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Reserved on : 16.06.2025
Pronounced on : 25.06.2025

IN THE HIGH COURT OF KARNATAKA AT BENGALURU

DATED THIS THE 25TH DAY OF JUNE, 2025

BEFORE

THE HON'BLE MR. JUSTICE M. NAGAPRASANNA

WRIT PETITION No.24162 OF 2024 (GM - POLICE)

BETWEEN:

SRI VIKAS M.DEV
S/O LATE MR. M.C.MAHADEVA
AGED ABOUT 31 YEARS
RESIDING AT NO.39, 2ND 'A' CROSS
NAGARBHAVI VILLAGE
BENGALURU – 560 072.

... PETITIONER

(BY SRI SAMEER SHARMA, ADVOCATE)

AND:

1 . THE COMMISSIONER OF POLICE
OFFICE OF THE COMMISSIONER OF POLICE
INFANTRY ROAD, BENGALURU – 560 001.

2 . DEPUTY COMMISSIONER OF POLICE
WEST DIVISION, NO.13
TANK BUND ROAD
UPPARPETE CHICKPET
BENGALURU – 560 053.

3 . ASSISTANT COMMISSIONER OF POLICE
KENGERI SUB - DIVISION
JNANABHARATHI POLICE STATION
BANGALORE UNIVERSITY CAMPUS
MYSORE ROAD, BENGALURU – 560 056.

4 . SUB-INSPECTOR OF POLICE
ANNAPOORNESHWARINAGAR POLICE STATION
KENGERI GATE SUB-DIVISION
10TH BLOCK, 5TH BLOCK, 2ND STAGE
NAGARABHAAVI, BENGALURU – 560 072.

... RESPONDENTS

(BY SRI SPOORTHY HEGDE N., HCGP)

THIS WRIT PETITION IS FILED UNDER ARTICLE 226 OF THE CONSTITUTION OF INDIA PRAYING TO DIRECT THE RESPONDENTS HEREIN TO CONDUCT A PRELIMINARY ENQUIRY INTO THE COMPLAINTS DTD. 18.06.2024 AND 26.06.2024 PREFERRED BEFORE THE R-2 TO 4 BY THE PETITIONER (ANNX-A1 TO A3) AND THEREBY CALL FOR A MEDICAL REPORT / OPINION FROM AN INDEPENDENT EXPERT BODY / AUTHORITY AS TO THE COMMISSION OF MEDICAL NEGLIGENCE AS DETAILED IN THE SAID COMPLAINTS, IN TERMS OF THE DICTA LAID DOWN BY THE HONBLE SUPREME COURT IN THE CASES OF JACOB MATHEW V. STATE OF PUNJAB AND ANR.(2005) 6 SCC 1), MARTIN F. D'SOUZ V. MOHD.ISHFAQ (2009)3 SCC1) AND LALITA KUMARI V. GOVERNMENT OF UTTAR PRADESH AND ORS. (2014) 2 SCC 1) (ANNX-B1 TO B3) AND THEREBY TAKE CONSEQUENTIAL STEPS IN ACCORDANCE WITH THE PRINCIPLES LAID DOWN IN THE SAID CASES.

THIS WRIT PETITION HAVING BEEN HEARD AND RESERVED FOR ORDERS ON 16.06.2025, COMING ON FOR PRONOUNCEMENT THIS DAY, THE COURT MADE THE FOLLOWING:-

CORAM: **THE HON'BLE MR JUSTICE M.NAGAPRASANNA**

CAV ORDER

The petitioner, bereaved and aggrieved, approaches this Court invoking its writ jurisdiction, seeking justice for a lamentable demise – the untimely death of his father, allegedly occasioned by medical negligence. In furtherance whereof, seeks the following prayer:

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> A. Issue a writ of mandamus or any other writ, order or direction directing the respondents herein to conduct a preliminary enquiry into the complaints dated 18.06.2024 and 26-06-2024 preferred before the respondent Nos. 2 to 4 by the petitioner (Annexures 'A1' to 'A3') and thereby call for a medical report/ opinion from an independent expert body/authority as to the commission of medical negligence as detained in the said complaints, in terms of the dicta laid down by the Hon'ble Supreme Court in the case of Jacob Mathew v. State of Punjab and another [(2005) 6 SCC 1], Martin F.D'Souza v. Mohd. Ishfaq [(2009) 3 SCC 1] and Lalita Kumari v. Government of Uttar Pradesh and others [(2014) 2 SCC 1] (Annexures 'B1' to 'B3') and thereby take consequential steps in accordance with the principles laid down in the said cases."

2. Heard Sri Sameer Sharma, learned counsel appearing for the petitioner and Sri Spoorthy Hegde N., learned High Court Government Pleader appearing for the respondents.

3. Facts, in brief, germane are as follows: -

The substratum of the facts unfolds a poignant tale. The petitioner's father late M.C. Mahadeva was diagnosed with Hiatus Hernia. During the treatment of Hiatus Hernia, develops a complication of watermelon stomach and then becomes a patient of Chronic Kidney Disease ('CKD'). A man reliant on dialysis for survival became ensnared in the vortex of medical interventions where hope turns into horror. For a patient of CKD regular dialysis is imperative. For the purpose of dialysis, insertion of HD Catheter is again a necessity, as the problem aggravates during dialysis taking place other than through catheter. To the father of the petitioner, one Dr. Veerabhadra Gupta, in charge of dialysis facility at G.M.Hospitals, inserted HD Catheter on 19-02-2024.

4. On 29-03-2024, on consultation with the same Doctor, the Doctor suggested removing of the previously inserted HD catheter on the score that it may lead to complications in the long run and suggested insertion of a Perma Catheter which is a permanent catheter. The petitioner's father was then advised to approach Dr. Sumanth Raj K.B., a vascular surgeon at G.M. Hospitals to take the process forward – the process of insertion of Perma Catheter. The petitioner with his family and his father met the said Doctor on 01-04-2024. The surgery for insertion of Perma Catheter was scheduled on 04-04-2024. Before commencement of the surgery, all protocols were taken including consent of the petitioner who was the son of patient, with regard to Perma Catheter procedure. The assurance, according to the averment in the petition was, it was a small procedure of insertion of a Perma Catheter and the surgery would last for about 30 minutes, but for 4 hours the surgery is said to have gone on. The consent given by the petitioner for insertion of Perma Catheter was to be on the right side, but the procedure that was done on the father of the petitioner was a left Catheter insertion. This change was never intimated to the petitioner. Therefore, what was taken as consent was insertion of Perma

Catheter on the right side, but what was done as procedure was on the left side.

5. **Post-surgery, the father of the petitioner was tormented by excruciating pain and discomfort.** On examination it was found that there was no blood back-flow through the Catheter. He was immediately shifted to Fortis Hospital for corrective procedure on the next day i.e., on 05-04-2024. He was again operated, during the operation the condition of the father of the petitioner deteriorated and suffered cardiac arrest. Thereafter, the father of the petitioner succumbed to all the aforesaid procedures on 15-04-2024. It is the case of the petitioner-son that life of the father of the petitioner is now lost on account of negligence and callous act of Doctors at G.M. Hospital and Fortis Hospital who did not take consent of anybody for the operation. The nature of the operation intended to the carried out on the father of the petitioner in Fortis Hospital was changed from right hand side of the body to the left-hand side of the body. This procedure after procedure has led to cardiac arrest, is the averment in the petition.

6. The petitioner, on the death of his father due to alleged gross medical negligence, approached the jurisdictional police to register a complaint on 18-06-2024. The complaint was summarily rejected by rendering a non-cognizable report, as according to the Police, it was a case to be preferred before the Karnataka Medical Council. The petitioner then knocks at the doors of higher ups – respondents 2 and 3, the Assistant Commissioner of Police and the Deputy Commissioner of Police who also did not take any action whatsoever. It is then the petitioner is before this Court in the subject petition, seeking the aforesaid registration of crime, at least against the Doctors who were completely negligent.

7. The learned counsel appearing for the petitioner would vehemently contend that there is gross negligence on the part of Doctors who inserted the Catheter at a wrong place and blocked the jugular vein. Blocking of the jugular vein led to stoppage of blood flow back from the Catheter. He would contend that if this cannot be a *prima facie* medical negligence, what else could it be. The life of a breadwinner of the family is lost by a wrong insertion of the

Perma Catheter. It is his submission that it is a different circumstance if the father of the petitioner had succumbed to other problems that would emerge from the consequence of CKD patient, but that is not the issue. He would also submit that a preliminary inquiry or a report was sought from the Victoria Hospital, which has clearly opined that the Doctor who operated for the purpose of Perma Catheter is responsible. He would seek a mandamus for registration of crime by placing reliance upon several judgments of the Apex Court.

8. Per-contra, the learned High Court Government Pleader would vehemently refute the submissions in contending that the complaint cannot become a crime for criminal negligence on the part of Doctors, but at best it can be a complaint before the Karnataka Medical Council under the Karnataka Medical Registration Act, 1961. He would submit that a complaint is registered before the Karnataka Medical Council and a notice is issued to the Doctors both of G.M. Hospital and Fortis Hospital on 10-6-2025. He would, therefore, seek dismissal of the petition, holding that it does not

amount to criminal negligence and no crime should be permitted to be registered against the Doctors.

9. I have given my anxious consideration to the submissions made by the respective learned counsel and have perused the material on record.

10. The afore-narrated facts are not in dispute. They are a matter of record. Five facets starkly emerge from the complaint.

- **The consent of the petitioner was not obtained for the change of type of surgery;**
- **Catheter is inserted on the wrong side without the consent of the petitioner;**
- **H.D. Catheter was again inserted when permission/consent was obtained for perma Catheter;**
- **Surgery was performed by the duty Doctor instead of the surgeon;** and

- **The Doctors have allegedly failed to take corrective measures to alleviate the deteriorating condition of the patient in the emergency.**

11. Heavy reliance is placed on the judgment of the Apex Court in the case of **JACOB MATHEW v. STATE OF PUNJAB**[1]. In the said judgment the Apex Court has laid down certain guidelines for prosecuting medical professionals. The guidelines are found at paragraphs 48 to 52. They read as follows:

> *"….. …. ….*
>
> ***Conclusions summed up***
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> **48.** We sum up our conclusions as under:
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> (*1*) Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence as given in *Law of Torts*, Ratanlal&Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: "duty", "breach" and "resulting damage".

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[1] (2005) 6 SCC 1

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

(*3*) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that

branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.

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

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

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

(*7*) To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

(*8*) *Res ipsa loquitur* is only a rule of evidence and operates in the domain of civil law, especially in cases of torts and helps in determining the onus of

proof in actions relating to negligence. It cannot be pressed in service for determining *per se* the liability for negligence within the domain of criminal law. *Res ipsa loquitur* has, if at all, a limited application in trial on a charge of criminal negligence.

49. In view of the principles laid down hereinabove and the preceding discussion, we agree with the principles of law laid down in *Dr. Suresh Gupta case* [(2004) 6 SCC 422: 2004 SCC (Cri) 1785] and reaffirm the same. *Ex abundanti cautela*, we clarify that what we are affirming are the legal principles laid down and the law as stated in *Dr. Suresh Gupta case* [(2004) 6 SCC 422: 2004 SCC (Cri) 1785]. We may not be understood as having expressed any opinion on the question whether on the facts of that case the accused could or could not have been held guilty of criminal negligence as that question is not before us. We also approve of the passagefrom *Errors, Medicine and the Law* by Alan Merry and Alexander McCall Smith which has been cited with approval in *Dr. Suresh Gupta case* [(2004) 6 SCC 422: 2004 SCC (Cri) 1785] (noted vide para 27 of the Report).

Guidelines — Re: prosecuting medical professionals

50. As we have noticed hereinabove that the cases of doctors (surgeons and physicians) being subjected to criminal prosecution are on an increase. Sometimes such prosecutions are filed by private complainants and sometimes by the police on an FIR being lodged and cognizance taken. The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to a rash or negligent act within the domain of criminal law under Section 304-A IPC. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment. He has to seek bail to escape arrest, which may or may not be granted to him. At the end he may be exonerated by acquittal or discharge but the loss which he has suffered to his reputation cannot be compensated by any standards.

51. We may not be understood as holding that doctors can never be prosecuted for an offence of which rashness or negligence is an essential ingredient. All that we are doing is to emphasise the need for care and caution in the interest of society; for, the service which the medical profession renders to human beings is probably the noblest of all, and hence there is a need for protecting doctors from frivolous or unjust prosecutions. Many a complainant prefer recourse to criminal process as a tool for pressurising the medical professional for extracting uncalled for or unjust compensation. Such malicious proceedings have to be guarded against.

52. Statutory rules or executive instructions incorporating certain guidelines need to be framed and issued by the Government of India and/or the State Governments in consultation with the Medical Council of India. So long as it is not done, we propose to lay down certain guidelines for the future which should govern the prosecution of doctors for offences of which criminal rashness or criminal negligence is an ingredient. A private complaint may not be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service, qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying the Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)] test to the facts collected in the investigation. A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been levelled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor proceeded against would not

> **make himself available to face the prosecution unless arrested, the arrest may be withheld."**
>
> (Emphasis supplied)

The Apex Court delineates the delicate balance between holding medical professionals accountable and shielding them from vexatious prosecution.

12. Subsequently, in the case of **MARTIN F.D'SOUZA v. MOHD. ISHFAQ**[2], the Apex Court clarified that whenever a complaint is filed against a Doctor, the criminal Court should refer the matter to a competent Doctor or committee of Doctors, specialized in the field, relating to which the medical negligence is attributed. The Apex Court holds as follows:

> **"41.** As observed by the Supreme Court in *Jacob Mathew case* [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] : (SCC pp. 22-23, paras 28-29)
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> > "*28*. A medical practitioner faced with an emergency ordinarily tries his best to redeem the patient out of his suffering. He does not gain anything by acting with negligence or by omitting to do an act. Obviously, therefore, it will be for the complainant to clearly make out a case of negligence before a medical practitioner is charged with or proceeded against criminally. A surgeon with shaky hands under fear of legal action cannot perform a successful operation and a

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[2] (2009) 3 SCC 1

quivering physician cannot administer the end-dose of medicine to his patient.

29. If the hands be trembling with the dangling fear of facing a criminal prosecution in the event of failure for whatever reason—whether attributable to himself or not, neither can a surgeon successfully wield his life-saving scalpel to perform an essential surgery, nor can a physician successfully administer the life-saving dose of medicine. Discretion being the better part of valour, a medical professional would feel better advised to leave a terminal patient to his own fate in the case of emergency where the chance of success may be 10% (or so), rather than taking the risk of making a last ditch effort towards saving the subject and facing a criminal prosecution if his effort fails. Such timidity forced upon a doctor would be a disservice to society."

… … ….

Protection to doctors in criminal cases

47. In para 52 of Jacob Mathew case [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] the Supreme Court realising that doctors have to be protected from frivolous complaints of medical negligence, has laid down certain rules in this connection : (SCC p. 35)

"(i) A private complaint should not be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor.

(ii) The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion, preferably from a doctor in government service, qualified in that branch of medical practice who can normally be expected to give an impartial opinion applying the Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test.

(iii) A doctor accused of negligence should not be arrested in a routine manner simply because a

charge has been levelled against him. Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest should be withheld.

Precautions which doctors/hospitals/nursing homes should take

(a) Current practices, infrastructure, paramedical and other staff, hygiene and sterility should be observed strictly. Thus, in Sarwat Ali Khan v. Prof. R. Gogi [OP No. 181 of 1997 decided on 18-7-2007 (NC)] the facts were that out of 52 cataract operations performed between 26-9-1995 and 28-9-1995 in an eye hospital, 14 persons lost their vision in the operated eye. An enquiry revealed that in the operation theatre two autoclaves were not working properly. This equipment is absolutely necessary to carry out sterilisation of instruments, cotton, pads, linen, etc. and the damage occurred because of its absence in working condition. The doctors were held liable.

(b) No prescription should ordinarily be given without actual examination. The tendency to give prescription over the telephone, except in an acute emergency, should be avoided.

(c) A doctor should not merely go by the version of the patient regarding his symptoms, but should also make his own analysis including tests and investigations where necessary.

(d) A doctor should not experiment unless necessary and even then he should ordinarily get a written consent from the patient.

(e) An expert should be consulted in case of any doubt. Thus, in Indrani Bhattacharjee [OP No. 233 of 1996 decided on 9-8-2007 (NC)] , the patient was diagnosed as having "mild lateral wall ischaemia". The

doctor prescribed medicine for gastroenteritis, but he expired. It was held that the doctor was negligent as he should have advised consulting a cardiologist in writing.

(f) Full record of the diagnosis, treatment, etc. should be maintained.

… … ….

65. From the aforementioned principles and decisions relating to medical negligence, with which we agree, it is evident that doctors and nursing homes/hospitals need not be unduly worried about the performance of their functions. *The law is a watchdog, and not a bloodhound*, and as long as doctors do their duty with reasonable care they will not be held liable even if their treatment was unsuccessful. However, every doctor should, for his own interest, carefully read the Code of Medical Ethics which is part of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 issued by the Medical Council of India under Section 20-A read with Section 3(*m*) of the Indian Medical Council Act, 1956.

… … …

102. While this Court has no sympathy for doctors who are negligent, it must also be said that frivolous complaints against doctors have increased by leaps and bounds in our country particularly after the medical profession was placed within the purview of the Consumer Protection Act. To give an example, earlier when a patient who had a symptom of having a heart attack would come to a doctor, the doctor would immediately inject him with morphia or pethidine injection before sending him to the Cardiac Care Unit (CCU) because in cases of heart attack time is the essence of the matter. However, in some cases the patient died before he reached the hospital. After the medical profession was brought under the Consumer Protection Act vide *Indian Medical Assn.* v. *V.P. Shantha* [(1995) 6 SCC 651] , doctors who administer morphia or pethidine injection are often blamed and cases of medical negligence are filed against them. The result is that many doctors have stopped giving (even as family physicians) morphia or pethidine injection even in emergencies despite the fact that from the symptoms the

doctor honestly thought that the patient was having a heart attack. This was out of fear that if the patient died the doctor would have to face legal proceedings.

103. Similarly in cases of head injuries (which are very common in roadside accidents in Delhi and other cities) earlier the doctor who was first approached would start giving first aid and apply stitches to stop the bleeding. However, now what is often seen is that doctors out of fear of facing legal proceedings do not give first aid to the patient, and instead tell him to proceed to the hospital by which time the patient may develop other complications.

104. Hence courts/Consumer Fora should keep the above factors in mind when deciding cases related to medical negligence, and not take a view which would be in fact a disservice to the public. The decision of this Court in *Indian Medical Assn.* v. *V.P. Shantha* [(1995) 6 SCC 651] should not be understood to mean that doctors should be harassed merely because their treatment was unsuccessful or caused some mishap which was not necessarily due to negligence. In fact in the aforesaid decision it has been observed (vide SCC para 22): (*V.P. Shantha case* [(1995) 6 SCC 651] , SCC p. 665)

> "*22*. In the matter of professional liability professions differ from other occupations for the reason that professions operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond the professional man's control."

105. It may be mentioned that All India Institute of Medical Sciences has been doing outstanding research in stem cell therapy for the last eight years or so for treating patients suffering from paralysis, terminal cardiac condition, parkinsonism, etc. though not yet with very notable success. This does not mean that the work of stem cell therapy should stop, otherwise science cannot progress.

106. We, therefore, direct that whenever a complaint is received against a doctor or hospital by the Consumer Fora (whether District, State or

National) or by the criminal court then before issuing notice to the doctor or hospital against whom the complaint was made the Consumer Forum or the criminal court should first refer the matter to a competent doctor or committee of doctors, specialised in the field relating to which the medical negligence is attributed, and only after that doctor or committee reports that there is a prima facie case of medical negligence should notice be then issued to the doctor/hospital concerned. This is necessary to avoid harassment to doctors who may not be ultimately found to be negligent. We further warn the police officials not to arrest or harass doctors unless the facts clearly come within the parameters laid down in *Jacob Mathew case* [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] , otherwise the policemen will themselves have to face legal action.

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111. The courts and the Consumer Fora are not experts in medical science, and must not substitute their own views over that of specialists. It is true that the medical profession has to an extent become commercialised and there are many doctors who depart from their Hippocratic oath for their selfish ends of making money. However, the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence just because of some bad apples.

112. It must be remembered that sometimes despite their best efforts the treatment of a doctor fails. For instance, sometimes despite the best effort of a surgeon, the patient dies. That does not mean that the doctor or the surgeon must be held to be guilty of medical negligence, unless there is some strong evidence to suggest that he is."

(Emphasis supplied)

The Apex Court holds about precaution that has to be taken by a Doctor. The Apex Court further enshrines the principle that no Doctor should face ignominy of criminal process, unless credible medical opinion supports the allegation.

13. The other issue that would emerge is not obtaining of the consent from the petitioner for change in the procedure. The Apex Court in the case of **SAMIRA KOHLI v. DR. PRABHA MANCHANDA**[3] has summarized the principles of consent. The Apex Court holds as follows:

> "…. …. ….
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> **48.** Having regard to the conditions obtaining in India, as also the settled and recognised practices of medical fraternity in India, we are of the view that to nurture the doctor-patient relationship on the basis of trust, the extent and nature of information required to be given by doctors should continue to be governed by the Bolam test rather than the "reasonably prudential patient" test evolved in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] . It is for the doctor to decide, with reference to the condition of the patient, nature of illness, and the prevailing established practices, how much information regarding risks and consequences should be given to the patients, and how they should be couched, having the best interests of the patient. A doctor cannot be held negligent either in regard to diagnosis or treatment or in disclosing the risks involved in a particular surgical procedure or treatment, if the doctor has acted with normal care, in accordance with a recognised

[3] (2008) 2 SCC 1

practice accepted as proper by a responsible body of medical men skilled in that particular field, even though there may be a body of opinion that takes a contrary view. Where there are more than one recognised school of established medical practice, it is not negligence for a doctor to follow any one of those practices, in preference to the others.

49. We may now summarise principles relating to consent as follows:

(*i*) A doctor has to seek and secure the consent of the patient before commencing a "treatment" (the term "treatment" includes surgery also). The consent so obtained should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what he is consenting to.

(*ii*) The "adequate information" to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not. This means that the doctor should disclose (*a*) nature and procedure of the treatment and its purpose, benefits and effect; (*b*) alternatives if any available; (*c*) an outline of the substantial risks; and (*d*) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

(*iii*) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorised additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorised, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorised procedure until patient regains consciousness and takes a decision.

(*iv*) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(*v*) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment.

50. We may note here that courts in Canada and Australia have moved towards *Canterbury* [464 F 2d 772 : 150 US App DC 263 (1972)] standard of disclosure and informed consent, vide *Reibl* v. *Hughes* [(1980) 114 DLR 3d 1 : (1980) 2 SCR 880 : (1980) 2 RSC 880 (Can SC)] decided

> by the Canadian Supreme Court and *Rogers* v. *Whitaker* [109 ALR 625 : 67 ALJR 47 : (1993) 4 Medical Law Rep 79 (1992)] decided by the High Court of Australia. Even in England there is a tendency to make the doctor's duty to inform more stringent than Bolam test adopted in *Sidaway* [1985 AC 871: (1985) 2 WLR 480: (1985) 1 All ER 643 (HL)]. Lord Scarman's minority view in *Sidaway* [1985 AC 871: (1985) 2 WLR 480: (1985) 1 All ER 643 (HL)] favouring *Canterbury* [464 F 2d 772: 150 US App DC 263 (1972)], in course of time, may ultimately become the law in England. A beginning has been made in *Bolitho* v. *City and Hackney Health Authority* [1998 AC 232 : (1997) 3 WLR 115 : (1997) 4 All ER 771 (HL)] and *Pearce* v. *United Bristol Healthcare NHS Trust* [(1999) 48 BMLR 118 : (1999) PIQR 53 : (1999) ECC 167] . We have, however, consciously preferred the "real consent" concept evolved in *Bolam* [(1957) 1 WLR 582 : (1957) 2 All ER 118] and *Sidaway* [1985 AC 871 : (1985) 2 WLR 480 : (1985) 1 All ER 643 (HL)] in preference to the "reasonably prudent patient test" in *Canterbury* [464 F 2d 772: 150 US App DC 263 (1972)] , having regard to the ground realities in medical and health care in India. But if medical practitioners and private hospitals become more and more commercialised, and if there is a corresponding increase in the awareness of patient's rights among the public, inevitably, a day may come when we may have to move towards *Canterbury* [464 F 2d 772: 150 US App DC 263 (1972)] . But not for the present."
>
> (Emphasis supplied)

The Apex Court reaffirms the sanctity of informed consent and holds that no deviation from an agreed procedure is permissible, save for dire emergencies. It holds that consent given for a specific treatment/procedure cannot be taken for conducting some other treatment or procedure.

14. The Apex Court, further, in the case of **NIZAM'S INSTITUTE OF MEDICAL SCIENCES v. PRASANTH S. DHANANKA**[4] holds that consent given for excision biopsy does not mean consent for removal of tumour mass and it cannot be implied. The Apex Court holds as follows:–

"…. …. ….

> **39.** Allied to this finding is the question as to whether the required consent for the excision of the tumour had been taken from the complainant or his parents. The Commission has noted that some discussion between the complainant, his parents and Dr. Satyanarayana had taken place in the OPD and the possibility of deferring the operation had been mooted but notwithstanding this discussion, the complainant had been admitted to the hospital on 19-10-1990 and operated upon on 23-10-1990.
>
> **40.** The Commission has observed that as blood had been donated by the relatives of the complainant, it was likely that they had the information that a surgery was planned, as they were educated and enlightened persons. **The Commission has, accordingly, held on the basis of the evidence of Dr. Satyanarayana "that once the consent for excision biopsy through thoracotomy was given, the consent for a moment (sic removal) of the mass was implied".**
>
> **41.** We see from the cross-examination of the complainant that no consent for the operation had been taken. Moreover, it is significant that even though the record of the case had been produced before the Commission, it was with some reluctance and after several specific orders,

[4] **(2009) 6 SCC 1**

but the written consent which had allegedly been taken is not a part of the record.

42. It is equally significant that in the written submissions which had been filed, a copy of the consent form of NIMS has been appended but not the actual consent taken from the complainant. It must, therefore, be held that the withholding of the aforesaid document raises a presumption against NIMS and the attending doctors. We find that the consent given by the complainant for the excision biopsy cannot, by inference, be taken as an implied consent for a surgery (save in exceptional cases), as held by this Court in *Samira Kohli* v. *Dr. Prabha Manchanda* [(2008) 2 SCC 1] .

43. The two issues in *Samira Kohli case* [(2008) 2 SCC 1] which are relevant for our purpose and raised before the Bench were: (SCC p. 15, para 17)

> "(*i*) Whether informed consent of a patient is necessary for surgical procedure involving removal of reproductive organs? If so, what is the nature of such consent?
>
> (*ii*) When a patient consults a medical practitioner, whether consent given for diagnostic surgery can be construed as consent for performing additional or further surgical procedure—either as conservative treatment or as radical treatment—without the specific consent for such additional or further surgery?"

These two questions were answered in the following terms: (SCC pp. 16-18, paras 18 & 21)

> **"*18*. Consent in the context of a doctor-patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. For example, when a patient enters a dentist's clinic and sits in the dental chair, his consent is implied for examination, diagnosis and consultation. *Except where consent can be clearly and obviously implied, there should be express***

***consent*. There is, however, a significant difference in the nature of express consent of the patient, known as 'real consent' in UK and as 'informed consent' in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and 'real' when (*i*) the patient gives it voluntarily without any coercion; (*ii*) the patient has the capacity and competence to give consent; and (*iii*) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. On the other hand, the concept of 'informed consent' developed by American courts, while retaining the basic requirements of consent, shifts the emphasis on the doctor's duty to disclose the necessary information to the patient to secure his consent.** 'Informed consent' is defined in *Taber's Cyclopedic Medical Dictionary* thus:

> '*Consent that is given by a person after receipt of the following information: the nature and purpose of the proposed procedure or treatment; the expected outcome and the likelihood of success; the risks; the alternatives to the procedure and supporting information regarding those alternatives; and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment. Also included are instructions concerning what should be done if the procedure turns out to be harmful or unsuccessful*.'
>
> (emphasis supplied)

* * *

21. The next question is whether in an action for negligence/battery for performance of an unauthorised surgical procedure, the doctor can put forth as defence the consent given for a particular operative procedure, as consent for any additional or further operative procedures performed in the interests of the patient. In *Murray* v. *McMurchy*[(1949) 2 DLR 442: (1949) 1 WWR 989] the Supreme Court of British Columbia, Canada, was considering a claim for battery by a patient who underwent a caesarean section. During the course of caesarean section, the doctor found fibroid tumours in the patient's uterus. Being of the view that such tumours would be a danger in case of future pregnancy, he performed a sterilisation operation. The Court upheld

the claim for damages for battery. It held that sterilisation could not be justified under the principle of necessity, as there was no immediate threat or danger to the patient's health or life and it would not have been unreasonable to postpone the operation to secure the patient's consent. The fact that the doctor found it convenient to perform the sterilisation operation without consent as the patient was already under general anaesthesia, was held to be not a valid defence. A somewhat similar view was expressed by the Court of Appeal in England in *F. (Mental Patient: Sterilisation), In re* [(1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)] , and the Supreme Court of Nova Scotia, Canada in *Marshall* v. *Curry* [(1933) 3 DLR 260 : 60 CCC 136] . It was held that the additional or further treatment which can be given (outside the consented procedure) should be confined to only such treatment as is necessary to meet the emergency, and as such needs to be carried out at once and before the patient is likely to be in a position to make a decision for himself. Lord Goff observed: (AC pp. 76 H-77 B)

> '… Where, for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures.' "

44. The Court in *Samira Kohli case* [(2008) 2 SCC 1] also considered the possibility that had the patient been conscious during surgery and in a position to give his consent, he might have done so to avoid a second surgery but observed that this was a non-issue as the patient's right to decide whether he should undergo surgery was inviolable. This is what the Court had to say: (*Samira Kohli case* [(2008) 2 SCC 1] , SCC pp. 18-19, para 23)

> "*23*. It is quite possible that had the patient been conscious, and informed about the need for the additional procedure, the patient might have agreed to it. It may be that the additional procedure is beneficial

> and in the interests of the patient. It may be that postponement of the additional procedure (say removal of an organ) may require another surgery, whereas removal of the affected organ during the initial diagnostic or exploratory surgery, would save the patient from the pain and cost of a second operation. Howsoever practical or convenient the reasons may be, they are not relevant. What is relevant and of importance is the inviolable nature of the patient's right in regard to his body and his right to decide whether he should undergo the particular treatment or surgery or not. Therefore at the risk of repetition, we may add that unless the unauthorised additional or further procedure is necessary in order to save the life or preserve the health of the patient and it would be unreasonable (as contrasted from being merely inconvenient) to delay the further procedure until the patient regains consciousness and takes a decision, a doctor cannot perform such procedure without the consent of the patient."
>
> **45.** It is clear from the evidence in the case before us that there was no urgency in the matter as the record shows that discussions for the deferment of the proposed excision biopsy had taken place between the complainant, his parents and Dr. Satyanarayana in the OPD and the consent for the procedure had been obtained. Also in the light of the observations in the cited cases, any implied consent for the excision of the tumour cannot be inferred."
>
> (Emphasis supplied)

15. The Apex Court has further held that consent is not required in exceptional circumstances, when surgery is required to be performed for saving the life or health of a patient in the case of

S.K. JHUNJHUNWALA v. DHANWANTI KAUR[5]**,** wherein it is held as follows:

"….. …. ….

> **27.** According to Respondent 1, the appellant could not have done so because she had not given her consent to him to perform this surgery on her. In other words, according to Respondent 1, she had given her express consent in writing to perform only "laparoscopy surgery" but the appellant instead of performing "laparoscopy surgery" proceeded to perform conventional surgery and in that process removed her gall bladder. It is due to this reason, according to Respondent 1, a clear case of negligence on the part of the appellant is made out which entitles Respondent 1 to claim compensation in terms of money.
>
> **28.** The State Commission did not accept the aforementioned submission of Respondent 1 but this submission found favour to the National Commission for holding the appellant guilty of negligence in performance of his duty in performing the surgery. We do not agree with the reasoning of the National Commission on this issue for more than one reason mentioned below.
>
> **29.** First, Clause 4 of the Consent Form dated 7-8-1996 at p. 282 of the SLP paper book, which is duly signed by Respondent 1, in clear terms, empowers the performing doctor to perform such additional operation or procedure including the administration of a blood transfusion or blood plasma as they or he may consider substitute necessary or proper in the event of any emergency or if any anticipated condition is discovered during the course of the operation.
>
> **30. Second, in terms of Clause 4 of the Consent Form, the appellant was entitled to perform the conventional surgery as a substitute to the former one having noticed some abnormalities at the time of performing laparoscopy that it would not be possible**

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[5] (2019) 2 SCC 282

for the team of doctors attending Respondent 1 to continue further with laparoscopy of the gall bladder.

31. In other words, we are of the view that there was no need to have another consent form to do the conventional surgery in the light of authorisation contained in Clause 4 itself because the substitute operation was of the same organ for which the former one was advised except with a difference of another well-known method known in medical subject to get rid of the malady.

32. Third, there is an evidence on record and we are inclined to accept the evidence that the appellant having noticed while performing laparoscopy that there was some inflammation, adhesion and swelling on gall bladder, he came out of operation theatre and informed Respondent 1's husband who was sitting outside the operation theatre about what the condition of Respondent 1's gall bladder was, and sought his consent to perform the substitute operation. It is only after the consent was given by the husband of Respondent 1, the appellant proceeded to do conventional surgery.

33. In our opinion, there is no reason to disbelieve this fact stated by the appellant in his evidence. It is, in our opinion, a natural conduct and the behaviour of any prudent doctor, who is performing the operation to apprise the attending persons of what he noticed in the patient and then go ahead accordingly to complete the operation.

34. It is not the case of Respondent 1 that her husband was neither present in the hospital on that day nor was he not sitting outside the Operation Theatre and nor he ever met the appellant on that day. In our opinion, a clear case of grant of consent to the appellant to perform the substituted operation of gall bladder of Respondent 1 was, therefore, made out to enable the appellant to perform the conventional surgery, which he actually performed.

35. The National Commission while recording the finding on the issue of consent against the appellant

relied upon the decision of this Court in *Samira Kohli* v. *Prabha Manchanda* [*Samira Kohli* v. *Prabha Manchanda*, (2008) 2 SCC 1 : (2008) 1 SCC (Civ) 421] . In our view, the said decision itself has made an exception to the cases observing in para 49 of the judgment which reads as under : (SCC p. 29)

> **"*49*. … (*iii*) … The only exception to this rule is where the additional procedure though unauthorised, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorised procedure until patient regains consciousness and takes a decision."**

36. In our opinion, the case of the appellant also falls in the excepted category mentioned by this Court because the appellant having noticed the abnormalities in the gall bladder while performing laparoscopy surgery proceeded to perform the conventional surgery and that too after obtaining fresh consent of Respondent 1's husband. In other words, it was not an unauthorised act of the appellant and he could legally perform on the basis of original consent (Clause 4) of Respondent 1 as also on the basis of the further consent given by Respondent 1's husband.

37. That apart, we also find that Respondent 1 never raised the objection of "consent issue" to the appellant or/and opposite party Respondent 2 hospital and it was for the first time in the complaint, she raised this issue and made a foundation to claim compensation from the appellant. **Nothing prevented her or her husband to raise the issue of consent immediately after performance of the surgery while she was in hospital as an indoor patient and even after discharge that being the natural conduct of any patient. It was, however, not done**."

(Emphasis supplied)

16. If the principles summarised by the Apex Court from **JACOB MATHEW** to **S.K.JHUNJHUNWALA** are considered on the bedrock of the facts obtaining in the case at hand, they undoubtedly meet the guidelines so laid down *qua prima facie* medical negligence. Whether the crime should be directed to be registered in such a case is also considered by the 5 Judge Bench of the Apex Court in the case of **LALITA KUMARI v. GOVERNMENT OF U.P**.[6] The Apex Court holds as follows:

> ***"Exceptions***
>
> **115.** Although, we, in unequivocal terms, hold that Section 154 of the Code postulates the mandatory registration of FIRs on receipt of all cognizable offences, yet, there may be instances where preliminary inquiry may be required owing to the change in genesis and novelty of crimes with the passage of time. One such instance is in the case of allegations relating to medical negligence on the part of doctors. It will be unfair and inequitable to prosecute a medical professional only on the basis of the allegations in the complaint.
>
> … … …
>
> ***Conclusion/Directions***
>
> **120.** In view of the aforesaid discussion, we hold:
>
> **120.1.** The registration of FIR is mandatory under Section 154 of the Code, if the information discloses commission of a cognizable offence and no preliminary inquiry is permissible in such a situation.

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[6] (2014) 2 SCC 1

120.2. If the information received does not disclose a cognizable offence but indicates the necessity for an inquiry, a preliminary inquiry may be conducted only to ascertain whether cognizable offence is disclosed or not.

120.3. If the inquiry discloses the commission of a cognizable offence, the FIR must be registered. In cases where preliminary inquiry ends in closing the complaint, a copy of the entry of such closure must be supplied to the first informant forthwith and not later than one week. It must disclose reasons in brief for closing the complaint and not proceeding further.

120.4. The police officer cannot avoid his duty of registering offence if cognizable offence is disclosed. Action must be taken against erring officers who do not register the FIR if information received by him discloses a cognizable offence.

120.5. The scope of preliminary inquiry is not to verify the veracity or otherwise of the information received but only to ascertain whether the information reveals any cognizable offence.

120.6. As to what type and in which cases preliminary inquiry is to be conducted will depend on the facts and circumstances of each case. The category of cases in which preliminary inquiry may be made are as under:

(*a*) Matrimonial disputes/family disputes
(*b*) Commercial offences
(*c*) Medical negligence cases
(*d*) Corruption cases
(*e*) Cases where there is abnormal delay/laches in initiating criminal prosecution, for example, over 3 months' delay in reporting the matter without satisfactorily explaining the reasons for delay.

The aforesaid are only illustrations and not exhaustive of all conditions which may warrant preliminary inquiry.

> **120.7** While ensuring and protecting the rights of the accused and the complainant, a preliminary inquiry should be made time-bound and in any case it should not exceed fifteen days generally and in exceptional cases, by giving adequate reasons, six weeks' time is provided. The fact of such delay and the causes of it must be reflected in the General Diary entry.
>
> **120.8.** Since the General Diary/Station Diary/Daily Diary is the record of all information received in a police station, we direct that all information relating to cognizable offences, whether resulting in registration of FIR or leading to an inquiry, must be mandatorily and meticulously reflected in the said diary and the decision to conduct a preliminary inquiry must also be reflected, as mentioned above."
>
> (Emphasis supplied)

The Apex Court holds that a preliminary inquiry would be required in six categories of cases. One such category is medical negligence case. Whether the preliminary inquiry is conducted or not in the case at hand, is again a matter of record.

17. In the wake of the petitioner's insistence for registration of a crime, a Committee is constituted/appointed by the respondents to look into the problem as to whether there is negligence or not. The report of the Committee is as follows:

> "Committee has gone through the records and following are the observations:

Mr. M.C. Mahadeva aged about 65 years male is diagnosed as Chronic Kidney Disease (Renal Biopsy proven Chronic interstitial Nephritis) undergoing hemodialysis through temporary right internal jugular vein catheter.

He was admitted at G.M. Hospital on 04-04-2024 at 11.08 a.m. for Permacath insertion which is necessary for all Chronic Kidney Disease patients who are undergoing hemodialysis before AV fistula creation.

As per the records he was posted for Permacath insertion on the same day at 3.00 pm.

Nurse's note (Page No.15) revealed that patients received from 1st floor OT at 3.45 p.m. Right permacath insertion by Vascular Surgeon was abandoned due to presence of thrombus in Right Jugular vein which was informed to Nephrologists.

At MICU left lJC insertion done at 6.30 p.m. then shifted to ward.

Post procedure, Chest X-ray page No.29 provided by G.M. Hospital showed ectopic position of left lJC (our observation).

For the above procedure proper consent form was not available in the records provided. Hemodialysis order was given by Nephrologist on same day. No records were available in the documents whether HD done or not.

On 05-04-2024 patient was discharged with stable vitals.

Patient got admitted at Fortis Hospital on 05-04-2024. (Document showed that he was referred for Permacath insertion by outside hospital without reference letter from GM hospital).

After proper consent patient was taken up for Permacath insertion in Cath lab.

Left lJV was canulated under ultrasound and fluoroscopic guidance with left lJV HD catheter in situ (which was put at outside hospital) and Permacath was inserted by vascular surgeon at Fortis hospital on 05-04-2024.

During this procedure priorly inserted left lJV HD Catheter at outside hospital slipped out. Patient immediately developed Hemopneumothorax with fall of blood pressure.

They suspected tear in subclavian vein with punctured pleura.

Emergency left lCD insertion was done by CTVS team.

Patient was intubated and taken immediately to Cath Lab for Left Subclavian vein stenting. During the procedure patient had 2 episodes of Cardiac asystole (page No.25) which was treated appropriately.

Subsequently patient developed post Hypoxic sequele then patient managed with hemodialysis and other proper measures.

Patient had Gl Bleeding & Malena which was managed by medical gastroenterologist and also septicemia which was treated appropriately.

Patient continued to deteriorate and died on 15-04-2024 at 8.50 p.m. due to possibility of sepsis with septic shock.

Opinion:

Hemopneumothorax is well known complication of internal jugular vein catheter insertion.

Permacath is necessary for all CKD patients who are undergoing dialysis. Photocopy of Chest X-ray provided in the documents showed that left lJC was not in proper position. (This can be confirmed by Radiologist).

And how to manage this improperly positioned lJC situation can be obtained by Vascular Surgeon."

(Emphasis added)

The Medical Committee constituted post facto, observes *inter alia* that the left internal jugular catheter was incorrectly positioned – a deviation not minor, but potentially fatal. When a jugular vein is cut or ruptured, most immediate symptom would be severe bleeding and is in medical domain that it would result in low blood pressure, difficulty in breathing and can sometimes lead to coronary thrombus. The report opines that Hemopneumothorax is well known complication of internal jugular vein catheter insertion. Permacath is necessary for all CKD patients and left lJC was not in proper position. Therefore, there is a rupture in the jugular vein.

18. It is further germane to notice the opinion of the Victoria Hospital dated 07-12-2024, which is rendered pursuant to a direction of this Court. The report is as follows:

"Hemopneumothorax is well known complication of internal jugular vein catheter insertion.

> **Permacath is necessary for all CKD patients who are undergoing dialysis photocopy of chest X-ray provided in the documents showed that Left IJC was IJC was not in proper position. (This can be confirmed by Radiologist)".**
>
> (Emphasis added)

The report confirms that the catheter caused Hemopneumothorax, a complication known, but avoidable with proper care.

19. When the sanctity of medical care is breached by alleged negligence, it is not merely a lapse of procedure, but a desecration of dignity inherent in human life. The patient, entrusting their vulnerability to the hands of the Doctor, becomes the silent victim of apathy. Their right to life of dignity gets extinguished, not by fate but by failure. In the mosaic of facts and the binding precedents quoted hereinabove, this Court finds it imperative to uphold the dignity of human life. The petitioner who has lost his father, under circumstances that cry for an investigation, cannot be left remediless. The petition thus deserves to succeed.

20. For the aforesaid reasons, the following:

O R D E R

(i) Writ petition is allowed.

(ii) *Mandamus issues* to the jurisdictional police – respondent No.4 to register a First Information Report on the basis of the petitioner's complaint and proceed further in accordance with law, within 2 weeks from the date of receipt of a copy of this order.

Sd/-
(M.NAGAPRASANNA)
JUDGE

bkp
CT:SS