and advancing knowledge, it may not be possible to exactly predict which premature baby will develop ROP and to what extent and why." [emphasis supplied] On a review of the literature on ROP, the

Supreme Court in V. Krishnakumar (supra) set out the screening guidelines as follows:

> Year Source First screening Who to screen 2006 American Academy 31 weeks PCA or 4 <1500 gm birth of Paediatrics et al. weeks after birth, weight or <32 weeks whichever is later. GA or higher.
>
> 2003 Jalali S et al. Indian J 31 weeks PCA or 3-4 <1500 gm birth Ophthalmology weeks after birth, weight or <32 weeks whichever is earlier. GA or higher.

2003	Azad et al. JIMA	32 weeks PCA or 4-5 weeks after birth, whichever is earlier.	<1500 gm birth weight or <32 weeks GA or higher.
2002	Aggarwal R et al. Indian J. Paediatrics	32 weeks PCA or 4-6 weeks after birth, whichever is earlier.	<1500 gm birth weight or <32 weeks GA.
1997	American Academy of Paediatrics et al.	31-33 weeks PCA or 4-6 weeks after birth.	<1500 gm birth weight or <28 weeks GA or higher.
1996	Maheshwari R et al. National Med. J. India	32 weeks PCA or 2 weeks after birth, whichever is earlier.	<1500 gm birth weight or <35 weeks GA or 02>24 hrs.
1988	Cryotherapy ROP Group	4-6 weeks after birth.	<1250 gm birth weight.

> This Court observed that ROP starts developing 2 to 4 weeks after birth when it is mandatory to do the first screening of the child. As per the report of AIIMS “it may not be possible to exactly predict which premature baby will develop ROP and to what extent and why”. This would necessitate the need for a check-up in all such cases.
>
> 11.2.4 It is clear from the above medical literature that ROP is a visually progressive disease, which can be treated successfully if it is diagnosed on time. ROP advances through 5 stages. Medical literature suggests that Stage 3 can be treated by Laser or Cryotherapy treatment in order to eliminate the abnormal vessels. Even at Stage 4, in some cases, the central retina or macula remains intact thereby keeping intact the central vision. When the disease progresses to Stage 5, there is a total detachment, and the retina becomes funnel shaped, leading to blindness.
>
> 11.2.5 We have carefully perused the original Medical Records of the Appellant No.1-Hospital, which were provided in a sealed cover to the Court.

We find that there is an entry at Page 100 of the medical records dated 25.04.2005 recorded at 9:00 a.m. which reads as under:

> “ 25/4/05

9 AM Stable
Wt: 1.56 kg
Accepting cup feeds
S/E – NAD

D19 of Inj Amphocan

Plan for Discharge tomorrow
Adv:
- Breast feeds
- Cont. rest
- ROP Checkup (Dr Jha) ”

[emphasis supplied]

At the bottom of page 102 of the medical records, there is another entry dated 26.04.2005, which reads as under:

“ 26/4 by Dr. SNJ

No ROP

Review, 2 weeks. ”

The said noting is signed by Dr. S.N. Jha – Appellant No.4. There is, however, no time mentioned against this noting.

A visual examination of the original medical records/Treatment Sheet shows that this entry is not recorded in the same sequence as all previous and subsequent notings. The entries recorded at Page 100 and Page 102 have been made at the bottom of the page. The date “26/4” is mentioned in a different column, unlike the other entries made before and after this entry. There is no time of the ophthalmological examination by Appellant No.4-Dr. S.N. Jha on 26.04.2005 mentioned in the record, unlike all other notings by other doctors, who have examined the patient, where the time is clearly recorded.

On the next page i.e. page 103 of the medical record, it is mentioned as “Day 28” i.e. 26.04.2005 on the top of the page. The first entry on that date is recorded at 10.30 am. This would indicate that the baby was not examined prior to 10.30 a.m. by any doctor.

There is no contemporaneous record to corroborate that ROP screening was done by Appellant No.4 on 26.04.2005. The Nurses’ Daily Record or Treatment Sheet do not mention that the dilation of the pupils of the baby were carried out by administration of Cyclopentolate (0.5%) and Phenylephrine (2.5%) drops to conduct test of ROP.

We had orally enquired from the learned counsel appearing on behalf of Appellant No.4- Dr. S.N. Jha about the approximate time at which the ROP check-up was done by him on 26.04.2005. The counsel was unable to specify the time at which the baby was examined by him. 11.2.6 The Respondent No.1-baby was discharged on 29.04.2005.

The Complainants were provided with a Discharge Slip. The Discharge Slip does not contain any advice for a mandatory follow-up for ROP. Rather, the Discharge Slip only advised the Complainant to bring the Respondent No.1 for a review to the Paediatrics OPD on Wednesday or Saturday at 4 P.M. 11.2.7 The Counsel for the Hospital and the Doctors contended that post-discharge, the Respondent No.2-Complainant did not bring the baby to the speciality Paediatric OPD for a check-up as advised in the Discharge Summary.

11.2.8 We have seen the original medical records produced by the Appellant No.1-Hospital, and find that on both occasions, i.e. 04.05.2005 and 13.07.2005, the Complainants went correctly to the Paediatrics Unit of the General OPD. Hence, the contention of the Appellants is liable to rejected as being completely baseless.

11.2.9 The Complainant took the baby for a follow up check-up post-discharge to the Paediatrics-III Department on two occasions i.e. 04.05.2005 and 13.07.2005.

The baby was examined by Appellants No. 2 and 3 on 04.05.2005. In the Treatment Sheet, there is no recommendation to have ROP test done, nor was the patient advised to come back after two weeks. The noting on 04.05.2005 is extracted hereinbelow for ready reference:

“ MAHARAJA AGRASEN HOSPITAL
Punjabi Bagh, New Delhi – 26
Ph. 252266465 to 54 (10 lines)
General OPD Prescription

MAH No.: 0505404 Date : 04-05-05
Deptt./Unit …..PAEDIATRICS-III WED, SAT…09:00 To 11:00

Consultants : Dr. G.S. Kochhar / Dr.Naveen Jain B/O POOJA SHARMA Age /Sex 1 Mths Male.

Wt 1.65 kg FUC 32 weeks preterm AGA with HMD with bilateral pneumothorax with fungal septicemia.

Baby stable.

Adv.

- Breast feeds.
- Continue supplements.

Signature Dr. Naveen Jain. ”

The Complainant took the baby for a further follow-up on 13.07.2005 to the Paediatrics-III Department. The baby was examined by Dr. Manoj on behalf of Appellant No.2. The medical record even on this date does not mention any advice for an ROP test. The attending doctor only advised that a BERA test be done. The noting on 13.07.2005 is reproduced hereinbelow for ready reference:

“ MAHARAJA AGRASEN HOSPITAL
Punjabi Bagh, New Delhi – 26
Ph. 252266465 to 54 (10 lines)
General OPD Prescription

MAH No 05052879 Date 13-07-05
Deptt.: PAEDIATRICS-III WED, SAT…09:00 To 11:00

Consultants : Dr. G.S. Kochhar / Dr.Naveen Jain RISHABH SHARMA Age /Sex 4 Mths Male.

B/O Pooja Sharma

Wt 4 kg
Dr. Manoj Advice – BERA test

Calcirol sachet (3)
Visyneral-Z drops 8 drops daily.
RB tone drop 5 drops.
Syp. Lactocal 1/2 tsf.

Dr. G.S. Kochhar (Signature) ”

It is thus abundantly clear that the baby was rightly taken to the Paediatrics Unit of the General OPD Clinic at the chronological age of 4 to 5 weeks, when the onset of ROP could have been detected. However, there was no advice given by the treating doctors i.e. Appellants Nos. 2 and 3 – the Consultant Paediatricians, nor the Appellant No.4 – Ophthalmologist to conduct the ROP test. 11.2.10 We find that the ROP was neither advised, nor carried out at all by the Appellant No.1-Hospital, or Appellant No.4-Dr. S.N. Jha, the Senior Ophthalmologist, throughout the period of hospitalisation of the baby, or even after discharge.

The baby was born in the 32nd gestational week, and was 1.49 kgs at birth. As per standard protocol, the ROP screening ought to have been done between 3-4 weeks from birth. The baby remained admitted for 27 days in the Hospital from 02.04.2005 to 29.04.2005. There is no justification whatsoever why the mandatory screening of ROP was not done for the baby, while he was under the direct care and supervision of the Appellants.

We affirm the findings of the National Commission of gross negligence by the Appellant Nos. 2 to 4-Doctors, and deficiency of service by the Appellant No.1- Hospital. 11.3 Report of the Medical Board constituted by AIIMS 11.3.1 A perusal of the AIIMS Report 11.05.2012 shows that it was premised on the alleged entry recorded by Appellant No.4 - Dr. S.N. Jha on 26.04.2005, which records that ROP test was conducted, and no ROP was detected.

We have already recorded a finding that the entry made in the Treatment Sheet (at pages 100 and 102 of the original Medical Records) seems to be an interpolation done subsequently to cover up the failure of the Hospital and the Doctors to advise or conduct the mandatory ROP check-up and follow-up protocol.

The second point contained in the AIIMS Report that the baby was not taken to the Paediatrics OPD is wholly fallacious. We have seen the medical records, and find that the baby was, in fact, taken to the Paediatrics Unit of the General OPD. Hence, the basis of the Report is misconceived, and cannot be relied upon. 11.3.2 It is well-settled that a court is not bound by the evidence of an expert, which is advisory in nature. The court must derive its own conclusions after carefully sifting through the medical records, and whether the standard protocol was followed in the treatment of the patient. The duty of an expert witness is to furnish the Court with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the Court to form an independent opinion by the application of this criteria to the facts proved by the evidence of the case.8 Whether such evidence could be 8Ramesh Chandra Aggarwal vs. Regence Hospital Ltd. & Ors. (2009) 9 SCC 709; State of H.P. v. Jai Lal (1999) 7 SCC 280 : 1999 SCC (Cri) 1184 accepted or how much weight should be attached to it is for the court to decide.9 11.3.3 We accept the view taken by the National Commission in disregarding the opinion of the Medical Board constituted by AIIMS.

11.3.4 The Complainants have discharged the initial burden of proof10 by making out a case of clear negligence on the part of the Appellant No.1-Hospital and the Paediatric doctors under whose care the baby was admitted, as also Appellant No.4 – Dr. S.N. Jha, the senior Ophthalmologist attached to the Appellant No.1-Hospital.

The Appellant No.1 - Hospital and the Appellants Nos. 2-4 - Doctors have failed to satisfy the Court that ROP tests were conducted at any point of time, or that the Complainants were even advised to get the ROP test done. 11.4 Medical Negligence and Duty of Care 11.4.1 Medical negligence comprises of the following constituents: (1) A legal duty to exercise due care on the part of the medical professional; (2) failure to inform the patient of 9Malay Kumar Ganguly v. Dr. Sukumar Mukherjee, (2009) 9 SCC 221 : (2010) 2 SCC (Cri) 299 : (2009) 3 SCC (Civ) 663; V. Kishan Rao v. Nikhil Super Speciality Hospital, (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460 10 Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka, (2009) 6 SCC 1 : (2009) 2 SCC (Civ) 688; Savita Garg v. National Heart Institute (2004) 8 SCC 56 the risks involved; (3) the patient suffers damage as a consequence of the undisclosed risk by the medical professional; (4) if the risk had been disclosed, the patient would have avoided the injury; (5) breach of the said duty would give rise to an actionable claim of negligence.

The cause of action for negligence arises only when damage occurs, since damage is a necessary ingredient of this tort. In a complaint of medical negligence, the burden is on the complainant to prove breach of duty, injury and causation. The injury must be sufficiently proximate to the medical practitioner's breach of duty. In the absence of evidence to the contrary adduced by the opposite party, an inference of causation may be drawn even though positive or scientific proof is lacking.11 11.4.2 Medical negligence is the breach of a duty of care by an act of omission or commission by a medical professional of ordinary prudence. Actionable medical negligence is the neglect in exercising a reasonable degree of skill and knowledge to the patient, to whom he owes a duty of care, which has resulted in injury to such person. The standard to 11 Postgraduate Institute of Medical Education & Research v. Jaspal Singh, (2009) 7 SCC 330 : (2009) 3 SCC (Cri) 399 : (2009) 3 SCC (Civ) 114 be applied for adjudging whether the medical professional charged has been negligent or not, in the performance of his duty, would be that of an ordinary competent person exercising ordinary skill in the profession. The law requires neither the very highest nor a very low degree of care and competence to adjudge whether the medical professional has been negligent in the treatment of the patient.12 11.4.3 The degree of skill and care required by a medical practitioner stated in Halsbury's Laws of England13 is as follows:-

> "22. Negligence.—Duties owed to patient. A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give; and a duty of care in his administration of that treatment. A breach of any of these duties will support an action for negligence by the patient.
>
> 35. Degree of skill and care required.—...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

12 Refer to Laxman Balkrishna Joshi (Dr.) v. Dr. Trimbak Bapu Godbole, (1969) 1 SCR 206 :

> AIR 1969 SC 128; Kusum Sharma v. Batra Hospital (2010) 3 SCC 480 : (2010) 2 SCC (Cri) 1127 : (2010) 1 SCC (Civ) 747

13 4th Edn., Vol. 26 pp. 17-18; 4th Edition, Vol.30, Para 35 ordinary skill would have taken had he been acting with ordinary care." [emphasis supplied] 11.4.4 Lord Denning, in Hucks v. Cole14, held that a medical practitioner would be liable only where his conduct falls below the standards of a reasonably competent practitioner in his field.

11.4.5 In earlier judgments, this Court referred to the Bolam test laid down in Bolam v. Friern Hospital Management Committee15. In this case, the doctor treating the patient suffering from mental illness was held not to be guilty of medical negligence by the Queen's Bench Division for failure to administer muscle-relaxant drugs and using physical restraint in the course of electro-convulsive therapy. McNair, J., in his opinion, explained the law in the following words16:

"... where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-

14 (1968) 118 New LJ 469; followed in Postgraduate Institute of Medical Education & Research v. Jaspal Singh, (2009) 7 SCC 330 : (2009) 3 SCC (Cri) 399 : (2009) 3 SCC (Civ) 15 Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582: : (1957) 2 All ER 118 (WLR p. 586) established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." [emphasis supplied] The ratio of the Bolam case is that it is enough for the doctor to show that the standard of care and the skill exercised by him was that of an ordinary competent medical practitioner exercising an ordinary degree of professional skill. McNair, J., held that17:

"... he [a Doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art." 11.4.6 In the subsequent judgment rendered in Eckersley v. Binnie18, Bingham, L.J. explained the Bolam test in the following words: (Con LR p. 79) "From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in the knowledge of new advances, discoveries and developments in his field. He should have such an awareness as an ordinarily competent practitioner would have of the deficiencies in his (WLR. P 587) 18(1988) 18 Con LR 1; followed in Jacob Mathew v. State of Punjab, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369; S.K. Jhunjhunwala v. Dhanwanti Kaur, (2019) 2 SCC 28 knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet.

(Charlesworth & Percy, ibid., para 8.04)" [emphasis supplied] A medical professional should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes reasonable skill that other ordinarily competent members of his profession would bring. 11.4.7 This Court followed the Bolam test in Jacob Mathew v. State of Punjab19 wherein it was held that the Bolam test has been widely accepted as decisive of the standard of care required by medical practitioners, and it is invariably cited with approval before the courts in India, and applied as a touchstone to test the pleas of medical negligence. The court summed up the law on

medical negligence in the following words:

> "48. (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'.
>
> (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] holds good in its applicability in India." [emphasis supplied] 11.4.8 In recent years, the Bolam test has

been discarded by the courts in England. In Bolitho v. City and Hackney Health Authority20, a five judge bench of the House of Lords ruled that21 :

20 (1998) 1 AC 232 : (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL) (AC pp. 241 G-H and 242 A-B) "... the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the Bolam22 case itself, McNair J. stated that the defendant had to have acted in accordance with the practice accepted as proper by a " responsible body of medical men." Later, .. he referred to "a standard of practice recognised as proper by a competent reasonable body of opinion." Again, in the passage which I have cited from Maynard's23 case, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives—responsible, reasonable and respectable—all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter." [emphasis supplied] Lord Browne-Wilkinson, speaking for the bench, in his opinion stated that despite a body of professional opinion approving the doctor's conduct, a doctor can be held liable for negligence, if it is demonstrated that the professional opinion is not capable of withstanding logical analysis24:

22 [1957] 1 W.L.R. 583, 587 23 [1984] 1 W.L.R. 634, 639 (AC p.243 A-E) "These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

[emphasis supplied] 11.4.9 A five judge bench of the Australian High Court in Rogers v. Whitaker25 identified the basic flaw involved in approaching the standard of duty of care of a doctor as laid down in Bolam (supra), and held that:

> "5. ....The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single comprehensive duty covering all the ways in which a doctor is 25 (1992) 109 Aus LR 625: [1992]HCA 58 called upon to exercise his skill and judgment" 26; it extends to the examination, diagnosis and treatment of the patient and the provision of information." "12. In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill.27 But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade.28 Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam principle has not always been applied. 29 Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life".

[emphasis supplied] 11.4.10 A seven-judge bench of the U.K. Supreme Court in a more recent judgment delivered in Montgomery v Lanarkshire Health Board30 traced the changes in the jurisprudence of medical negligence in England, and held that "patients are 26 Sidaway v. Governors of Bethlem Royal Hospital [1985] UKHL 1; (1985) AC 871 27 Cook v. Cook [1986] HCA 73; (1986) 162 CLR 376, at pp 383-384; Papatonakis v. Australian Telecommunications Commission [1985] HCA 3; (1985) 156 CLR 7, at p 36; Weber v. Land Agents Board (1986) 40 SASR 312, at p 316; Lewis v. Tressider Andrews Associates Pty. Ltd. (1987) 2 Qd R 533.

28 Florida Hotels Pty. Ltd. v. Mayo [1965] HCA 26; (1965) 113 CLR 588) 29 Albrighton v. Royal Prince Alfred Hospital (1980) 2 NSWLR 542; E v. Australian Red Cross [1991] FCA 20; (1991) 99 ALR 601) [2015] UKSC 11 now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession". The Supreme Court noted that the courts have tacitly ceased to apply the Bolam test in relation to the advice given by the doctor to their patients. The Court summed up the law on medical negligence in the following words:

> "82. In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended

treatment and possible alternatives, and the risks of injury which may be involved.

87. The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in Sidaway by Lord Scarman, and by Lord Woolf MR in Pearce, subject to the refinement made by the High Court of Australia in Rogers v Whitaker, which we have discussed at paras 77-73. An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it." [emphasis supplied] 11.4.11 This Court in V. Kishan Rao v. Nikhil Super Speciality Hospital31 has opined that the Bolam test requires re-

consideration. A.K. Ganguly, J. speaking for this Court, observed that:

"23. Even though Bolam test was accepted by this Court as providing the standard norms in cases of medical negligence, in the country of its origin, it is questioned on various grounds. It has been found that the inherent danger in Bolam test is that if the courts defer too readily to expert evidence medical standards would obviously decline. Michael Jones in his treatise on Medical Negligence (Sweet and Maxwell), 4th Edn., 2008 criticised the Bolam test as it opts for the lowest common denominator. The learned author noted that opinion was gaining ground in England that Bolam test should be restricted to those cases where an adverse result follows a course of treatment which has been intentional and has been shown to benefit other patients previously. This should not be extended to certain types of medical accidents merely on the basis of how 31 (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460 common they are. It is felt "to do this would set us on the slippery slope of excusing carelessness when it happens often enough" (see Michael Jones on Medical Negligence, para 3-039 at p. 246).

25. Even though Bolam test "has not been uprooted" it has come under some criticism as has been noted in Jackson & Powell on Professional Negligence (Sweet and Maxwell), 5th Edn., 2002. The learned authors have noted (see para 7-047 at p. 200 in Professional Negligence) that there is an argument to the effect that Bolam test is inconsistent with the right to life unless the domestic courts construe that the requirement to take reasonable care is equivalent with the requirement of making adequate provision for medical care. In the context of such jurisprudential thinking in England, time has come for this Court also to reconsider the parameters set down in Bolam test as a guide to decide cases on medical negligence and specially in view of

> Article 21 of our Constitution which encompasses within its guarantee, a right to medical treatment and medical care.
>
> 26. In England, Bolam test is now considered merely a "rule of practice or of evidence. It is not a rule of law" (see para 1.60 in Clinical Negligence by Michael Powers QC, Nigel Harris and Anthony Barton, 4th Edn., Tottel Publishing). However, as in the larger Bench of this Court in Jacob Mathew v. State of Punjab, Lahoti, C.J. has accepted Bolam test as correctly laying down the standards for judging cases of medical negligence, we follow the same and refuse to depart from it." [emphasis supplied] 11.4.12 More recently, this Court in Arun Kumar Manglik v.

Chirayu Health and Medicare (P) Ltd.32 has held that the standard of care as enunciated in Bolam (supra) must evolve in consonance with its subsequent interpretation adopted by English and Indian courts.

11.4.13 Applying the aforesaid principles to the facts of the present case, Appellant Nos. 2 and 3 viz. Dr. G.S. Kochhar and Dr. Naveen Jain, the Consultant Paediatricians, undoubtedly possessed the skill and qualifications of a Paediatrician, and the baby was placed under their direct care and treatment from birth till he was 3 ½ months old. They owed a duty of care to the baby and his parents. Appellant No.4- Dr. S.N. Jha, the Senior Consultant Ophthalmologist, who was engaged by the Appellant No.1- Hospital, and was the specialist in the Ophthalmology Department, ought to have followed the standard protocol for screening the Respondent No.1-baby for ROP, which is prescribed at the chronological age of 3 to 4 weeks after birth.

32 (2019) 7 SCC 401 11.4.14 Appellant Nos.1 to 3 are liable for medical negligence since at no stage were the parents of Complainant No.1 either advised or guided about the possibility of occurrence of ROP in a premature baby, nor was the baby examined by Appellant No.4, the Ophthalmologist as per standard protocol. The doctors ought to have been fully aware of the high chances of occurrence of ROP in a pre-term baby. The lack of care constitutes a gross deficiency in service.

After discharge on 29.04.2005, the baby was brought on 04.05.2005 at the chronological age of 5 weeks. Even on this date, no ROP test was either advised or conducted.

The baby was brought for a further follow up check-up on 13.07.2005, by which time the baby was 3 ½ months old. Even on this visit, the Appellants did not advise or guide the Respondent No.2-Complainant to have the ROP test conducted.

11.4.15 After reviewing the medical literature setting out the contemporaneous standards and established protocols on ROP, the reasonable standard of care for a premature baby, mandates screening and checking up for ROP. It is a medically accepted position that ROP is a reversible disease, if diagnosed up to Stage 3. Had the ROP test been conducted by the Appellants, there would have been timely detection of the onset of ROP, which at that stage would have been reversible.

On account of the negligence of the Appellants 2 to 4, the disease remained undiagnosed. It came to be diagnosed on 03.12.2005, when the baby was 8 months old, by Shroff Charity Eye Hospital. By this time, the ROP had reached Stage 5, when it becomes irreversible leading to total blindness of the Respondent No.1- baby.

11.4.16 We affirm the findings of the National Commission to hold that the Appellant No.1-Hospital, Appellant Nos. 2 and 3- the Paediatricians, and Appellant No.4 – Dr. S.N. Jha, the Senior Ophthalmologist, owed a legal duty of care to the Complainants/Respondents No.1 and 2. The failure to inform the Respondent No.2-mother of the necessity to have the ROP test conducted in the case of a pre-term baby, and the high risk involved which could lead to total blindness, was a breach of duty. Furthermore, the failure to carry out the ROP test, which is mandated by standard protocol, while the baby was under their direct care and supervision from birth till he was 3 ½ months old, amounted to gross negligence by the Doctors, and deficiency of service by the Hospital. The consequential damage caused to the baby by not having conducted the mandatory ROP test, which led to the total blindess of the baby, has given rise to an actionable claim of negligence.

11.4.17 It is well established that a hospital is vicariously liable for the acts of negligence committed by the doctors engaged or empanelled to provide medical care.33 It is common experience that when a patient goes to a hospital, he/she goes there on account of the reputation of the hospital, and with the hope that due and proper care will be taken by the hospital authorities. 34 If the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify the acts of commission or omission on behalf of their doctors. 35 33 Savita Garg v. National Heart Institute (2004) 8 SCC 56; Balram Prasad (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327; Achutrao Haribhau Khodwa v. State of Maharashtra (1996) 2 SCC 634; V. Krishnakumar v. State of Tamil Nadu, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 34 Savita Garg v. National Heart Institute (2004) 8 SCC 56 : (2004) 8 Scale 694 35 Savita Garg v. National Heart Institute (2004) 8 SCC 56 : (2004) 8 Scale 694 11.4.18 Accordingly, we hold Appellant No.1-Hospital to be vicariously liable for the acts of omission and commission committed by Appellant Nos. 2 to 4. We hold all the Appellants as being jointly and severally liable to pay compensation to the Complainants.

11.5 Compensation 11.5.1 Having affirmed the findings recorded by the National Commission on the question of medical negligence and deficiency in service by the Appellants, the issue whether the compensation awarded by the National Commission was just and reasonable is required to be determined.

The Complainants had claimed Rs. 1,30,25,000/- as compensation before the National Commission. The National Commission vide the Impugned Judgment awarded a total sum of Rs. 64,00,000/- to the Complainants along with interest.

11.5.2 This Court vide Order dated 06.11.2019 directed the Appellants to release a sum of Rs.5,00,000/- (Rupees Five Lakhs) in favour of the Respondent No.2-Complainant from the amount lying deposited by the Appellant No.1-Hospital in the Court.

This Court further directed the Complainant/Respondent No.2 to file an affidavit regarding the education received by the Respondent No.1, and the level of proficiency he had attained.

11.5.3 Accordingly, the Respondent No.2- Complainant has stated on affidavit that the Respondent No.1, who is now 14 years old, was studying in a Government Senior Secondary School for Blind Boys, Kingsway Camp from 2013 to 2017, and barely received education for 4 years, up to 5th standard. The Respondent No.1 was forced to leave school since the Respondent No.2-Complainant was unable to bear his educational, co-curricular and transportation expenses. The father of Respondent No.1, who was working as a security guard with the Municipal Corporation of Delhi, had expired in 2013. The Respondent No.2-Complainant stated that she is currently employed as a part-time receptionist since 2017, and earns Rs. 5,500/- per month as salary, and receives Rs. 2,500/- per month under the Delhi Vidhwa Pension Yojna. She further stated that Respondent No.1 received Rs. 2,500/- per month under the Delhi Government's Scheme for Subsistence Allowance to Persons with Special Needs.

11.5.4 The grant of compensation to remedy the wrong of medical negligence is within the realm of law of torts. It is based on the principle of restitutio in integrum. The said principle provides that a person is entitled to damages which should as nearly as possible get that sum of money which would put him in the same position as he would have been if he had not sustained the wrong.36 11.5.5 In our considered view, having regard to the finding that the medical negligence in the instant case occurred in 2005, and the litigation has been pending before this Court for over 3 years, coupled with the fact that the additional monthly expenses such as the care of an attendant/nurse, educational expenses of the patient in a special school, assistive devices etc. have not been taken into account, it would serve the ends of justice if the compensation awarded 36 Livingstone v. Rawyards Coal Co., (1880) LR 5 AC 25 (HL)]; followed in Malay Kumar Ganguly v. Sukumar Mukherjee, (2009) 9 SCC 221 : (2009) 3 SCC (Civ) 663 : (2010) 2 SCC (Cri) 299 and V. Krishnakumar v. State of T.N., (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546; Balram Prasad v. Kunal Saha, (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327 by the National Commission is enhanced, by a further lump-sum amount of Rs. 12,00,000 (Rupees Twelve Lakhs). 11.5.6 In conclusion, we pass the following directions to secure the interest and welfare of Respondent No.1. These directions are being passed to ensure that the compensation received is utilized for the welfare of Respondent No.1, to enable him to acquire suitable education and equip him to become self- reliant.

We direct that the compensation of Rs. 76,00,000/- awarded to the Respondent No.1- Master Rishabh Sharma s/o Mrs. Pooja Sharma (in C.A. No. 6619 of 2016), be utilized in the following manner:

a) Rs. 60,00,000/- (Rupees Sixty Lacs Only) is allocated exclusively for Respondent No.1- Master Rishabh Sharma for his education, welfare, and sustenance;

b) Rs. 15,00,000/- (Rupees Fifteen Lacs Only) is allocated to Mrs. Pooja Sharma, the mother of Master Rishabh Sharma, as his care-giver, after deduction of an amount of Rs.5,00,000/- already disbursed to her.;

c) Rs. 1,00,000/- (Rupees One Lac Only) is awarded towards litigation costs, payable to Mr. Jai Dehadrai, Advocate and Mr. Sidharth Arora, Advocate, who have represented the Complainants on a pro bono basis (as stated by them) in this Court.

11.5.7 The amount of Rs. 60,00,000/- awarded to Master Rishabh Sharma shall be disbursed in the following manner:

A. Rs. 50,00,000/- be deposited in a Five Years' Post Office Time Deposit Scheme in the name of Master Rishabh Sharma with Mrs. Pooja Sharma as his natural guardian. Let five deposits in multiples of Rs.

10,00,000/- each be made. The deposits shall be opened in the Post Office Savings Bank Account of the Supreme Court Post Office, New Delhi. The account shall be operated by Mrs. Pooja Sharma under the supervision of the concerned Registrar of this Court.

The aforesaid five deposits aggregating to Rs.50,00,000/- will fetch Master Rishabh Sharma an annual interest income of Rs.3,85,000/, which will be credited into a Savings Account with the Post Office. Out of the said sum, Rs.1,50,000/- shall be invested annually in a 15 Year Public Provident Fund ("PPF") Account to be opened in the name of Master Rishabh Sharma with UCO Bank, Supreme Court, Tilak Marg, New Delhi. These yearly investments, going by the provisions of the Income Tax Act, 1961, will be tax free.

After having invested Rs.1,50,000/- every year in a PPF account, the rest of the yearly income amounting to Rs.2,35,000/- p.a. (from and out of Rs.3,85,000/-) which is equivalent to about Rs.20,000/-per month, shall be utilized by Respondent No.2-Mrs. Pooja Sharma for the education and upbringing of Respondent No.1.

B. Rs.4,50,000/- shall be deposited in a Five Year Post Office Monthly Income Scheme Account ("MIS Account") with the Supreme Post Office in the name of Master Rishabh Sharma so that it will give him monthly interest of 7.6% p.a., that is to say Rs.2,850/- per month, which shall be utilized by his Mrs. Pooja Sharma primarily for the upbringing of Respondent No.1.

C. The balance of Rs. 5,50,000/- from the amount deposited by the Appellants, shall be invested in a Five Year Fixed Deposit Account ("FD Account") to opened with UCO Bank, Supreme Court, Tilak Marg, New Delhi in the name of Master Rishabh Sharma.

The interest accruing therefrom may be utilized by Mrs. Pooja Sharma in such manner as is deemed appropriate.

D. These investments will ensure an annual income of approximately Rs. 4,50,000/-. With the investment of Rs. 1,50,000/- in a PPF Account, which will be tax free, as the annual income of Rs. 3,00,000/- will be within the permissible tax exemption limit of Rs.

3,00,000/- plus Rs. 75,000/- (Disability Allowance under Section 80U of the Income Tax Act,1961).

E. All these deposits on maturity shall be re-invested by Respondent No.2 – Pooja Sharma with the concurrence of the concerned Registrar of this Court on such terms, which will fetch a high rate of interest, and preserve the corpus for the benefit of Respondent No.1. At no stage, will the Respondent No.2 be permitted to withdraw any amount from these deposits without the permission of the concerned Registrar.

11.5.8 We direct the concerned Registrar of this Court to be associated with Respondent No.2- the mother of Master Rishabh Sharma, in giving effect to the directions issued hereinabove.

12. Accordingly, we allow Civil Appeal No. 9461 of 2019 (Diary No. 15393 of 2019) filed by the Complainants.

13. Civil Appeal No. 6619 of 2016 filed by the Hospital and the Doctors is dismissed. The Appellant Nos. 1 to 4 in Civil Appeal No. 6619 of 2016 are directed to deposit the balance amount of. Rs. 44,00,000/- in this Court within a further period of 12 weeks from today.

14. An affidavit of compliance with respect to the deposit of compensation be filed by the Appellants before this Court.

15. We have been informed by the Registry of this Court that the amount of Rs. 32,00,000/-, which was deposited by the Appellants pursuant to Order dated 29.07.2016 of this Court, and kept in a Fixed Deposit with UCO Bank, has accrued an interest of about Rs. 3,80,954/-. We direct that this interest amount be made over to Mrs. Pooja Sharma, the mother and care-giver, for the welfare and education of Master Rishabh Sharma, for the current year.

16. The original medical records be returned by the Registry to the counsel for the Appellant No.1-Hospital.

Pending Applications, if any, are accordingly disposed of. Ordered accordingly.

.....J. (UDAY UMESH LALIT) .....J. (INDU MALHOTRA)
New Delhi December 16, 2019.