NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 1941 OF 2017

1. DR. MANIK CHANDRA KHAN
S/O LATE HRISIKESH KHAN 65/55 TENTULTALA LANE
VILLAGE AND POST: MANKUNDU
HOOGHLY-712139
WEST BENGAL
2. DR. MANIK CHANDRA KHAN
.
3. GAURAV ROY
. .....Complainant(s)

Versus

1. DR. AMIT SAHA & 5 ORS.
M/S EXTENT MEDICAL & SURGICAL CENTRE 1032,
RUE-DE-CORDIERIE, BARABAZAR, CHANDANNAGAR,
HOOGHLY-712136
WEST BENGAL
2. DR. SOUBHIK PANJA
M/S EXTENT MEDICAL & SURGICAL CENTRE 1032,
RUE-DE-CORDIERIE, BARABAZAR, CHANDANNAGAR,
HOOGHLY-712136
WEST BENGAL
3. DR. PRITAM DATTAGUPTA
M/S EXTENT MEDICAL & SURGICAL CENTRE 1032,
RUE-DE-CORDIERIE, BARABAZAR, CHANDANNAGAR,
HOOGHLY-712136
WEST BENGAL
4. DR. ARNAB SINGHA
M/S EXTENT MEDICAL & SURGICAL CENTRE 1032,
RUE-DE-CORDIERIE, BARABAZAR, CHANDANNAGAR,
HOOGHLY-712136
WEST BENGAL
5. DR. RAJDEEP CHAKRABORTY
M/S EXTENT MEDICAL & SURGICAL CENTRE 1032,
RUE-DE-CORDIERIE, BARABAZAR, CHANDANNAGAR,
HOOGHLY-712136
WEST BENGAL
6. M/S EXTENT MEDICAL & SURGICAL CENTRE
1032, RUE-DE-CORDIERIE, BARABAZAR,
CHANDANNAGAR,
HOOGHLY-712136
WEST BENGAL .....Opp.Party(s)

BEFORE:
HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER
HON'BLE MR. BINOY KUMAR,MEMBER

For the Complainant :
For the Opp.Party :

Dated : 06 Apr 2023

ORDER

Appeared at the time of arguments

For the Complainant : Dr. Kunal Saha, A.R. with
Mr. Rabin Majumder, Advocate
Ms. Akansha Srivastava, Advocate
with Dr. Manik Ch. Khan, Complainant -1

For the Opp. Parties : Mr. Sanjay Kr. Ghosh, Advocate
Ms. Rupali Ghosh Advocate

Pronounced on: 6th April 2023

ORDER

DR. S.M. KANTIKAR, PRESIDING MEMBER

"Every death in an institutionalized environment of a hospital does not necessarily amount to medical negligence on a hypothetical assumption of lack of due medical care."[1]

1. The Present Complaint has been filed under section 21 (Read with Section 24-A) of the Consumer Protection Act, 1986 (for short "the Act") by Dr. Manik Chandra Khan & Gouranga Maji (hereinafter referred to as the 'Complainants') against M/s. Extent Medical and Surgical Centre & its 5 Doctors (hereinafter to be referred as the 'Opposite Parties') for alleged medical negligence causing death of daughter of the Complainant No.1.

The Complaint:

2. Ms. Sanchita Khan (since deceased herein referred to as a "Patient") was suffering from fever and on 26.10.2015 her father took her to Dr. Amit Saha (OP-1) at Extent Medical & Surgical Centre (OP-6) at Chandannagar. The OP-1 prescribed medicines and few lab investigations. The next day (27.10.2015), at 11 am, the patient's fever spiked to 105^0 F and it decreased around 2 pm. She had loose motion also which, stated by OP-1, was due to side effect of Moxclav (Amoxicillin). He admitted her in OP-6 hospital on 28.10.2015. It was alleged that the OP-1 visited the patient on the same day, but the time of visit was not specified. On 29.10.2015, the patient developed urticarial rash due to side effect of medicines and doctors changed the medicines, the Inj. Pause was stopped, and Inj. Corts was started. At 10.25 am, the OP-1 visited the patient, he did not discontinue Inj. Levosulpiride, as it was Sulphur-containing drug, and the patient had a known allergy to Sulpha drugs as recorded in the medical history. In the evening at 7.40 pm, OP-1 visited again but he did not inform the family of the patient's about her serious condition. Thereafter, on next day 30.10.2015, in the evening, the Complainant No.1 found that his daughter suffered respiratory distress, therefore he started examining the patient, but the nurse came and rashly snatched stethoscope from his hand and called OP-1. The patient's condition further deteriorated with shortness of breath and alleged that she was shifted to High Dependency Unit (HDU) instead of ICU and put on Oxygen by CPAP machine. On next day 31.10.2015, the OP-1 visited at 9.30 am, there was no improvement, but the serious condition was not

informed to her relatives. On next day i.e. 01.11.2015, the patient's condition worsened, and she was shifted to the High Dependency Unit (HDU) and placed on Oxygen by CPAP machine. The OP-1 did not visit the patient for more than 24 hours until the patient's death at 8.30 am. It was alleged that if ICU/ITU facility was not available at OP-6 hospital, the OP-1 should have referred the patient to another hospital. Thus, entirely it amounts to gross and willful negligence of OP-1 towards the serious patient.

3. The Complainants raised several other allegations like lack of informed consent, false qualification of the OP-1, manipulation of medical records, and mismanagement of the patient's care, not done proper investigations, failure to correct anemia and wrong medication etc. The quality of the chest X-ray was poor, and the ECG was conducted just before the patient's death, thus there was lack of proper monitoring and care. The Complainant No. 1 was not aware of that the OP-1 was not 'Physician'. He came to know from IMA, Chandannagar that OP- 1 was MD in Preventive & Social medicine (P& SM) and not a MD General medicine, but to mislead the patients, his prescription was printed as 'MD (Cal)'. In that case OP-1 should not have treated the patient under his care, but should have referred her to the Physician. The cause of death, was recorded as respiratory failure, community-acquired pneumonia, and bronchial asthma. Being aggrieved the Complainants filed this complaint and prayed Compensation amounting to Rs.4,69,81,448/- under different heads.

4. The Opposite Parties filed their written versions and denied the allegations. The OPs raised few preliminary objections that complainant was not a consumer, on limitation, exaggerated claim etc. The Complaint was filed afterthought beyond 2 years thus barred by limitation. The Complainants are not Consumer because it was filed by her father of deceased and he concealed several facts like her marital status, medical insurance and details of her employment. The employment certificate raises doubt on correctness of employment of the Sanchita. The Complaint was filed with highly exaggerated claim. The complainants have not filed expert opinion.

5. The OPs submitted that Dr. Amit Saha (OP-1) is a MBBS and passed M.D. in Preventive & Social Medicine in 1993. He has not made any false declaration or claimed himself as M.D. in General Medicine. The Complainants calling him as "a quack" was highly derogatory and defamatory. The OPs submitted that entire treatment was under the supervision of OP -1 to 5. The OPs submitted the chronology of treatment that- the patient took treatment from 3 doctors before coming to OP-1. She was a known Asthmatic, and diagnosed it as Broncho-Pneumonia-right side.. Initially, Dr. Rajdeep Chakraborty (OP-5) started treatment for Lower Respiratory Tract Infection (LRTI). The ABG report was informed by OP-5 to the OP-1 who advised moist Oxygen 2 ltr/min, Tab Clonazepam (0.5) stat, Syr. Macbery 10ml stat & TDS. Thereafter, the OP-1 visited the patient and noted the findings as Cough with blood tinged sputum, Temp 102^0 F, Chest has occasional Rhonchi, Pulse-124/min, BP-110/70 mm Hg and SPO_2-99% (2 L/min O_2). For loose motion prescribed Tab Decolic-1 Tab TDAC and stool exam with microscopy was advised. OP-5 later examined the patient and prescribed medication for cough and vomiting and advised lnj. Zofer 4mg 2 ampoules stat then 1 amp SOS and Alex Logenze SOS. At 9.30 pm OP-1 visited the patient and noted complaints of Cough, no dyspnea, high Tempt↑ 102°F, Chest was clear and advised lnj Pause (500 mg) IV TID and continued other medicines and Nebulization with Duolin & Budecort. The treatment continued under the supervision of OP-1 and OP-5. The patient was prescribed symptomatic drugs like Levosulpiride and Paracetamol (Neumol) by OP-1. The Injection Neumol (Paracetamol) was prescribed 500 mg IV 4 times and patient became afebrile. It was not an overdose of Paracetamol. There was no record of hypothermia. According to the literature the overdose of Injection if it was given more than 4000 mg / day.

6. On 30.10.2015 at 12.00 pm, Dr. **Pritam Dattagupta (OP-3)**, examined the patient and noted Crepts in both lungs, shortness of breath (SOB), Orthopnea, and an SPO_2-86-88% at rest. He advised to continue moist O_2 at the rate of 2L/min. At 1.15 pm O.P.No.3 again examined her and findings were same, then he advised Tab Sorbitrate 5 one stat. On 01/11/2015 at 6:30 am suction was done and she was again put back on non-invasive ventilation. At 7.20 am the OP-2 on duty Medical Office noted sudden deteriorating condition of the patient. Her SPO_2 became 40%, Pulse Rate 67/min, BP was not recordable. The Cardio-pulmonary resuscitation (CPR) was started and she was put on mechanical ventilation after obtaining telephonic consent from her father. The consent form for intubation and ventilation was signed by the patient's husband Mr. Goutanga Maji. The Complainant No.1 came to nursing home around 8 am, saw his daughter on mechanical ventilation and found her alive as he himself examined her. At 8.10 am OP-2 noted persistent bradycardia and her blood pressure was not recordable. CPR was done and inj. Atropine and Adrenaline was given, but she did not recover and at 8.30 am declared dead.

7. The parties on both the completed their pleadings, filed written arguments with relevant medical literatures. We have heard the arguments from the parties.

8. **Arguments on behalf of Complainants**:

The Authorized representative (AR) Dr. Kunal Saha argued the matter; the Complainant No.1 was also present with him. AR argued on the following points:

i) Lack of informed consent:

He submitted that the first consent obtained on 25.10.2015 was *void- ab-initio* which bears signature of Complainant No. 1 only and none of the OPs signed it. The signature was taken by nurse at the time of admission of the patient to the nursing home. No Doctor was present to discuss or explain the pros and cons of treatment offered. As per the clinical notes the patient was conscious alert and cooperative thus fit for giving consent but they will not take informed consent from the patient. She was competent to decide what treatment had to be accepted or rejected. It was the act of omission and the OPs carried out all procedures in absence of valid consent. He further argued that so called second consent was obtained from the Complainant No. 2 -the husband of deceased on 1.11.2015 , it was also not signed by the doctor. It was obtained after death of the patient.

ii) **The fraud played by OP No 1. Dr. Amit Saha by furnishing misleading information:**

He further argued that Dr Amit Saha committed serious fraud, his letterheads bears M.D.(Cal) without specifying his actual speciality and the signboard at OP-6 Centre displayed his name as a Physician along with two other doctors. Actually he holds MD in P & SM but mentioned as a M.D. (Cal) only to mislead the patients. His name was also reflected as a critical care consultant. It was not a valid qualification recognised by MCI in the critical care medicine. The AR brought our attention to the code of medical ethics prescribed by West Bengal Medical Council 2002 as

"Do not claim to be a Specialist unless you have a special qualification in that branch. Once you say you are one, do not undertake work outside your specialty even for your friends".

Therefore, OP-1 was neither a physician nor a critical care consultant. He was committing fraud, unfair practices which deserves severe penalty.

iii) Serious mismanagement of the patient leading to her death.

AR submitted that total management of the patient was wrong. The hospital knowing well that Dr. Amit Shah was not a physician and their hospital was not well equipped, they would have referred the patient to other hospitals having better facility. There was no Respiratory Consultant or an Intensivist . Thus, it amounts to intentionally killing the patient by the treating with limited knowledge. It was a crime, to manage complex case of respiratory medicine by unqualified OP-1. The hospital violated the code of medical ethics of WBMC which denotes

> ***"In case of serious illness especially in doubtful or difficult condition the Physician should request consultations; in every consultation, the benefit of the patient is of primary importance. All Physicians interested should be candid with the patient, a member of his family or responsible friend".***

iv) He further argued that OP No.1 holding MD degree in Social and Preventive Medicine but posing himself as a Specialist in General Medicine i.e. a Physician or a Pulmonologist did not care for ABG Report (dated 28/10/15 at 11.03 AM) with Hb% 6.8 gm/dl. His pattern of writing Prescriptions and Clinical Notes itself indicate his deficiency and careless attitude towards the patient.

v) He further argued that the doctors failed to carry investigations to arrive at correct diagnosis. At the time of admission only ABG was performed but no other investigations like CBC, Widal, H1 N1 antigen and electrolytes performed. The MRI or CT scan and ECHO were not done though available at next door. The AR further argued that the medicines were wrongly given and not used judiciously. The patient was allergic to Sulpha drugs in spite of that patient was injected levosulpiride IV 3 times to daily. Its Chemical

formula is -**$C_{15}H_{23}N_3O_4S$[2].** This drug was used mainly in psychiatric disorders, may sometimes be used in gastro-esophageal reflux disorders and dyspepsia. The respiratory distress was due to adverse reaction of injection levosulpiride as it was contraindicated in asthma and in hypokalemia. The OP-1 unnecessarily gave injection Neumol 500 mg (paracetamol) IV 4 times daily when the fever was 101.2^0F just a tablet Paracetamol would have been sufficient. Moreover the temperature came down to the normal on the next day after admission but the injection Neumol 500 mg 4 times daily were continued till the death of the patient. Injection pause 500 mg IV 3 times a day that is Cinnamic acid ordinary used to stop heavy bleeding during the menstrual cycle. It was used in this patient without asserting bleeding time (BT) and clotting time (CT) when the patient showed blood tinged sputum. The OP-1 prescribed antibiotics, without any proper indication or justification and with negative Sputum culture report. As per clinical findings noted by OP-1, the patient was improving with SABA (Short Acting Beta Agonist e.g. Levoline or Levosalbutamol 0.63mg) and ICS (Inhaled Cortico Steroids e.g. Budicort or Budesonide 200 mg) and injection Cortico Steriod (inj. Hydrocortizone), which were already continuing. There was no justification of use of injection Aminophylline and drug Doxophylline.

9. He brought our attention to the Exhibits D7, D11 and D15 and the references from the text Book of Pharmacology by Goodman and Gillman 13th edition. As per clinical findings the patient was improving with ***SABA and ICS***. So, there was no justification of prescribing Inj. Aminophylline when there was clinical improvement with SABA and ICS. Serum Theophylline estimation was not done due to lack of knowledge and expertise during administration of Xanthine derivative drugs like Doxofyllin and Aminophyllin.

10. AR further argued that on 01/11/2015 the CPR was not done properly. Instead of resuscitating the patient, he was killed by administration of undiluted Inj Adrenaline through IV wrongly used Inj. Atropine. As per International norms simultaneous IV Atropine and Adrenaline is contra indicated. Inj. Adrenaline 2 ampoules was injected I.V. Stat at 8.10 AM without dilution and without the advice of RMO.

11. The AR pointed out the deficiency in ABG reporting. pH was 4.72 mentioned in hand written notes such blood pH is impossible, the patient will not survive with such pH. As per medical norms if the pH of blood goes above 7.8 and below 6.8 there will be severe interference in tissue oxygenation. Thus quality of report was questionable from OP-6 hospital. The ABG reports revealed not only disturbances in the blood pH but there were electrolyte disturbances which the doctors did not bother to correct, which indicate negligence and deficiency in service. The very pattern of his writing in the narrow blank space on the left side of his signature reveals suspected interpolation.

12. On lack of ICU care the AR argued that the patient was kept in General Ward and HDU, which proves that OP – 6 Nursing Home did not have any ICU and it is most unfortunate that such serious patient could not have access to ICU care. The OPs never bothered to transfer or shift the deceased patient to a better hospital with better and ICU facilities. He placed reliance on the case **Malay Kumar Ganguly vs Dr. Sukumar Mukherjee & Ors[3],** wherein the Hon'ble Supreme Court observed that, "In our opinion, if hospitals knowingly failed to provide some amenities that are fundamental for the patient, it would certainly amount to medical malpractice."

13. The AR argued that the 'Community Acquired Pneumonia' mentioned in the death certificate as antecedent cause of death, but the diagnosis was not based on any documentary medical evidence or clinical notes.

According to AR, entire episode indicates negligent attitude and high level of carelessness of the OPs in patient management.

14. **Arguments on behalf of Opposite Parties**:

During arguments learned counsel for OPs reiterated their details of treatment and patient care. He submitted that the patient had a history of fever since 20.10. 2015 and she took treatment and once admitted to nursing home on 23.10.2015 under the care of an ENT surgeon. She underwent diagnostic tests including an X-ray of her chest, which diagnosed her with pneumonia. However, the patient did not disclose the previous treatment received from the ENT. Her fever showed high spike to 105°F on 24.10.2015 and she consulted with Dr. Ghosh, MBBS. She was also treated on 26.10.2015 by her father. Few blood tests with

Malaria and Dengue tests were done again. On 27.10.2015, the patient's father took her to OP-6 Centre with all the lab investigations. He was aware of the available services and facilities at OP-6. He did not follow the advice of OP-1 but chose to undergo selective tests for his daughter. The ECHO and Genexpert test advised by OP-1 were not done.

15. The learned Counsel brought our attention to the medical record to prove that the patient was treated as per the standard norms. The OP-1 advised to stop inj. Doxofyllin and advised to start inj. Aminophylline 1 amp 8 hourly and to continue all other medicines. On 01.11.2015, the patient was in severe respiratory distress and OP-2 Dr. Soubhik Panja started CPR, Oropharyngeal suction, ETT insertion and administered Inj. atropine and inj. adrenaline each 1 amp IV stat. The mechanical ventilation was started, but unfortunately, the patient could not survive. The cause of death was declared to be respiratory failure in a case of community acquired pneumonia and asthma.

Discussion:

16. The WBMC passed an Order on 04.09.2018 and held that there was no medical negligence while treating the patient by Dr. Amit Saha (OP-1). The Complainant challenged the order of WBMC before the Board of Governors in Suppression of Medical Council of India, which affirmed the Order of WBMC. The relevant observation in the Order dated 18.09.2020 of the Ethics Committee of Board of Governors is reproduced as below:

> "The Committee further noted that after examination of the complaint and hearing all the concerned doctors, the WBMC passed an order dated 04.09.2018, the relevant part of WBMC is as under:
>
> The Council, at its meeting dated 14.06.2018 accepted the observations of the concerned P & E Cases Committee that
>
> (a) the concerned medical practitioner had a training in critical care medicine under the Department of Health & Family Welfare, Government of West Bengal.
>
> (b) he had correctly diagnosed the case and treatment given was correct.
>
> (c) the complainant accepted the cause of death as per death certificate.
>
> (d) there was no negligence on his part. However inspite of Dr. Amit Saha being a hold of MD (Preventive and Social Medicine), his use of MD in his prescription pad and not mentioning of his Registration No. thereon was a violation of Code of Medical Ethics and Dr. Saha be issued with a letter of caution for this violation."

Therefore, the Board of Governors did not find negligence of OP-1.

17. About the qualification and competence of OP-1, we have perused the certificate issued by Superintendent of District Hospital, Hoogly. It clearly stated that OP-1 has served as Medical Officer of ICCU for about 16 years at a tertiary care center Calcutta National Medical College & Hospital. He successfully treated all sorts of cardiac emergencies independently. Then in Nov 2013 he underwent training in Critical Care at S.S.K.M. Hospital. He has placed few certificates of participation in CCU management programs organized by SingHealth and Govt. of West Bengal. Since then he has been regularly keeping himself updated in Critical Care by faculties from Singapore General Hospital. Therefore, in our view, the OP-1 was competent for the medical management of patient. Mere displaying **M.D.(Cal)** is no way misleading or unfair, but his clinical experience and competence has been proved by the certificates . Moreover, his basic qualification is MBBS, thus stating him as a "QUACK" was an absurd allegation made by the Complainant who himself is a doctor- ENT specialist. In our considered view, OP-1 treated the patient as per the reasonable standard of care. Moreover there was no Physician available in Chandannagar during 'Durga Puja' vacations.

18. It should be borne in mind that **Levosulpiride** is not a sulpha drug, but it is a pro-kinetic agent frequently combined with Proton pump inhibitors like Omeprazole/ Pantoprazole. It can increase acetylcholine levels in the body. This combined action makes it effective in treating:

- Gastroesophageal reflux disease (GERD) – acid from the stomach moves back into the esophagus
- Abdominal discomfort – tenderness, pain, loss of appetite, indigestion (dyspepsia), heartburn, constipation, loose motions, etc.
- Irritable bowel syndrome (IBS)
- Unexplained headaches, especially after meals
- Nausea and vomiting caused by chemotherapy or other cancer treatment

The AR and the Complainant No.1 being doctors, misguided this Commission that though the patient was allergic to Sulpher (sulpha drug), the OP-1 continued drug Levosulpiride.

19. Secondly, on 31.10.2015 patient was prescribed injection **Neumol** (Paracetamol) 500 mg IV- QID (4 times a day). The patient became afebrile as a result of treatment only. It was continued to prevent rise of temperature which could lead to dehydration. As such patient did not suffer hypothermia. From the several medical literature, the overdose of Paracetamol is considered if it exceeds 4000 mg / day. Therefore, in our view the allegations of use of Levosulpiride and Neumol are not sustainable. It was an accepted reasonable practice. Thirdly, blood pH 4.72 appears to be an inadvertent error in writing, and by any stretch of imagination such values never observed in practice of medicine.

20. As per the clinical notes dated 01.11.2015 at 7.20 AM, the on duty Medical Officer (OP-2) noted the sudden deteriorating condition of patient. There was fall in Sp02, it was 40%, PR 67/min, BP was not recordable. Immediate CPR started. Oro-pharengeal suction done, endotracheal tube inserted and IV injection Atropine and Adrenaline given in dilution. As per medical literature, injection Adrenaline is recommended in cardiac arrest and should be given IV in normal saline. The Complainant was informed and consent for intubation and mechanical ventilation was obtained over phone. After the death of patient, the OP-1 was confronted by the hostile family members of the patient. The entire medical record was handed over along with X-ray and ECG along with the death certificate to the Complainant No.1 on the same day .

Reference to the precedents and Legal Principles:

Catena of judgments from Hon'ble Supreme Court and this Commission have explained about what constitutes medical negligence.

21. In judgment reported as **Arun Kumar Manglik v.Chirayu Health and Medicare Private Limited & Anr**[4]**,**the Hon'ble Supreme Court held as under:

> "45. In the practice of medicine, there could be varying approaches to treatment. There can be a genuine difference of opinion. However, while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to "defensive medicine" to avoid claims of negligence, often to the detriment of the patient. Hence, in a specific case where unreasonableness in professional conduct has been proven with regard to the circumstances of that case, a professional cannot escape liability for medical evidence merely by relying on a body of professional opinion."

22. In **C.P. Sreekumar (Dr.), MS (Ortho) v. S. Ramanujam**[5] and in **Jacob Mathew case**[6] held that the allegations in the complaint are inviolable truth even though they remained unsupported by any evidence. The onus to prove medical negligence lies largely on by leading cogent evidence. A mere averment in a complaint which is denied by the other side can, by no stretch of imagination, be said to be evidence by which the case of the complainant can be said to be proved. It is the obligation of the complainant to provide the *facta probanda* as well as the *facta probantia*.

23. In another case **Kusum Sharma and Others v. Batra Hospital and Medical Research Centre and Others**[7]**,** it was held in para 78 as under:

> 78. It is a matter of common knowledge that after happening of some unfortunate event, there is a marked tendency to look for a human factor to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. A professional deserves total protection. The Penal Code, 1860 has taken care to ensure that people who act in good faith should not be punished. Sections 88, 92 and 370 of the Penal Code give adequate protection to the professionals and particularly medical professionals."

Thus, applying the law laid down in the judgments above, in the instant complaint, the Complainants have just made allegations which, in our view, are not an inviolable truth.

24. In the recent judgment, in the case of **Chanda Rani Akhouri vs M.S.Methusethupathi Mithupathi**[8] and in **Dr. Harish Kumar Khurana v. Joginder Singh and Others**[9], the Hon'ble Supreme Court held that even death of a patient cannot, on the face of it, be considered to be medical negligence.

> 27. It clearly emerges from the exposition of law that a medical practitioner is not to be held liable 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. In the practice of medicine, there could be varying approaches of treatment. There could be a genuine difference of opinion. However, while adopting a course of treatment, the duty cast upon the medical practitioner is that he must ensure that the medical protocol being followed by him is to the best of his skill and with competence at his command. At the given time, medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

25. The Complainant No. 1, being an ENT specialist practicing in that area for decades, can't plead his ignorance on the facilities available at OP-6 hospital, the qualification and competence of OP-1. His allegations are vague, unsustainable for use of Levosulpiride and Neumol. The patient was investigated, diagnosed and treated as per the reasonable standard of practice, thus no negligence is attributable to the OPs. Our view dovetails form the judgment of Hon'ble Supreme Court in **Devarakonda Suryasesha Mani v Care Hospital, Institute of medical Sciences**[10], wherein it was held as below:

> "..2. Unless the appellants are able to establish before this Court any specific course of conduct suggesting a lack of due medical attention and care, it would not be possible for the Court to second-guess the medical judgment of the doctors on the line of medical treatment which was administered to the spouse of the first appellant. In the absence of any such material disclosing medical negligence, we find no justification to form a view at variance with the view which was taken by the NCDRC.
>
> ***"Every death in an institutionalized environment of a hospital does not necessarily amount to medical negligence on a hypothetical assumption of lack of due medical care."***

26. Based on the discussion above we do not find any merit to conclusively attribute medical negligence of the opposite parties (the doctors and hospital). The Complaint fails.

It is dismissed. There shall be no Order as to costs.

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[1] IV (2022) CPJ 7 (SC)

[2] http//pubchem.ncbi.nlm.nih.gov

[3] AIR 2010 SC 1162

[4] (2019) 7 SCC 401

[5] (2009) 7 SCC 130

[6] (2005) 6 SCC 1

[7] (2010) 3 SCC 480

[8] (2021) 10 SCC 291

[9] (2021) SCC OnLine SC 673

[10] IV (2022) CPJ 7 (SC)

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DR. S.M. KANTIKAR
PRESIDING MEMBER

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BINOY KUMAR
MEMBER