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NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 168 OF 2003

1. SMT. SHOBHA AGARWAL
2321,WRIGHT TOWN
JABALPUR (M.P.)
482002
2. Shri. Manish Agarwal
Son Of Late Sharad Kumar Agarwal,
2321, Wright Town,
Jabalpur-482 002 (M.P.)
3. Smt. Mayuri Jain,
Daughter Of Late Sharad Agarwal,
2321, Wright Town,
Jabalpur - 482 002 (M.P.) ....Complainant(s)

Versus

1. THE ESCORTS HEART INSTITUTE & RESEARCH CENTER LTD. & ORS.
OKHLA ROAD
NEW DELHI
110025
2. DR. ASHOK SETH SENIOR CONSULTANT ,CARDIOLOGIST
ESCORT HEART INSTITUTE & RESEACH CENTER LTD.
OKHLA ROAD
NEW DELHI-110 025
3. THE MADICAL SUPERINTENDENT
ESCORTS HEART INSTITUTE & RESEARCH CENTER LTD.,
OKHLA ROAD
NEW DELHI-110 025.
4. THE MANAGER
ESCORT HEART INSTITUTE & RESEARCH CENTRE LTD.
OKHLA ROAD
NEW DELHI - 25 ....Opp.Party(s)

BEFORE:

HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER

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HON'BLE MR. DINESH SINGH,MEMBER

For the Complainant :
For the Opp.Party :

Dated : 21 Aug 2020

ORDER

Appeared at the time of arguments

For Complainant	:	Mr. G. N. Purohit, Sr. Advocate with Mr. Siddharth Gautam, Advocate
For Opposite Parties	:	Mr. Sanjeev Puri, Sr. Advocate with Mr. Kamal Kumar, Advocate Ms. Pragya Puri, Advocate

Pronounced on: 21 st August 2020

ORDER

PER DR. S. M. KANTIKAR, PRESIDING MEMBER

In the medical practice there are inherent potential conflicts of interest, which are not necessarily wrong or reprehensible. However, the Cardiologists' primary obligations in these contexts are to serve the best interests of the patients, above those of groups, institutions, and self-interests. The doctor's skill, expertise and knowledge is needed to reach the common man. From day today practice it is an issue whether an angioplasty-stent procedure for planned surgical revascularization is chosen because it is in the patient's best interest, or to increase the number of compensable interventions. The patients need to regain the trust, and the medical profession needs to re-establish its integrity.

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The Facts:

On 30.05.2000, Mr. Sharad Kumar Aggarwal (since deceased, herein referred to as 'the patient') from Jabalpur, for his some cardiac ailments, got admitted in The Escorts Heart Institute & Research Centre Ltd. - the OP-1 (herein referred to as 'the EHIRC- Hospital') at New Delhi. He underwent Stress test, ECHO, Tread Mill Test (TMT) and Angiography. There was no coronary artery blockage. The Ejection Factor (EF) was 35% and Global Hypokinesia was noted. The patient was discharged on 03.06.2000 with followed up advice. Thereafter, at Jabalpur, patient was under regular check-up from one Cardiologist. The patient's EF was improved to 58%. The patient suffered some chest discomfort on 28.08.2001 and hospitalised in Anant Nursing Home at Jabalpur. Dr. Sanjay Nema, Cardiologist examined the patient and diagnosed it as "unstable angina". He advised for immediate Coronary Angiography from higher centre EHIRC at New Delhi, and an urgent appointment was sought at OP-1 hospital from Dr. Ashok Seth (OP-2), the Senior Consultant Cardiologist and the Chief of the Cath Lab and interventional Cardiology. On the next day 29.08.2001, the patient was taken from Jabalpur to Nizamuddin by train with necessary life support equipment. The patient was accompanied by Dr. Rajendra Aggarwal, his one Cardiologist friend from Nagpur. On 30.08.2001 morning they reached Nizamuddin railway station and by ambulance, the patient was taken to the OP-1 hospital at around 8 AM. The Cardiologist Dr. Ashok Seth (OP-2) examined patient at 10 AM and advised Coronary Angiography (for short 'CAG'). As asked by OP-2, the patient's attendants deposited advance sum of Rs. 1.5 lakh at OP-1. Dr. Rajendra Agrawal requested to OP-2 to perform Angiography by himself but at around 12.30 PM it was performed by another Cardiologist on the instructions of OP-2. Thereafter, in the evening, as called by the OP-2, the patient's wife along with Rajkumar Agarwal, A.K. Bansal and Dr. Rajendra Agarwal met OP-2. He told them that Angioplasty is to be done next day early morning and there was no need of by-pass surgery. Dr. Rajendra Agrawal asked OP-2 why Angioplasty was not done during Angiography procedure itself, but OP-2 replied that as he was busy in OPD today (i.e. 30.08.2001), it was posted for tomorrow and assured that the patient was in stable condition, nothing to worry. The accompanying person Dr. Rajendra Agarwal requested OP-2 as to whether he may be allowed to be present during the procedure of Angioplasty and also to stay in emergency ward with the patient, but same was denied by the OP-2 and assured that everything would be all right when the patient is in the hands of experts and in a good hospital. He suggested Dr. Rajendra Agarwal to go back to Nagpur, no need of stay.

2. On the next day i.e. 31.08.2001 the Angioplasty was posted at 2.00 PM. Complainants alleged that the patient was not provided a proper room or bed throughout night on 30.08.2001, but patient was kept in lobby of emergency ward on the stretcher (trolley). On 31.08.2001, the patient was to be shifted to Cath Lab at 2 PM, but without assigning any reason the Angioplasty procedure was delayed up to 6 PM. Later on it was learned that one unscheduled VIP case was taken on priority before the patient's Angioplasty procedure. The patient was fasting since morning 7 AM and he was feeling some uneasiness, it was told to the staff on duty, but it was ignored. Again, the patient experienced more uneasiness at 1 PM, one doctor attended to him. Finally at 5.30 PM, the patient was taken to the Cath Lab, but till 6.15 PM Angiography procedure was not started. Suddenly, for the patient's attendees, there was emergency announcement from the reception counter and immediately Dr. Raj Kumar Aggarwal and Ashok Bansal reached the Cath Lab. The OP-2 informed them that the patient suffered cardiac arrest in the lobby of Cath Lab and he was revived once by electric shock, but again the patient developed 2 nd cardiac arrest and shocks were given again 5-6 times. The doctors could revive patient's respiration, but no improvement in the blood pressure, therefore, patient was shifted to Heart

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Command Unit on the ground floor. It was alleged that while shifting of the patient, the younger brother of patient saw a straight line on the monitor, which was suggestive of patient died already, but the doctors were befooling the attendants by reviving the patient. The patient declared dead at 8.35 PM. Thus, in the entirety, the complainants alleged the deficiency and negligence of the OP-2 during the treatment at OP-1 hospital. Being aggrieved, the wife of deceased with her daughter and son filed this complaint before this Commission and prayed compensation for Rs. 1.1 Crore

The Defense:

3. In the defense the OPs filed their written versions and denied all the allegations of deficiency in service and negligence. According to the OPs the Complaint is vague, wrong and devoid of any merit. OPs submitted that the patient arrived in EHIRC at 8.17 AM on 30.8.2001. He was initially attended by the Cardiologist on duty and started treatment for 'Unstable Angina'. At 10 AM, Dr. Ashok Seth (OP-2) examined the patient and suggested Angiography to avoid further delay for the subsequent treatment. The ECHO findings were same as done before in June 2000 and no change or deterioration in EF value. The lab investigations and cardiac enzymes were satisfactory. On the same day around 12.30 PM Angiography procedure was performed by one senior colleague of OP-2 and after the procedure patient was shifted back to the emergency ward. The Angiography revealed new blockage of 90% in the LAD, 50% stenosis in LCx, 100% blockage of OM1 and diffuse disease in RCA. The OP-2 submitted that as per recommendations for treatment unstable angina and its risk, the patient requires individualization of management based on clinical judgement. Such patients should usually be admitted to the hospital and require continuous ECG monitoring and defibrillation capability where a 12 lead ECG can be obtained expeditiously and interpreted within 10 minutes. However, they do not ordinarily require to be kept in an Intensive Care Unit (ICU). The OP-2 placed one article from the International Journal of American College of Cardiology (Annexure – VI) which stated that such a patient can be put in a normal ward where ECG and defibrillator is available, still the patient was kept in the emergency which was the intensive care unit. Thus, for the patient extra precaution was taken by the institute.

4. The OP-2 discussed the Angiography report with the attendants/relatives of the patient and gave them two treatment options either a By-pass surgery or an Angioplasty. However, OP-2 denied that he told about no need of by-pass surgery. The OP-2 further denied that he gave total assurance about the safe condition and survival of the patient. He denied having made any such sweeping statements. The patient's relatives themselves agreed for Angioplasty and it was fixed on the next day at 2 PM. OPs further submitted that at EHIRC the doctors treat all patients at par and denied that before Angioplasty the patient was kept waiting for long time to accommodate an unscheduled VIP case. The list of patients dated 31.08.2001 did not consist any VIP's name for Angiography and/or Angioplasty. The decision for Angioplasty of this patient was taken in the night on 30.08.2001 and at the last minute his name was added in the list of 31.08.2001, as a 1st case at 2 PM though few other serious patient were in the list. It was denied that for the whole night on 30.08.2001, the patient was kept in the lobby of emergency ward on stretcher trolley. The patient was kept in the emergency ward under continuous supervision of trained doctors and nurses. The patient remained stable throughout the night, he was under continuous cardiac monitoring and showed stable electrical activity. At about 1.00 PM the patient complained of uneasiness, whereupon the dosage of Nitroglycerine (NTG) in the drip was increased and the patient felt better. It was denied that the patient was on life support- mechanical ventilator. The patient remained asymptomatic till he shifted to the Cath Lab at 5.30 PM and just before transfer

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to Angioplasty table, he developed ventricular fibrillation (VF) at around 6.45 PM. The doctors in Cath Lab immediately started the cardio-respiratory resuscitation, the DC 360 joules shock was given and the cardiac rhythm reverted to normal sinus rhythm. But again transiently patient had ventricular tachycardia and hypotension. Therefore, patient was intubated; DC cardioversion was done and put on ventilator. Temporary pacing was done and the patient was put on high doses of inotropes. Thereafter, OP-2 himself informed the relatives about the condition of the patient and same was documented in the case sheet. The patient was shifted from Cath Lab to the Heart Command Center on the ground floor, but the condition of patient continued to deteriorate and he was declared dead at 8.35 PM. According to the OP-2 such sudden death in the patient of unstable angina on medical treatment is rare, but it is not unforeseen even that can happen to any cardiac patient at any time without any warning. He filed one published study paper on mortality data in the patients of unstable angina (Annexure – VIII). The death of patient was neither due to delay nor any negligence during the treatment of the patient.

Arguments:

5. Heard the argument from both the sides. Perused the entire material on record *inter alia* the medical record from OP-1 hospital. Learned senior counsel for both the sides reiterated their respective affidavits of evidence and made their additional submissions.

6. The learned senior counsel for Complainant vehemently argued that previously almost one year back in June 2000, the patient was took treatment in OP-1 Hospital for his cardiac problem and thereafter he was under treatment of one Cardiologist/Physician at Jabalpur. On 28.08.2001 he suffered unstable angina and was referred to again to OP-2 at EHRIC. The learned senior counsel submitted that the patient was brought from Jabalpur to EHRIC on 30.08.2001. The investigations like ECHO and Angiography revealed severe TVD, LVEF 35% and apical hypokinesia. In our view considering the serious condition of patient, it was the duty of OP-2 to proceed for angioplasty immediately during the same CAG procedure. But, OP-2 posted the Angioplasty for next day, without any explanation. Even though, on the next day, it was further delayed from 2 PM to 6 PM, without any plausible explanation. The learned senior counsel further argued that as an Interventional Cardiologist the OP-2 was ultimately responsible for entire procedural aspects like informing various options of treatment and their risks and benefits determining the appropriateness and timing of each invasive procedure. It seems there was a conflict between the patient's best interest and the physician's own personal interest. It was an unethical approach of OP-2 towards such patients and he was interested in financial gain of the EHIRC. The learned senior counsel reiterated that it was gross negligence caused sudden death of the patient. He further submitted that the 'Critical Flowchart Sheet' was fabricated. He relied upon the following decisions of the Hon'ble Supreme Court:

i) ***Malay Kr. Ganguly vs. Dr. Sukumar Mukherjee & Ors.,*** *(2009) 10 SCALE;*

ii) ***Nizam's Institute of Medical Sciences Vs. Prasanth S. Dhananka & Ors.,*** *(2009) 6 SCC 1;*

iii) ***V. Kishan Rao Vs. Nikhil Super Speciality Hospital & Anr.,*** *(2010) 5 SCC 513;*

iv) ***Bolam Vs. Friern Hospital Management Committee*** *, 1957 (1) WLR 582*

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7. The learned senior counsel for OPs reiterated their affidavit of evidence. He further submitted that the patient was treated with due care in accordance with accepted medical practice and protocol. Complainant failed to produce any medical literature or any independent expert opinion to prove its case. There was no medical negligence attributable to OP's nor was any medical negligence proved against the OP's. The claim of complainant to Rs.1.10 crore is highly exaggerated and without any basis. To strengthen his arguments, he relied upon the case ***Kusum Sharma & Ors. Vs. Batra Hospital and Medical Research Center & Ors** ., (2010) 3 SCC 480.*

Analysis and Conclusion:

8. The patient was referred by one Physician/ Cardiologist from Jabalpur to EHRIC for the management of unstable angina. The referral letter is reproduced as below:

ANANT INSTITUTE OF MEDICAL SCIENCES

JABALPUR

Letter to whomsoever it may concern

28.08.2001

> Mr. Sharad Agrawal is suffering from Unstable Angina. He is admitted in ICCU of Anant Institute of Medical Sciences. He requires urgent Coronary Angiography and interventional procedure. He is referred to higher centre Escort Hospital, New Delhi for further evaluation.

Dr. Sanjay Nema

MD

On bare perusal of the referral letter it is apparent that the patient was specifically referred to EHIRC and the appointment of the Cardiologist OP-2 was confirmed. On 30.08.2001 the OP-2 examined the patient, however he did not perform CAG, and it was done by another Cardiologist. It shows the OP-2 was more inclined to attend his OPD patient than the care of the instant serious patient. Though, it may not sound any negligence of the OP-2 but certainly is not ethically acceptable.

9. It is surprising to note that in spite of serious cardiac condition (TVD), the patient was kept in emergency ward throughout the whole night on 30.08.2001. Such patient should not be kept in emergency ward for more than 2 hours but needs cardiac ICU management or to be shifted to Cath Lab or operation theatre for emergency cardiac intervention. In our view, it was not a standard of care expected from EHIRC a super speciality cardiac hospital, the care expected was more than the normal hospitals.

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10. We have perused the entire medical record and gone through the standard books and articles on Cardiology. In the instant case, the basic purpose of Coronary Angiography was to find out the cause of unstable angina- blockage of coronaries and depending on severity decision of Angioplasty or By-pass may be taken while doing the CAG procedure itself, to avoid myocardial infarction (MI) and mortality. Admittedly, the Angiography revealed very significant blocks in all the three Coronary vessels, which requires immediate Coronary Revascularisation. The patient was at high risk of unpredictable complete blockage of Coronaries which may produce myocardial infarction, ventricular arrhythmia, cardiac failure or death.

11. We further note that the doctor, who performed CAG on 30.08.2001, did not immediately bring the attention of OP-2 about the significant findings in CAG. In the whole night of 30.08.2001 the patient was kept in the trolley bed in the emergency ward and not on stretcher trolley as the complainant alleged. On 31.08.2001, the 2D ECHO was performed before CAG clearly revealed Akinetic anterior wall of Apex and Hypokinetic lateral wall, mid-based septum and LVEF was 35%. Thus, with the combined reading of CAG and ECHO, it was suggestive of the patient had suffered MI and actually needed emergency Cardiac intervention either by Angioplasty or By-pass surgery. It was unfortunate that the Angioplasty procedure fixed on the next day, thus it was not a reasonable practice.

12. We note, the Angioplasty procedure was scheduled at 2 PM on 31.08.2001. The OP-2 in its evidence stated that there was no electrical instability in the ECGs. The medical record shows the patient complained of uneasiness since morning and it was increased at 1.00 PM. Series of ECGs was taken between 7.00AM to 2.30PM [(Annexure IX) page no. 120 to 124 – Part – II]. The ECGs show lot of ST changes, ST elevation in AVR lead and ST depression in the anterior and inferior leads, thus it is clear that since morning the patient had non-ST elevation MI. (NSTEMI). At 1.30 pm the duty doctor just increased the dosage of NTG. The duty doctor failed to read or interpret the ECGs carefully and also those ECGs were not seen by OP-2. In our view, it was not acceptable standard of care; it was the breach in the duty of care.

13. The Electrocardiography (ECG) is one of the most commonly used diagnostic tests, it contains information routinely used to guide clinical decision making in hospitalized patients. Despite the technological advances, the need for human oversight in the interpretation of ECG monitoring data is important. It is a non-invasive, inexpensive, simple, and reproducible technique. The ECG remains a gold standard for diagnosis of transient myocardial ischemia and therefore interpretation of ECG is vital, but it is taken casually many times. ECG is critical in the assessment and management acute coronary syndrome patients. It helps to differentiate infarction with ST elevation (STEMI) (requiring reperfusion therapy) from unstable angina and infarction without ST elevation (NSTEMI). ECG is a powerful prognostic too, therefore it should be borne in mind that prompt attention and good ECG interpretation will avoid a mistake and helps in MI treatment. To ascertain myocardial necrosis, the estimation of Creatine Phosphokinase MB (CKMB) showing two or more high values within 24 hours is the gold standard used worldwide. Now, recently Troponin-T or Troponin-I test is diagnostic. In our view most of the times treating Cardiologist takes seriously the MI with ST elevation (STEMI), but the NSTEMI is ignored; NSTEMI patients need equal attention.

14. Admittedly, the Angioplasty procedure which was scheduled at 2 PM was delayed for 3 ½ hours. The OPs failed to put forth the reasons for such delay. Nothing was coming from the medical records or from the evidence of OP. On bare perusal of the ECGs, 2D ECHO and CAG

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reports, it was the fit case for emergency by-pass surgery than Angioplasty. The OPs failed in their duty of care and it was a deficiency in service and casual approach toward the hospitalised patient.

15. We are not convinced and not inclined to discuss about the delay caused due to an unscheduled VIP patient taken before the instant patient. In our view the patient care is paramount, whether "VIP" or "Ordinary". A VIP may, albeit, avail of treatment from anywhere, with the highest standard of care, but equal attention and equal care is necessary for the ordinary common patient also. On perusal of the entries in medical record few doubts are created in our mind. The "Critical flowchart sheet" showed the date mentioned as 31.08. 2004 instead of 2001 . It is logical that a person in the year 2001 will not make such mistake to write 2004. In the hospital bill Rs.500/- charged against the room rent, which is second imagination of such lower room rent at EHIRC. The complainant alleged that the patient was already dead at the time of shifting to the Heart Command Unit. In the defence, the OP hospital did not produce any cogent evidence like ECGs or cardiac monitor tracings during the resuscitation or after shifting of patient to the Heart Command Unit. It is well said that to avoid litigation, the first rule is to keep good records. *"No record or notes - no defence"* is a well-tested aphorism. The second rule is to maintain competence.

16. The health care industry has undergone a sea change in competitive economics and survival due to corporate culture. The patients have unrealistic expectations about the benefits of the treatment and have suboptimal understanding of the options of alternative treatments, the procedural risks, the benefits, etc. The patients are uniquely vulnerable in medical matters, not only because of the illness itself but also because of their relative lack of knowledge, particularly in high-risk and complex situations such as cardiac intervention or surgery.

17. A breach in the duty of care occurs when one fails to fulfil his or her duty of care to act reasonably in some aspect. Generally, if a doctor does not act in a reasonable manner to prevent foreseeable injuries to the patient, the duty of care is breached. As for duty to avoid adverse outcomes, doctor has an obligation to avoid foreseen risks. However, violation of such duty was notable in the instant case. We would like to rely upon the decision of Hon'ble Supreme Court in the case of **Dr. Laxmn B. Joshi vs Dr.Trimbak B Godbole & Anr.,** AIR 1969 SC 128, which laid down certain duties of doctor that: (a) Duty of care in deciding whether to undertake the case (b) Duty of care in deciding what treatment to give, and (c) Duty of care in the administration of that treatment. A breach of any of the above duties may give a cause of action for negligence and the patient may on that basis recover damages from his doctor. The doctor owes certain duty towards the patient and the doctor can decide the method of treatment, which is more suitable for the patient. In the instant case we find he OP-2 failed in the duty of care towards the patient.

18. On the basis of foregoing discussion medical negligence is well established and we find the hospital and treating doctor liable of material delay / deficiency / negligence. In the cases of medical negligence the damages can be compensatory or punitive. In the instant case such preventive treatment was the standard of care, and thus that failure to offer treatment amounts to a lost opportunity to prevent injury. This 'loss of a chance' doctrine addresses the level of risk reduction or lost opportunity necessary to pass the proximate causation threshold. The complainant must show a greater than 50% chance of a better result to begin with or to show that the OP's negligence led to a lost opportunity for a better result, irrespective of the degree of loss. However, in India the doctrine of 'loss of chance' is yet to be looked into.

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19. The basis of computing compensation lies in the principle of *"restitutio in integrum,"* which refers to ensuring that the person seeking damages due to a wrong committed to him is in the position that he would have been had the wrong not been committed as held by Hon'ble Supreme Court in **Malay Kumar Ganguly vs. Sukumar Mukherjee & Ors.** , (2009) 9 SCC 221. The manner in which medical negligence compensation is calculated depends not just on the injury sustained or the death caused but is also contingent on the victim's income and standard of living, but it prompts the question, how does one assess how much a life is worth? As held by the Hon'ble Supreme Court in the **Kusum Sharma's case,** (2010) 3 SCC 480, every case is required to be considered independently because it would be inappropriate to not give the facts of every situation due importance.

20. Reverting back to the facts of the case before us, the patient was suffering from unstable angina and Triple Vessel Disease, the prognosis was unpredictable. It is conclusively established that there was deficiency and negligence in treatment on the part of the OPs. Judicious and timely use of the treatment options for management of unstable angina with NSTEMI would have been the appropriate and the accepted standard of medical care, which the OPs failed to do.

21. Based on the foregoing discussion, medical negligence is determined against the hospital and the doctor. The complaint is allowed.

22. Considering the facts and specificities of the instant case, we are of considered view that compensation of Rs. 25 lakh with interest at the rate of 8% per annum from the date of death of the patient would be just and equitable.

23. Accordingly the OP-1 hospital and the OP-2 doctor are directed, jointly and severally, to pay Rs. 25 lakh with interest at the rate of 8% per annum from the date of death of the patient till its realisation to the complainants within 6 weeks from today.

24. A copy each of this Order be sent to all the parties by the Registry within 3 days of its pronouncement, without fail.

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DR. S.M. KANTIKAR
PRESIDING MEMBER

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DINESH SINGH
MEMBER