Arun Kumar Manglik vs Chirayu Health And Medicare Private Ltd ... on 9 January, 2019

Equivalent citations: AIRONLINE 2019 SC 639, (2019) 134 ALL LR 312, (2019) 197 ALLINDCAS 51, (2019) 2 CURCC 39, (2019) 2 RECCIVR 225, (2019) 3 ANDHLD 1, (2019) 3 MAD LJ 81, (2019) 3 SCALE 333, (2019) 4 ACJ 2409, (2019) 4 CIVILCOURTC 414, (2019) 4 CIVLJ 299, (2019) 4 PUN LR 500, 2019 (7) SCC 401

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Bench: Hemant Gupta, Dhananjaya Y Chandrachud

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REPORTABLE

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NOS. 227-228 OF 2019
(@SLP (C) Nos. 30119-30120 of 2016)

ARUN KUMAR MANGLIK Appellant(s)

VERSUS

CHIRAYU HEALTH AND MEDICARE PRIVATE LTD. & ANR. Respondent(s

WITH

CIVIL APPEAL NO. 229 OF 2019
(@ SLP(C) No. 865 OF 2019)
@ Diary No. 44846/2018

JUDGMENT

Dr Dhananjaya Y Chandrachud, J.

1 Delay condoned.

2 Leave granted.

3 The National Consumer Disputes Redressal Commission [NCDRC] 1 has set aside an order of the MP State Consumer Disputes Redressal Commission 2 holding the Reason:

> 1 NCDRC 2 SCDRC respondents guilty of medical negligence in the treatment of the spouse of the appellant which eventually led to her death on 15 November 2009. In consequence, the award of compensation of Rs. 6,00,000 awarded, together with interest, has been reversed.

4 The spouse of the appellant, Madhu Manglik, was about 56 years of age, when on 14 November, 2009, she was diagnosed with dengue fever. The report of the pathological laboratory, Glaze Pathology, reported the following state of health:

> "RBC- 4.21 Million/cmm Hb-12,1 gm/d/ TLC-1900/Cmm Platelet Count 1.79 lakh/cmm Dengue Ns 1 Antigen - Positive" The patient was admitted to Chirayu Health & Medicare hospital at Bhopal at about 7 am on 15 November 2009. She was immediately admitted to the Intensive Care Unit.
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> Though she was afebrile, she reported accompanying signs of dengue fever including headache, body ache and a general sense of restlessness. The patient had a prior medical history which included catheter ablation and paroxysmal supra ventricular tachycardia suggestive of cardiac complications.

5 Upon admission at about 7.30 am, basic investigations were carried out. The blood report, together with the accompanying clinical examination indicated the following position:

> "Hb 13.4 TLC 3000/Cumm, Platelet count 97000/cumim, PS for MP no malarial parasite seen Blood urea 21 mg% Serum bilirubin img% SGPT 521 U/L, SGOT 105Mg/dl ELECTROLYTE Sodium 140 meq/L Potasium 4.0 meq/L Ex R4 Urine test normal Ex R6 10.00 am – Pulse-88/min, Bp. 130/88 mm Hg Temp. A febrile c/o Pain in abdomen At 2.00 pm – p-128/min, mildly febrile BP – 110/70 mm Hg" Since the patient was complaining of abdominal discomfort, an ultrasonography of the abdomen was carried out.

6 By 6 pm, on the date of admission the patient was sinking, her blood pressure was non-recordable, extremities were cold and the pulse was non-palpable. In the meantime, the patient was placed on a regime of administering intravenous fluids. The administration of 2500ml of fluids was planned over the course of 24 hours. Between 7 am and 6 pm, she was administered about 1200 ml of fluids. The patient developed bradycardia and cardiac arrest. Faced with this situation, the treating doctors

administered about 1.5 litres of extra fluids. Fluids and colloids were administered for increasing the blood pressure.

7 Since the blood pressure of the patient did not improve, she was administered ionotropes (dopamine & non adrenaline). At 6.45 pm, the patient suffered a cardiac arrest. Her cardiac levels were monitored. At 6.55 pm she was examined by Dr C C Chaubey.

8 Belatedly, at 7.15 pm, another blood sample was taken, which indicated the following results:-

> "Hb – 8.1/d/ TLC-7,400/Cumm Platelet count 19000/cmm Ex R 10 Total protein-3.9 gms% A/G Ratio – 2 SGOT 169 IU/L"

9 At 8 pm, the patient had a cardiac arrest. She was declared dead at 8.50 pm. 10 A complaint of medical negligence was instituted before the Medical Council of India.

11 The Ethics Committee of the Medical Council of India came to the conclusion on 20 February 2015 that though the treating doctors had administered treatment to the patient in accordance with the established medical guidelines, the treatment was not timely. The Ethics Committee, prima facie, found that there was professional misconduct on the part of both the Director of the Hospital Dr Ajay Goenka (respondent No. 2) and Dr Abhay Tyagi. The Ethics Committee observed thus:

> ".....After perusing the statements given by both the parties and documents on record in the case, the Ethics Committee discussed the matter in detailed and noted that the patient admitted in Chirayu Health & Medicare Pvt. Ltd., Malipura, Bhopal on the advice of Dr. A. Goenka but he never visited in hospital to see the patient. The committee further noted that treatment administered to the deceased in the hospital was correct as per the medical guidelines but not given timely. Although, Dr. Goenka did not went (sic)to hospital to see the patient as the patient admitted there as per his assurance and advice, therefore, the Ethics committee prima facie found that there is a professional misconduct on the part of both the doctors and decided to issue a warning to Dr. A. Goenka and Dr. Abhay Tyagi with the directions to be more careful in future while treating such type of patients/cases" (Emphasis supplied) 12 This recommendation was accepted by the Executive Committee of the Medical Council. The appellate order of the Medical Council was communicated on 15 July 2015.
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> 13 The appellant instituted a complaint before the SCDRC seeking an award of compensation in the amount of Rs. 48 lakhs on the ground that his spouse suffered an untimely death due to the medical negligence of the treating doctors at the hospital.
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> 14 By its judgment dated 27 April 2015, the SCDRC came to the conclusion that a case of medical negligence was established. An amount of Rs. 6 lakhs was awarded to the appellant by way of compensation, together with interest at the rate of 9 per cent per annum.

15 In appeal, these findings have been reversed by the NCDRC and in consequence, the claim stands dismissed.

16 Assailing the decision of the NCDRC, learned counsel appearing on behalf of the appellant submits that:

(i) The patient was admitted to the hospital on 15 November 2009 with a reported case of dengue, though in a stable condition;

(ii) The hospital and the treating doctors failed to follow the established protocol in treating a case of dengue;

(iii) The line of treatment was contrary to established guidelines, formulated by the World Health Organisation, titled "Dengue Guidelines for Diagnosis, Treatment, Prevention and Control";

(iv) Except for the blood sample which was taken at about 7.30 am, no further effort was made to determine the hematocrit levels (HCT) during the course of the day and it was only when the patient suffered a cardiac arrest after 6 pm that blood investigations were done at about 7.15 pm;

(v) The trajectory of the illness indicated that the platelet levels which stood at 1,79,000 on 14 November 2009 had recorded a steep decline and stood at 97,000 on 15 January 2009 when she was admitted to the hospital;

(vi) Admittedly, fluids were administered to the patient as a part of the treatment protocol;

(vii) The administration of fluids ought to have been accompanied by regular monitoring of blood levels which would have indicated that there was a precipitous decline in the platelet counts and in the HCT levels;

(viii) Plasma leakage, hemorrhagic fever or dengue shock syndrome are likely concomitants in the trajectory of such a disease;

(ix) In the absence of regular monitoring, the treating doctors were guilty of medical negligence. As a result of their negligence, the doctors precluded themselves from receiving information in regard to the status or progression of the disease;

(x) The findings of the SCDRC were reversed by the NCDRC without any basis or justification;

(xi) NCDRC has found fault with the patient's family for the administration of aspirin in the day preceding her admission to the hospital;

(xii) The fact that she was administered aspirin was disclosed to the treating doctors at the time of admission, which is satisfactorily established by the medical records of the case;

(xiii) NCDRC, in the first appeal, has displaced the findings of fact which have been arrived at by the SCDRC without any basis in the evidence on record; and

(xiv) On the question of compensation, the appellant had also instituted a first appeal before the NCDRC since the award of compensation was inadequate. On the material which was placed on the record before the original authority, it is necessary for this Court to allow the appeal and to suitably enhance the amount of compensation.

17 On the other hand, learned counsel appearing on behalf of the respondents submitted that:

(i) The patient had been suffering from fever from several days prior to her admission to the hospital. She was stable at the time of admission on 15 November 2009;

(ii) The patient did not go into a situation of a dengue shock syndrome or hemorrhagic fever during the course of the day when she was admitted to the hospital;

(iii) In such a situation, no requirement of regular monitoring of HCT was warranted in accordance with the guidelines which have been prescribed by the Directorate of National Vector Borne Diseases Control Programme (DNVBDCP);

(iv) The above guidelines, which have been prescribed by the Union of India under the National Rural Health Mission, would indicate that it is only in a situation involving dengue hemorrhagic fever or dengue shock syndrome that further steps would be necessary;

(v) The fluids which were administered to the patient did not require a monitoring of the blood more than twice a day and it was only in the evening that the HCT levels were required to be evaluated;

(vi) The patient had prior cardiac complications for which she had been on an aspirin regime prior to admission to the hospital. She was carefully monitored by a team of four doctors at the hospital;

(vii) The treatment protocol which was followed was consistent with the guidelines which have been prescribed both by WHO as well as by the National Vector Borne Diseases Control Programme;

(viii) As held in the decision of this Court in Kusum Sharma v Batra Hospital and Medical Research Centre3, the duty of care which is required of a doctor is one

involving a reasonable degree of skill and knowledge; and

(ix) The patient in the present case had prior complications and the treatment which was administered followed an established protocol.

3 (2010) 3 SCC 480 18 The rival submissions now fall for consideration. 19 We will proceed on the basis of the facts as they stand admitted on the basis of the record and in the counter affidavit which has been filed by the respondents. 20 Between 14 January 2009 when the blood report of the patient was obtained from Glaze Pathology Lab and the morning of the following day on which she was admitted to the hospital, the platelet count had recorded a precipitous decline from 1,79,000 to 97,000. This undoubtedly, as the hospital urges in the present case, is a consequence of dengue. The patient had tested positive in the Dengue Antigen test. At 7.30 am, on 15 January 2009, her Hemoglobin was reported to be 13.4. The patient was thereafter placed on a treatment protocol involving the administration of intravenous fluids. 21 The condition of the patient was serious enough to require her admission to the Intensive Care Unit of the hospital. The hospital has justified the administration of about 1200 ml of fluid between 7 am and 6 pm when she developed bradycardia and cardiac arrest.

22 The real bone of contention in the present case is not the decision which was taken by the doctors to place the patient on a regime of intravenous fluids which, for the purposes of the present appeals, the Court ought to proceed as being on the basis of an established protocol.

23 The essential aspect of the case, which bears out the charge of medical negligence, is that between 7.30 am when the patient was admitted to hospital and 6 pm when she developed cardiac arrest, the course of treatment which has been disclosed in the counter affidavit does not indicate any further monitoring of essential parameters particularly those which could be detected by a laboratory analysis of blood samples.

24 Since her admission and through the day, the patient was administered intravenous fluids. The fluids were enhanced at 6 pm by 1.5 litres after she developed cardiac arrest. The record before the Court indicates that even thereafter, it was only at 7.15 pm that her blood levels were monitored. The lab report indicated a hemoglobin level of 8.1 and platelet count at 19,000. By then, the patient had developed acute signs of cardiac distress and she eventually died within a couple of hours thereafter. 25 The requirement of carefully monitoring a patient in such a situation is stipulated both by the guidelines of the World Health Organisation on which the appellant has placed reliance as well as in those incorporated by the Directorate of the National Vector Borne Diseases Control Programme in 2008.

26 The WHO guidelines indicate that Dengue is a ‘systemic and dynamic disease’ which usually consists of three phases i.e. febrile, critical and recovery. There had been a precipitous decline in the patient’s platelet count the day she was admitted to the hospital. The WHO guidelines inter alia state as follows:

"2.1.2 Critical phase ..... Progressive leukopenia (3) followed by a rapid decrease in platelet count usually precedes plasma leakage. At this point patients without an increase in capillary permeability will improve, while those with increased capillary permeability may become worse as a result of lost plasma volume. The degree of plasma leakage varies. Pleural effusion and ascites may be clinically detectable depending on the degree of plasma leakage and the volume of fluid therapy. Hence chest x-ray and abdominal ultrasound can be useful tools for diagnoses. The degree of increase above the baseline haematocrit often reflects the severity of plasma leakage." Clause 2.3.2.2 of the WHO guidelines deals with patients who should be referred for in-

hospital management (Group B).

" Patients may need to be admitted to a secondary health care centre for close observation, particularly as they approach the critical phase. These include patients with warning signs, those with co-existing conditions that may make dengue or its management more complicated (such as pregnancy, infancy, old age, obesity, diabetes mellitus, renal failure, chronic haemolytic diseases), and those with certain social circumstances (such as living alone, or living far from a health facility without reliable means of transport). If the patient has dengue with warning signs, the action plan should be as follows:

• Obtain a reference haematocrit before fluid therapy. Give only isotonic solutions such as 0.9% saline, Ringer's lactate, or Hartmann's solution. Start with 5–7 ml/kg/hour for 1–2 hours, then reduce to 3–5 ml/kg/hr for 2–4 hours, and then reduce to 2– 3 ml/kg/hr or less according to the clinical response (Textboxes H, J and K).

• Reassess the clinical status and repeat the haematocrit. If the haematocrit remains the same or rises only minimally, continue with the same rate (2–3 ml/kg/hr) for another 2–4 hours. If the vital signs are worsening and haematocrit is rising rapidly, increase the rate to 5–10 ml/kg/hour for 1–2 hours.

Reassess the clinical status, repeat the haematocrit and review fluid infusion rates accordingly.

Give the minimum intravenous fluid volume required to maintain good perfusion and urine output of about 0.5 ml/kg/hr. Intravenous fluids are usually needed for only 24–48 hours. Reduce intravenous fluids gradually when the rate of plasma leakage decreases towards the end of the critical phase. This is indicated by urine output and/or oral fluid intake that is/are adequate, or haematocrit decreasing below the baseline value in a stable patient.

• Patients with warning signs should be monitored by health care providers until the period of risk is over. A detailed fluid balance should be maintained. Parameters that should be monitored include vital signs and peripheral perfusion (1–4 hourly until the patient is out of the critical phase), urine output (4–6 hourly), haematocrit (before and after fluid replacement, then 6–12 hourly), blood

glucose, and other organ functions (such as renal profile, liver profile, coagulation profile, as indicated).

Patients should be monitored by health care providers for temperature pattern, volume of fluid intake and losses, urine output (volume and frequency), warning signs, haematocrit, and white blood cell and platelet counts (Textbox L). Other laboratory tests (such as liver and renal functions tests) can be done, depending on the clinical picture and the facilities of the hospital or health centre." According to clause 7.1 of the guidelines of the Directorate of the National Vector Borne Diseases Control Programme (2008), the basic management of dengue patients admitted to hospital includes the following:

"- a mosquito-free environment in hospital

- close monitoring of patient vitals, input and output, oxygen saturation, sensorium

- early identification of warning signs and symptoms

- avoid NSAID and intramuscular injections

- psychological support for patient and family." The presence of the following signs and symptoms requires close monitoring and management (Clause 7.2):

"- respiratory distress

- oxygen desaturation

- severe abdominal pain

- excessive vomiting

- altered sensorium, confusion

- convulsions

- rapid and thready pulse

- narrowing of pulse pressure less than 20 mmHg

- urine output less than 0.5 ml/kg/h

- laboratory evidence of thrombocytopenia/coagulopathy, rising Hct, metabolic

- acidosis, derangement of liver/kidney function tests."

27 The patient had a prior medical history which included catheter ablation and paroxysmal supra ventricular tachycardia suggestive of cardiac complications and thus fell in the group of patients that require in-hospital management (Group B) under WHO guidelines. The patient was evidently suffering from abdominal discomfort and hospital authorities were required to closely monitor her condition. In failing to do so in a timely manner, the respondents were unable to meet the standard of reasonable care expected of medical services.

28 The issue is not whether the patient had already entered a situation involving haemorrhagic fever or a dengue shock syndrome when she was admitted on the morning of 15 November 2009. The real charge of medical negligence stems from the failure of the hospital to regularly monitor the blood parameters of the patient during the course of the day. Had this been done, there can be no manner of doubt that the hospital would have been alive to a situation that there was a decline progressively in the patient's condition which eventually led to cardiac arrest. 29 This Court has consistently held in its decisions (the decision in Kusum Sharma (supra) reiterates that principle) that the standard of care which is expected of a medical professional is the treatment which is expected of one with a reasonable degree of skill and knowledge. A medical practitioner would be liable only where the conduct falls below the standards of a reasonably competent practitioner in the field. 30 Decisions of this Court elucidate on the standard of care which is expected of medical practitioners. Medical negligence jurisprudence in India is characterized by a reliance on the 'Bolam test'.

In Bolam v Friern Hospital Management Committee4, the defendant doctor treating a patient suffering from mental illness was held not guilty of medical negligence by the Queens Bench for failure to administer muscle-relaxant drugs and using physical restraint in the course of electro-convulsive therapy. Justice McNair, in his directions to the jury, laid down the following standard of care:

> "...I myself would prefer to put it this way, that he 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. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view..." 4 [1957] 1 WLR 582 A careful reading of the Bolam case shows that the standard of "reasonableness" is implicit in the test. Thus, the court holds:
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> "...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 established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Mr. Fox-Andrews put it in this way, that in the case of a medical man, negligence means

> failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent. Mr. Fox-Andrews also was quite right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds." (Emphasis supplied) Bolam clarified that the standard imposes a duty on medical professionals to ensure that obsolete methods are not employed:
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> "...At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion."

31 A three judge Bench of this Court in Dr Laxman Balkrishna Joshi v Dr Trimbak Bapu Godbole5 stipulated that the standard to be applied by a medical practitioner must be of a "reasonable degree of care":

> "11. The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties viz. a duty of care in deciding whether to undertake the case, a duty of care in deciding what 5 AIR 1969 SC 128 treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires (cf. Halsbury's Laws of England 3rd Edn. Vol. 26 p. 17)."

32 In Jacob Mathew v State of Punjab6, a three judge Bench of this Court upheld the standard of the ordinary competent medical practitioner exercising an ordinary degree of professional skill, as enunciated in Bolam (supra). The Court held that the standard of care must be in accordance with "general and approved practice":

> "24. The classical statement of law in Bolam has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before the courts in India and applied as a touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. Firstly, 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. Secondly, 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 point of time on which it is suggested as should have been used."

33 In Indian Medical Association v V P Shantha7, a three judge Bench of this Court made the following observations:

> "Immunity from suit was enjoyed by certain professions on the grounds of public interest. The trend is towards narrowing of such immunity and it is no longer available to architects in respect of certificates negligently given and to mutual valuers. Earlier, barristers were enjoying complete immunity but now even for them the field is limited to work done in court and to a small category of pre-trial work which is directly related to what transpires in court...Medical practitioners do not enjoy any immunity and they can be sued in contract or tort on the 6 (2005) 6 SCC 1 7 (1995) 6 SCC 651 ground that they have failed to exercise reasonable skill and care." (Emphasis supplied)

34 A three judge Bench of this Court in State of Punjab v Shiv Ram8 and in Nizam's Institute of Medical Sciences v Prasanth S Dhananka9 affirmed the judgement in Jacob Matthew.

35 A two judge Bench of this Court in Kusum Sharma (supra) laid down guidelines to govern cases of medical negligence. Justice Dalveer Bhandari, speaking for the Court, held:

> "89. On scrutiny of the leading cases of medical negligence both in our country and other countries specially the United Kingdom, some basic principles emerge in dealing with the cases of medical negligence. While deciding whether the medical professional is guilty of medical negligence following well-known principles must be kept in view:
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> 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.
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> II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.
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> III. The medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

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

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

VI. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the 8 (2005) 7 SCC 1 9 (2009) 6 SCC 1 patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

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

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

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

X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurising the medical professionals/hospitals, particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

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

90. In our considered view, the aforementioned principles must be kept in view while deciding the cases of medical negligence. We should not be understood to have held that doctors can never be prosecuted for medical negligence. As long as the doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that the doctors must be able to perform their professional duties with free mind." (Emphasis supplied) He referred to the Bolam test and held thus:

"72. The ratio of Bolam case is that it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that the respondent charged with negligence acted in accordance with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. Firstly, 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. Secondly, 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 point of time on which it is suggested as should have been used." (Emphasis supplied) 36 The "Bolam test" has been the subject of academic debate and evaluation in India and other jurisdictions. Among scholars, the Bolam test has been criticized on the ground that it fails to make the distinction between the ordinary skilled doctor and the reasonably competent doctor.10 The former places emphasis on the standards adopted by the profession, while the latter denotes that negligence is concerned with departures from what ought to have been done in the circumstances and may be measured by reference to the hypothetical "reasonable doctor". The Court must determine what the reasonable doctor would have done and not the profession.

37 Since the formulation of the Bolam test, English Courts have formulated a significantly nuanced doctrine pertaining to the standard of care. In Maynard v West Midlands Regional Health Authority,11 Lord Scarman held thus:

"A case which is based on an allegation that a fully considered decision of two consultants in the field of their special skill was negligent clearly presents certain difficulties of proof. It is not enough to show that there is a body of competent professional opinion which considers that there was a wrong decision, if there also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances." 38 In Hucks v Cole,12 the Court of Appeal found the defendant guilty of medical negligence. Sachs LJ held thus:

"Where the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then however small the risk the courts must anxiously examine that lacuna, particularly if the risk can be easily and inexpensively avoided. If the court finds on an analysis of the reasons given for 10 Michael Jones, Medical negligence, Sweet and Maxwell, Fifth Edition (2017) 11 1985] 1 All ER 635 12 (1968) 118 New LJ 469 not taking those precautions that in the light of current professional knowledge there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact, and where necessary to state that it constitutes negligence." 39 In Bolitho v City and Hackney Health Authority,13 the House of Lords held that the course adopted by the medical practitioner must stand a test to reason:

> "...in my view, 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 Bolam 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, at p. 588, 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's 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) Granting due deference to the profession of medical practitioners, Lord Browne-
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> Wilkinson held that it is only in a 'rare case' when professional opinion is not capable of 'withstanding logical analysis', that the judge may hold that it is not reasonable or responsible:
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> "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 13 (1996) 4 All ER 771 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.

I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that

the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed." (Emphasis supplied)

40 Closer home, in V Kishan Rao v Nikhil Super Speciality Hospital,14 a two judge Bench of this Court highlighted the shortcomings of the Bolam test:

> "19. 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 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).
>
> 24 With the coming into effect of the Human Rights Act, 1998 from 2-

10-2000 in England, the State's obligations under the European Convention on Human Rights (ECHR) are justiciable in the domestic courts of England. Article 2 of the Human Rights Act, 1998 reads as under:

> "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."
>
> 25. Even though Bolam test "has not been uprooted" it has come under some criticism as has been noted in Jackson & Powell on 14 (2010) 5 SCC 513 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." (Emphasis supplied)

41 Our law must take into account advances in medical science and ensure that a patient-centric approach is adopted. The standard of care as enunciated in the Bolam case must evolve in

consonance with its subsequent interpretation by English and Indian Courts. Significantly, the standard adopted by the three-judge bench of this Court in Jacob Matthew includes the requirement that the course adopted by the medical professional be consistent with "general and approved practice" and we are bound by this decision.

42 In adopting a standard of care, Indian courts must be conscious of the fact that a large number of hospitals and medical units in our country, especially in rural areas, do not have access to latest technology and medical equipment. A two judge bench of this Court in Martin F D'Souza v Mohd. Ishfaq15 held thus:

> "37. The standard of care has to be judged in the light of knowledge available at the time of the incident and not at the date of the trial. Also, where the charge of negligence is of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time."

43 In the practice of medicine, there could be varying approaches to treatment. There can be a genuine difference of opinion. However, while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with 15 (2009) 3 SCC 1 medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to 'defensive medicine' to avoid claims of negligence, often to the detriment of the patient. Hence, in a specific case where unreasonableness in professional conduct has been proven with regard to the circumstances of that case, a professional cannot escape liability for medical evidence merely by relying on a body of professional opinion. 44 In the present case, the record which stares in the face of the adjudicating authority establishes that between 7.30 am and 7 pm, the critical parameters of the patient were not evaluated. The simple expedient of monitoring blood parameters was not undergone. This was in contravention of WHO guidelines as well as the guidelines prescribed by the Directorate of National Vector Borne Diseases Control Programme. It was the finding of the Medical Council of India that while treatment was administered to the patient according to these guidelines, the patient did not receive timely treatment. It had accordingly administered a warning to the respondents to be more careful in the future. In failing to provide medical treatment in accordance with medical guidelines, the respondents failed to satisfy the standard of reasonable care as laid down in the Bolam case and adopted by Indian Courts. To say that the patient or her family would have resisted a blood test, as is urged by the respondents, is merely a conjecture. Since no test was done, such an explanation cannot be accepted. 45 The NCDRC had before it a well-considered judgment of the SCDRC based on the evidence on the record. While the jurisdiction of an adjudicatory authority in a first appeal is co-extensive with that of the original authority, the NCDRC has displaced the findings of fact which have been arrived at by the SCDRC without any cogent reasoning.

46 The appellate authority has placed a considerable degree of reliance on the fact that the patient was on aspirin. This circumstance was drawn to the attention of the treating doctors at the time of admission. The NCDRC has merely observed that once she was admitted to the hospital, the patient was given medicines. This, in our view, is an insufficient basis to displace the findings of fact and

conclusions recorded by the SCDRC.

47 For the above reasons, we are of the view that the judgment of the NCDRC is unsustainable. There was no basis or justification to reverse the finding of medical negligence which was arrived at by the SCDRC.

48 However, in our view, there is no basis for recording a finding of medical negligence against the Director of the hospital. The Director of the hospital was not the treating doctor or the referring doctor. Hence, while the finding of medical negligence against the hospital would stand confirmed, the second respondent would not be personally liable.

49 That leads the Court to the question of damages. Finding the hospital and its Director guilty of medical negligence, the SCDRC directed compensation in the amount of Rs. 6 lakhs together with interest at 9 per cent.

50 While quantifying the compensation, the SCDRC was in error in holding that since the son and daughter of the appellant are "highly educated and working" and had not joined as complainants, the complainant himself would be entitled to receive compensation only in the amount of Rs. 6 lakhs.

51 The complainant has lost his spouse, who was 56 years of age. Though she was not employed, it is now well settled by a catena of decisions of this Court that the contribution made by a non-working spouse to the welfare of the family has an economic equivalent.

52 In Lata Wadhwa v State of Bihar,16 a three judge Bench of this Court computed damages to be paid to dependants of deceased persons as well as burn victims in the aftermath of a fire at the factory premises. The Court took into consideration the multifarious services rendered to the home by a home-maker and held the estimate arrived at Rs 12,000 per annum to be grossly low. It was enhanced to Rs 36,000 per annum for the age group of 34 to 59 years.

53 In Malay Kumar Ganguly v Sukumar Mukherjee,17 Justice S B Sinha held thus:

> "172. Loss of wife to a husband may always be truly compensated by way of mandatory compensation. How one would do it has been baffling the court for a long time. For compensating a husband for loss of his wife, therefore, the courts consider the loss of income to the family. It may not be difficult to do when she had been earning. Even otherwise a wife's contribution to the family in terms of money can always be worked out. Every housewife makes a contribution to his family. It is capable of being measured on monetary terms although emotional aspect of it cannot be. It depends upon her educational qualification, her own upbringing, status, husband's income, etc." Thus, in computing compensation payable on the death of a home-maker spouse who is not employed, the Court must bear in mind that the contribution is significant and capable of being measured in monetary terms.

54 In assessing the amount of compensation, we have been guided by the principle which has been laid down by the Constitution Bench in Lata Wadhwa and in National Insurance Company Ltd. v Pranay Sethi18 with suitable modifications in a case involving medical negligence.

55 In our view, the interests of justice would be met, if the amount of compensation 16 (2001) 8 SCC 197 17 (2009) 3 SCC 663 18 (2017) 13 SCALE 12 is enhanced. We accordingly, direct that the appellant shall be entitled to receive an amount of Rs. 15 lakhs by way of compensation from the first respondent. 56 The compensation, as awarded, shall carry interest at the rate of 9 per cent per annum from the date of the institution of the complaint before the SCDRC until payment or realisation. Payment should be effected within two months. 57 The appeals are allowed in these terms. There shall be no order as to costs.

...……..…..……..……..……..…….J. [DR. DHANANJAYA Y CHANDRACHUD] .....J. [HEMANT GUPTA] New Delhi;

January 9, 2019.

ITEM NO.4 COURT NO.11 SECTION XIV

S U P R E M E C O U R T O F I N D I A
RECORD OF PROCEEDINGS

Special Leave Petition (C) Nos. 30119-30120 of 2016 ARUN KUMAR MANGLIK Appellant(s) VERSUS CHIRAYU HEALTH AND MEDICARE PRIVATE LTD. & ANR. Respondent(s) WITH (IA No.174108/2018-CONDONATION OF DELAY IN FILING and IA No.174109/2018-EXEMPTION FROM FILING C/C OF THE IMPUGNED JUDGMENT) Date : 09-01-2019 These matters were called on for hearing today. CORAM :

HON'BLE DR. JUSTICE D.Y. CHANDRACHUD HON'BLE MR. JUSTICE HEMANT GUPTA For Appellant(s) Mr. Brijender Chahar, Sr. Adv.

Mr. Birendra Kumar Mishra, AOR Mr. Shashi Bhushan, Adv.

Ms. Poonam Atey, Adv.

For Respondent(s) Mr. Ankur Mittal, AOR Mr. U.C. Mittal, Adv.

Ms. Nidhi Mittal, Adv.

UPON hearing the counsel the Court made the following O R D E R Delay condoned.

Leave granted.

The appeals are allowed in terms of the signed reportable judgment.

Pending application(s), if any, shall stand disposed of.

(MANISH SETHI)
COURT MASTER (SH)

(SAROJ KUMARI GAUR)
BRANCH OFFICER

(Signed reportable judgment is placed on the file)