

*** IN THE HIGH COURT OF DELHI AT NEW DELHI**

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Reserved on: 13th April, 2015
Date of Decision: 10th July, 2015

+ W.P.(C) 4220/2011

DR. RAM AVTAR GARG

..... Petitioner

Through: Mr. Arun K. Sharma, Advocate
with petitioner in person.

versus

MEDICAL COUNCIL OF INDIA AND ORS.

..... Respondents

Through: Mr. T. Singhdev, Advocate for
R-1.
R-2 in person.
Mr. Praveen Khattar, Advocate
for R-3.

CORAM:

HON'BLE MR. JUSTICE VED PRAKASH VAISH

JUDGMENT

1. By way of present petition the petitioner impugns order dated 18.05.2011 passed by Ethics Committee of Medical Council of India whereby the quantum of punishment was enhanced from 'warning' as issued by Delhi Medical Council vide order dated 07.12.2010 to 'three months removal of the name of the petitioner from the Indian Medical Register/ State Medical Register'.

2. The facts as culled out from the petition are that a child patient, namely, Samiksha was brought to the casualty of Holy Family Hospital, Okhla, New Delhi at around 8:00 p.m. on 04.12.2009. The

child was sick for three months with a history of losing weight, recurrent vomiting and abdominal pain for the last 15 days and had not passed urine since that morning. The child, on examination by Dr. Shailesh Saxena a Resident Paediatrician on call duty, was found malnourished, dehydrated and less active. Certain treatment was prescribed in the casualty to be started just after admission.

3. On clinical examination of the child and history given in the casualty, provisional diagnosis was noted as “*Failure to thrive with recurrent vomiting and moderate dehydration*”. It is stated that the Resident Paediatrician on call duty Dr. Shailesh Saxena had prescribed the following investigation and treatment:

(i) Injection Emeset I.V.

(ii) Injection Rantac I.V.

(iii) I.V. Fluid with normal saline volus 200 ML start

Then N/2 saline + 5% Dextrose (1/100 KCL) 7.0 ml Per kg. per hour in the first four hours.

Then N/2 saline + 5% Dextrose (1/100 KCL) 1.5 litre in 24 hours.

The child was admitted in Room No.324 at 8:30 p.m. on 04.12.2009 and her treatment was started. The child was further examined in the room by Resident Paediatrician just after her admission at 8:50 p.m.

4. The relatives of the patient informed that they had earlier consulted many Doctors in Faridabad in the month of November, 2009. Previous ultrasound abdomen done in Faridabad showed “Mesenteric Lymphadenopathy”. It is stated that relatives of the patient were categorically told that the child was dehydrated and the first line of treatment is correction of the dehydration for which I.V. Fluid had been started. As the vitals of the child were stable and SpO2 was 97% without oxygen, she was admitted in the room and not in the Paediatric ICU. The child was seen in the midnight by Dr. Shailesh Saxena. Since, the patient had not passed urine, therefore, she was given normal saline I.V. Bolus 100 ML. After that the child passed urine. The child was given medicines/ fluids thereafter also.

5. It is further stated that on 05.12.2009 at 3:00 a.m. IV N/2 saline + 5% Dextrose (1/100 KCL) started at the rate of 20 drops per minute measuring about 60 ml per hour. At 9:00 a.m. I.V. Fluid was discontinued as per the instructions of the petitioner as child was taking oral Fluids. The child received 360 ML in 6 hours from 3:00 a.m. to 9:00 a.m. on 05.12.2009 and passed urine twice in the night. The patient was also seen by Paediatric Resident Dr. Sachin Jain and the petitioner, who is the Senior Consultant at 9:00 a.m. on 05.12.2009. Further investigations and treatment were prescribed after seeing the investigation reports. The patient was seen by Dr. Sachin Jain after seeing X-Ray film in X-Ray Department at 12:20 p.m. on 05.12.2009 which showed right sided Pneumonia. The child was stable with no respiratory distress. The petitioner was accordingly informed, who

told Dr. Sachin Jain that the treatment for Pneumonia had already been started on the basis of clinical examination in the morning.

6. The Paediatric Resident Doctor further saw the patient at 3:00 p.m. on 05.12.2009. The child was stable and there was no cyanosis and distress noted. She was again seen by the Paediatric Resident Doctor at 6:00 p.m. who directed starting of Nebulization with Budecort as the patient had developed mild respiratory distress. However, on 05.12.2009, at 7:00 p.m. the condition of the child all of a sudden deteriorated. The Paediatric Resident Doctor on call Dr. Sachin Jain came and examined the patient. Respiratory distress increased and SpO₂ fell to 89% with Oxygen. The patient was shifted to Paediatric ICU where she was treated by Dr. Isha Khetarpal, a Senior Paediatric Resident. The child had respiratory distress and was not maintaining SpO₂ with Oxygen. Senior Consultant Paediatrician on call Dr. S. Warsi was informed and treatment was discussed with her by the Senior Resident Paediatrician who also examined the patient and explained the serious condition of the child to her relatives. It is also stated that the patient had a cardiac arrest at 8:00 p.m. on 05.12.2009, thus, incubated Cardio Pulmonary Resuscitation was conducted and the patient revived and was put on ventilatory support at 8:15 p.m. Necessary Fluids/ Injections were given to the patient. When the patient had second cardiac arrest at 12:15 a.m. on 06.12.2009, I.V. Adrenaline repeated, Cardio Pulmonary Resuscitation continued. On 06.12.2009 at 1:05 a.m. Cardio Pulmonary Resuscitation continued, I.V. Adrenaline was repeated. However, the

child could not be revived and declared dead at 1:08 a.m. on 06.12.2009.

7. A complaint was made by respondent No.2 to the Delhi Medical Council (for short, 'DMC'), which issued notices to Dr. Y. Pande, Medical Superintendent (MS), Dr. R.A. Garg (petitioner herein), Dr. Shailesh Saxena, Dr. Sachin Jain, Dr. Praveen Kumar Rohtagi and Dr. Isha Khetarpal of Holy Family Hospital who filed their reply. DMC examined the complainant Mr. M.K. Gupta and the Doctors and thereafter vide order dated 07.12.2010 held that Dr. R.A. Garg (petitioner herein) and Dr. Sachin Jain failed to exercise reasonable degree of skill, knowledge and care in the treatment of the deceased child and issued warning to Dr. R.A. Garg (petitioner herein) and Dr. Sachin Jain.

8. The complainant/ respondent No.2 thereafter filed an appeal against the order of DMC dated 07.12.2010 before the Medical Council of India (for short, 'MCI'). The Ethics Committee considered the matter and passed the order dated 18.05.2011, which is impugned in the present petition.

9. Learned counsel for the petitioner vehemently contended that there was no new evidence before the Ethics Committee of MCI because of which it has enhanced the quantum of punishment from 'warning' to 'three months removal of the name of the petitioner from Indian Medical Register as well as State Medical Register'. He further submitted that the Ethics Committee is to decide whether the line of

treatment and medicines given were correct or not and this has been upheld by both the Ethics Committee, DMC as well as MCI.

10. Learned counsel for the petitioner further contended that the Ethics Committee consisted of Five Members who had heard the appeal, but the order passed by the MCI is based on opinion received from one Member of the Ethics Committee, which is bad in law. There is error of facts in the impugned order passed by the MCI.

11. It was also contended by counsel for the petitioner that the petitioner saw the child in the morning and advised the line of treatment which is required and the said line of treatment was held to be correct. Counsel for the petitioner also stated that the petitioner was never informed about the condition of the child and on 05.12.2009 after 1:00 p.m., the second Consultant Dr. S. Warsi was on duty, who saw the patient in the evening and as per the duty Roster Chart Dr. S. Warsi was on duty from 1:00 p.m. till next day morning, which fact has also been certified by the Director of the Holy Family Hospital.

12. Lastly it was also argued on behalf of the petitioner that in response to the complaint of the respondent No.2, the Hospital had already conducted an internal enquiry and exonerated all the Doctors including the petitioner.

13. *Per contra*, learned counsel for respondent No.1 contended that MCI rightly passed the impugned order after affording due opportunity to the parties and decided to remove the name of the petitioner from Indian Medical Register/ State Medical Register for a period of three months on the ground that the petitioner was found to have committed

a case of professional misconduct and the petitioner did not exercise due care and caution while treating the patient. He also submitted that the order passed by the MCI is neither without jurisdiction nor in violation of the principles of natural justice.

14. Respondent No.2/ complainant, who appeared in person and argued himself, submitted that the petitioner was negligent in performing his duty and failed to give proper treatment to the child. He alleged that medical negligence and professional misconduct had been conducted on the part of Doctors of Holy Family Hospital. He further contended that the child was given excessive dose of I.V. Fluid and the Augmentin Injection was not given to the patient. It was stated by respondent No.2 that the child was brought to the Hospital for check-up only as she had not passed urine since morning and having problems of vomiting. The patient was not looked after by the Doctors and no Doctor or medical staff performed their duties with requisite care and skill and it was due to overdose of IVF to the child which resulted in accumulation of Fluid in other body organs including lungs which was the main cause of death of the child. Respondent No.2 alleged negligence on the part of the petitioner.

15. Learned counsel for respondent No.3/ DMC submitted that the DMC considered the matter on complaint of the respondent No.2 dated 11.02.2010 and held that it appears to be a case of error in judgment on the part of Doctors and by order dated 07.12.2010 issued warning to the petitioner and Dr. Sachin Jain. The said order of DMC was never challenged by the petitioner and thus attained finality.

16. I have given my thoughtful consideration to the submissions made by learned counsel for the parties as well as respondent No.2, who appeared in person. I have also perused the material on record.

17. The child was admitted in the night in Emergency and treatment administered to the child was held to be correct. In this regard, reference may be had to the order of DMC dated 07th December, 2010 wherein the following observations were made: -

“

1. In light of the clinical condition with which the patient presented to the said Hospital, the correct diagnosis of failure to thrive with recurrent vomiting with moderate dehydration was made and the line of treatment adopted in the form of administration of I.V. fluid was as per standard protocol. The quantity of I.V. fluid administered was appropriate and there was no overdose.”

18. Further, the MCI in its order dated 18.05.2011 also observed as under: -

“

Consultant examined the child 13 hours after admission and no doctor examined the child between 9 am and 7 pm.

The child was admitted in the night, seen in the emergency by qualified doctors, and correctly shifted to Paediatrics ward, started on the acute care with preliminary investigations. The Consultant, Dr. R.A. Garg saw the child in the morning and advised the line of management. Subsequently, as per case notes, has been

attended by doctors and nurses periodically. There may have been difference of opinion in the management, but there has been no negligence. Hence this ground of challenge is NOT upheld and does not prove any negligence by the treating team.”

19. Thus, both DMC and MCI were of the opinion that the treatment was in line, there was no overdose and there was no negligence. The petitioner only saw the child in the morning at 9:00 a.m. and he was on call duty upto 1:00 p.m. on 05.12.2009 and Dr. S. Warsi, Senior Consultant Paediatric Department was on call duty after 1:00 p.m. on the said date. A certificate dated 20.09.2011 (Annexure P-1) issued by Director, Holy Family Hospital to this effect is also on record. During the course of arguments, the complainant/ respondent No.2 also conceded that he never informed or called the petitioner either on 04.12.2009 or 05.12.2009 regarding the condition of the child. It is not disputed by the complainant that the Doctors present there attended the child.

20. When the complaint was made to DMC, it duly considered the submissions of the parties and came to the following conclusion: -

“.....In the light of the above the Delhi Medical Council make the following observations: -

1. In light of the clinical condition with which the patient presented to the said Hospital, the correct diagnosis of failure to thrive with recurrent vomiting with moderate dehydration was made and the line of treatment adopted in the form of administration of I.V. fluid was as per standard protocol. The quality of I.V. fluid administered was appropriate and there was no overdose.

2. The observation of bilateral wheeze and crepts at 9 am (5.12.2009) on clinical examination was suggestive of chest infection which warranted prescription of antibiotics I.V. augmentin, I.V. gentamycin and salbutamol nebulisation, being commonly used drugs for treatment of pneumonia (right sided pneumonia as confirmed by Chest X-ray). It is further noted that as per records of the said Hospital, till 6 pm (5.12.2009), patient was reported to be stable and it was only at 6 pm that mild respiratory distress was noted with SPO2 of 87% and oxygen was started. The patient was shifted to IPCU at 7 pm. The patient was managed in ICU on antibiotics, oxygen with ventilatory support, however, her condition continued to deteriorate and the patient was declared dead with ARDS being the probable cause of death. As per the joint written statement of doctors of Holy Family Hospital ARDS which appeared on 5.12.2009 in the evening was continuum of the pre-existing pneumonia for which antibiotic treatment had already been started in the morning. It is further averred that ARDS can develop in very short span of time.

The Delhi Medical Council observes that even if we believe that diagnosis of pneumonia was made in the morning and treatment started, there was failure to pick up the deterioration in the child till evening leading to respiratory failure. All the notes till evening suggest that child was not so sick and had no respiratory distress. These findings do not appear to correlate with the size of consolidation. It is difficult to explain sudden deterioration, infact it is more likely that monitoring was not done adequately and deterioration was not picked up till it was too late. A moderate consolidation is likely to respond to augmentin but in case it does not, the patient will deteriorate gradually and worsening can be picked up if monitored carefully.

3. The Delhi Medical Council further found it very disconcerting that in this case the primary consultant Dr. R.A. Garg examined the patient only once, that too after

almost 13 hours of admission of patient in the hospital and subsequently did not examine her even once. It has been argued that after 1 pm (5.12.2009) Dr. R.A. Garg was off duty and as per Holy Family Hospital policy, it was customary that another consultant on call attends the patient whenever required. It was further submitted that in this case Dr. S. Warsi (Sr. Consultant Paediatrics) was on call duty on 5.12.2009 with whom treatment was discussed by Dr. Isha Khetarpal and Dr. S. Warsi examined the patient in PICU. The Delhi Medical Council notes that in this case, the patient was primarily managed by resident doctors with the consultants personally examining the patient just twice. The Delhi Medical Council observes that as per records of the said Hospital, Dr. R.A. Garg was the primary consultant and thus he alongwith his Resident Dr. Sachin Jain were primarily responsible for the treatment of late Samiksha Gupta.

4. The Delhi Medical Council also directs Medical Superintendent, Holy Family Hospital to review the system in place in the said Hospital.”

21. Vide order dated 07th December, 2012 the DMC gave warning to the petitioner and Dr. Sachin Jain. However, neither there was any new evidence nor material before the MCI nor any plausible justification was given for increasing the punishment from ‘warning’ to ‘removal of the name of the petitioner for a period of three months’. The order of MCI dated 18.05.2011 also suffers from error of facts. Dr. Sachin Jain was described as the Admitting Resident Doctor in the order whereas he was not on duty on 04.12.2009. The Admitting Doctor was Dr. Shailesh Saxena. Further, without providing any justifiable reason, in the impugned order dated 18.05.2011, the petitioner and Dr. Sachin Jain were described as negligent. However,

it has been stated in the impugned order that the petitioner and his team were not negligent. It has also been stated in the order dated 18.05.2011 that Dr. Sachin Jain had prescribed I.V. Fluid on 04.12.2009 whereas Dr. Sachin Jain was not on duty and neither had he prescribed I.V. Fluid. It has also been stated in the impugned order that four Doctors treated the child whereas five Doctors including the petitioner, Dr. S. Warsi, Dr. Shailesh Saxena, Dr. Sachin Jain and Dr. Isha Khetarpal treated the child. The name of Dr. S. Warsi on whose duty the patient had died had not been mentioned in the impugned order. There is no reason as to why Dr. S. Warsi, Senior Consultant Paedetrician was never summoned either by the DMC or by the MCI as she was also part of treating team of Doctors and saw the child on 05.12.2009 at 8:00 p.m. and under whose duty the child had passed away.

22. MCI in the impugned order has stated that the prescription of injection Augmentin and injection Gentamicin is correct. Various notings and entries in the chart of the patient clearly show and prove the fact that the patient was attended to by various Doctors. This is so held by the DMC as well as MCI and in the report of Medical Superintendent Dr. Y. Pande, Managing Director of the Hospital. The complainant/ respondent No.2 has failed to give any expert evidence to substantiate his allegations.

23. At this juncture, it is pertinent to mention here that it has also come to the knowledge of this Court that the meeting of the Ethics Committee held on 08.03.2011 and the minutes of the Ethics

Committee do not bear signature of Dr. Anil Narang, expert Member. No justifiable reason has been provided so as to indicate why the signature of Dr. Anil Narang was not obtained on the aforementioned minutes of meeting. Therefore, reasonable doubt appears about the intention of the Ethics Committee and regarding the validity of the quantum of punishment so determined.

24. Therefore, after perusing the record, no justifiable and plausible ground is found for supporting the enhancement of punishment by respondent No.1.

25. It must be remembered that all professionals including Doctors can make errors of judgment but if they are severely punished for this, no Doctor would be able to practice his vocation with equanimity. Indiscriminate proceedings and decisions against Doctors are counterproductive and serve the society no good. Such proceedings inhibit the free exercise of judgment by professionals in a particular situation. In Halsbury's laws of England Fourth Edition Volume 30, the degree of skill and care required by a Medical Practitioner is stated as follows: -

“35. Degree of skill and care required. The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in

accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men.

Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care.

.....”

26. This Court is of the view that a Medical Practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. He would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. There is a tendency to confuse a reasonable person with an error free person. An error of judgment may or may not be negligent. It only depends on the nature of prevailing circumstances.

27. It may not be out of place to mention here that in the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of another professional of the same skill. 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. The higher the acuteness in an emergency and the higher the complication,

the more are the chances of error of judgment. At times, the professional is confronted with making a choice between the devil and the deep sea and has to choose the lesser evil. The Doctor is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Which course is more appropriate to follow, would depend on the facts and circumstances of a given case but a Doctor cannot be penalized if he adopts the former procedure, even if it results in a failure. The usual practice prevalent now a days is to obtain the consent of the patient or of the person in charge of the patient, if the patient is not in a position to give consent before adopting a given procedure.

28. There may be a few cases where an exceptionally brilliant Doctor performs an operation or prescribes a treatment which has never been tried before to save the life of a patient when no known method of treatment is available. If the patient dies or suffers serious harm due to such a measure taken by the Doctor, should the Doctor be held liable? In my opinion, he should not be. Simply, because a patient has not favourably responded to a treatment given by a Doctor, the Doctor cannot be held straightaway liable by applying the doctrine of *res ipsa loquiter*. No sensible Doctor would intentionally commit an act or omission which would result in harm or injury to the patient since his professional reputation would be at stake. A Doctor faced with an emergency ordinarily tries his best to redeem the patient out of his sufferings. He does not gain anything by acting with negligence or

by omitting to do an act. It will, therefore, be for the complainant to clearly make out a case of negligence before a Doctor is charged with or proceeded against. It is evident that Doctors and Hospitals need not be unduly worried about the performance of their functions. The law is a watch-dog and not a bloodhound and as long as Doctors do their duty with reasonable care and caution, they should not be held liable even if their treatment was unsuccessful.

29. In the light of aforesaid discussion, the petition is allowed and the impugned order dated 18.05.2011 passed by the Ethics Committee of Medical Council of India is set aside. No order as to costs.

(VED PRAKASH VAISH)
JUDGE

JULY 10th, 2015
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