NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 74 OF 2009

1. UDAYAN & ORS.
S/O GOVIND SHROUTI Resident of 25, Cement Road, Shivaji Nagar
Nagpur - 440 010
Maharashtra
2. Mrs. Anita W/o. Udayan Shrouti,
R/o. 25, Cement Road, Shivaji Nagar,
Nagpur - 440 020
3. Chidanand S/o. Udayan Shrouti,
S/o. Govind Shrouti, R/o. 25, Cement Road, Shivaji Nagar,
Nagpur - 440 010
Maharashtra ....Complainant(s)

Versus

1. M/S. IMAGING POINT & ORS.
Consulting Radiologist & Sonologist, "Sitaram Smruti", Laxmi-Bhuvan, Square, Dharampeth
Nagpur
2. -
3. DR. DILILP GHIKE
R/o "Sitaram Smruti", Laxmi - Bhuvan Square, Dharampeth
Nagpur ....Opp.Party(s)

BEFORE:

HON'BLE MR. JUSTICE R.K. AGRAWAL,PRESIDENT
HON'BLE DR. S.M. KANTIKAR,MEMBER

For the Complainant : Appeared at the time of arguments through video conferencing
For Complainants : Mrs. Anita Shrouti, Complainant No. 2 in person
with Ms. Vrushali Pradhan, Advocate

For the Opp.Party : Appeared at the time of arguments through video conferencing
For OPs
: Mr. G.N. Shenoy, Advocate for OP-1 & 2
Mr. T.V.S. Raghvendra Sreyas, Advocate (Already deleted OP, vide Order dated 07.11.2019)

Dated : 25 May 2022

ORDER

DR. S. M. KANTIKAR, MEMBER

The most common type of litigation involving ultrasound is missing a foetal anomaly. The other causes include the failure to communicate the results of ultrasonic investigation in a timely manner; consequently the main reason for litigation is failure to offer termination of pregnancy as a result of failure to diagnose the defects at early stage.

Facts of this case are of very tragic proportion.

1. On 07.10.2006, Mrs. Anita Shrouti the Complainant No.2 (hereinafter referred to as "the Patient"), during her second pregnancy, consulted Dr. Sarita Bhonsule, Gynecologist and Obstetrician for and was remained under her follow-up for Ante Natal Care (ANC) till delivery. On 08.11.2006 Dr. Sarita Bhonsule for Ultra Sonography (USG) of Pelvis referred the patient to M/s. Imaging Point- the Opposite Party No. 1, the scanning centre. The USG was performed by the Radiologist Dr. Dilip Ghike, (hereinafter referred to as the "Opposite Party No. 2") and reported it as normal. Thereafter, subsequently the Opposite Party No. 2 performed 2nd USG on 08.01.2007 (17th to 18th week of pregnancy), 3rd USG on 12.03.2007 and 4th USG on 12.05.2007. It was alleged that all the USG were reported as "no obvious congenital anomalies in the fetal head abdomen and spine". The patient's elective Caesarian Section was performed by Dr. Sarita Bhansule on 26.05.2007 at Vaishnavi Maternity Home, Nagpur. After delivery the mother (patient) and the attendants (parents and relatives of patient) were shocked to see the grossly malformed male newborn. The newborn had agenesis of fingers, right leg below knee and left foot below ankle joint. The Complainants alleged that it was due to the Opposite Party No. 2 who negligently performed the USG and issued wrong reports. It was further alleged that it was possible to detect the anomaly between 12 to 14 weeks of pregnancy, but the Opposite Party No. 2 failed to detect anomalies during 2nd, 3rd and 4th USG, most importantly at 17 to 18 weeks. The mother [Complainant No. 2] and Mst. Chidanand [Complainant No.3] were discharged on 30.05.2007.

2. It was further alleged that the baby was thoroughly examined by Child Specialist Dr. Ravindra Bhonsule and found few other anomalies like problem with left eye closure, poor blink reflexes & watering and micrognathia with microglossia. There was left sided facial palsy and poor jaw opening which was causing feeding difficulty. Subsequently after proper immunization, the child was taken to Dr. S. Suresh at MEDISCAN, Chennai. On 21.08.2007, Dr. S. Suresh performed abdomen and KUB scan, fontanelle scan, echocardiograph (ECHO) of Mst. Chidanand, which were reported normal. Thereafter, the parents consulted Dr. Sujatha Jagdeesh, Genetic Consultant & Dysmorphologist at MEDISCAN who referred the child to Apollo First Med Hospitals for his abnormalities and limb hypo-genesis syndrome having oro-mandlbuiar disability. Dr. R. Venkataswami, a very senior Plastic Surgeon with specialisation in Hand Reconstructive & Microsurgery examined the child and confirmed that Mst. Chidanand had a facial palsy with lagopthalmos and micrognathia. He asked the parents to search for a company for prostheses of lower limb and called for review after 6-7 months for treatment of hands. He further advised to take an opinion of Ophthalmologist, accordingly on 22.08.2007 at Shankar

Netralaya Dr. Ravindra Mohan E, the Director of Oculoplasty and Orbit Service examined the eyes of Mst. Chidanand and noted normal closure of right eye but watery fluid from his left eye. He advised eye drops and further regular follow up with local Paediatric Ophthalmologist. Thereafter, the child was under follow-up of Dr. Amol Tamhne, a Paediatric Ophthalmologist at Nagpur. They took opinion form ENT surgeon Dr. Madan Kapre for Oro-mandibular Hypo genesis Syndrome and hearing problems of the child. The hearing in left ear was normal and moderate sensori-neural hearing loss in right ear. The doctors advised parental counselling and follow-up.

3. Again in the month of February, 2008 for 2nd follow up, Mst. Chidanand was taken to Chennai to Dr. R. Venkatswami and Dr. V. Purushothaman, who examined the child and advised leg prostheses for walking and suggested various activities for grasping and holding small objects. The thumb web was released later on. Dr. R. Mohan E asked the parents to wait till baby becomes 1 year old for his further intervention. In the month of June 2008, when Chidanand was 1 year old, he was taken for his leg prostheses to Otto Bock at Mumbai. He had been examined by Otto Bock expert team and decided to fit bilateral trastibial prostheses and accordingly, the order was placed. In July 2008, Mst. Chidanand was taken to Mumbai for measurements of both his legs and after a gap of three days, prostheses were given for his mobility. The parents were advised by Otto Block to consult Dr. S. Thote, who deals in manufacturing of artificial limbs in Nagpur. The child was also shown to Dr. Mukund Thatte, Mumbai, the Plastic Surgeon, Hand and Reconstructive Micro Surgery, who advised the treatment for webbing of hands, to make them more functional. It was further submitted that depending on the age and growth of the child, different types of prostheses are required, which incur heavy expenditure in lakhs. The parents were also required to visit hospital and to hospital incur expenditure on travel, stay and consultation of expert doctors.

4. It was alleged that Mst. Chidanand will have to undergo at least seven surgeries, two for webbing thumbs, two for Squint in eyes, one for jaw correction, for facial Palsy and one for removal of tongue tie. Child also needs speech therapy. The Complainants Nos. 1 and 2, being parents, always have a challenge and stress so much that they may need Psychiatric Counselling/Treatment by which their child never lead life.

5. Being aggrieved by the negligence, the couple, Mr. Udayan and Mrs. Anita, along with their son Chidanand, filed the instant Complaint of alleged medical negligence before this commission with the prayer for total compensation of Total Rs.10,08,80,637.62/- under different heads. In the support of their claim about future expenses they have filed estimate of different Otto Block prosthesis.

6.Initially, the Complaint was filed against M/s Imaging Point, Nagpur and two Radiologists - Dr. Raju Khandelwal and Dr. Dilip Ghike. However, vide our Order dated 07.11.2019, the name of Dr. Raju Khandelwal, the Radiologist was deleted from the array of the Parties.

Defense:

7. Dr. Dilip Ghike (Opposite Party No. 2) filed his reply and submitted that the Imaging Point (Opposite Party No. 1) was established in the year 1990 at Nagpur. It possesses sophisticated X-ray and Ultrasonography (USG) machines having adequate experienced staff. All types of USG

scans are performed at the Centre. Initially the 'Imaging Point' was a partnership firm between him and Dr. Raju Khandelwal. The partnership was dissolved on 30.04.2006 in terms of the Dissolution Deed. Therefore, there is no prima facie case or cause of action against Dr. Raju Khandelwal, that he neither examined nor performed any Ultrasound of the patient.

8. The Opposite Party No. 2 denied any negligence to perform and report the USGs of the patient. He raised preliminary objection on maintainability of the Complaint on the ground of highly exaggerated claim and many complicated questions of facts and law are involved which needs voluminous evidence, cross-examination of the parties or witnesses etc. which could not be disposed of in the summary proceedings. Therefore, the Civil Court will be proper for adjudication. He admitted that he performed routine Level– 1 scans for the patient on 08.11.2006, 08.01.2007, 12.03.2007 and 12.05.2007. The Opposite Party No. 1 charged the patient accordingly as Rs. 300/- to Rs. 400/- for the basic sonography on each occasion. He further submitted that for an anomaly scan (Level-II), USG which is known as target scan, would be charged as Rs. 1200/- . At no point of time, neither Gynecologist nor the patient (mother) asked the Opposite Party No. 2 to conduct the target scan. The patient was not charged for target scan. In the instant case, the USG was performed to assess the maturity of the fetus. The Complainant was deliberately resorting to the falsehood (suggestive falsy) to get favorable order. He further submitted that because of genetic mutation, there are chances of major or minor congenital anomalies. In the instant case, the child (Complainant No. 3) had multiple congenital anomalies because of some genetic mutations.

Arguments:

9. We have heard the arguments from the learned counsel for both the sides and perused the material on record.

Arguments of the Complainants:

The Complainant No. 2 argued the matter in person.

10. The Complainant No. 2 – Mrs. Anita, the mother of Child vehemently argued the matter. She reiterated the facts and prayed for deterrent penalty and compensation for the gross negligence of the Opposite Party No. 2 while conducting USG studies. She further submitted that the principle of **res-ipsa-loqiutor** is also squarely applicable in this case. She further argued her husband and herself kept faith in qualification and skills of Opposite Party No.2 and throughout pregnancy got her periodic ultrasounds done from him at his Imaging Point. They have expected due diligence from him, but he failed which resulted the irreparable damage. Her child Mst. Chidanand (Complainant No.3) will have to face its consequences all through his life, for no fault of him. The Complainants, in their support, filed medical literature and text from the standard text books on Obstetrics & Gynaecology [1] and Radiology [2] [3] .

The Complainants relied upon following Judgments:

i. Nizam's Institute of Medical Sci v Prasanth S. Dhananka & Ors. 2009 (6) SCC 1

ii. Dr. Balram Prasad v Dr. Kunal Saha, (2014) 1 SCC 384

v. Spring Meadows Hospital Vs. Harjot Ahluwalia, case (1998) 4 SCC 39.

vi. V.Kishan Rao Vs. Nikhil Super Spl. Hospital & Anr., 2010 CTJ 868(SC)(CP)

vii. Anil Dutt & Anr. vs Vishesh Hospital & Ors., 2016 SCC OnLine NCDRC 239

11. The learned Counsel for the Opposite Parties vehemently argued and brought our attention to the different medical text books on the subject. According to him, there are various types of Obstetric Scan (Routine, Target & Anomaly Scan) **.** In medical parlance, they are referred to as LEVELS and there is a vast difference between Level-I (Routine) scan and Level-II (Target / Anomaly) scan. Level-I sonographies are often referred to as a routine examination or a basic examination, and in contradistinction a Level-II scan is referred to as a Target scan or an Anomaly scan and is a specialized study which is undertaken to detect birth defects in the foetus.

Commonly all over the world, as a standard protocol during Level-I scan, the Radiologist will check for

a) Foetal presentation

b) Amniotic fluid volume

c) Foetal cardiac activity

d) Placental position

e) Foetal biometry

f) Maternal Cervix

g) Maternal adnexae

12. The reporting format of Level-I & Level-II scans are totally different. The Counsel brought our attention to the reporting format of Level-I & Level-II USG report scans from AIIMS and different doctors. The charges are different i.e. for routine USG Rs.400 whereas for Target (anomaly) scan. The instant patient was charged only Rs. 400/- only each time. The treating obstetrician was also aware the limitations of the standard and targeted sonography.

13. The learned Counsel for the Opposite Parties Nos. 1 & 2 relied upon the article – “Value of a Complete Sonographic Survey in Detecting Foetal Abnormalities” from American Institute of Ultrasound in Medicine [4] , in which, it is stated that the basic examination consists of a survey of intracranial, spinal, and abdominal anatomy, evaluation of the 4 chambered heart, and

assessment of the umbilical cord insertion site. The Counsel further relied on text book extracts from 'Callen's Ultrasonography in Obstetrics and Gynaecology'; 'American Institute of Ultrasound in Medicine (A.I.U.M.)'; and 'the Guidelines of American College of Radiologist'.

14. The learned Counsel further argued that unless and until there is a request from the referring doctor / patient for a Level-II (Target / Anomaly scan) the Radiologist will perform a Level-I scan regardless of the indication as a routine. He further submitted that on the basis of history, bio chemical abnormalities whenever foetal anomaly is suspected; level-II scan will be performed. [5]
During level-II scan detailed anatomical examination is performed when an anomaly is suspected on the basis of history, maternal serum screening tests.

15. The learned Counsel further stressed that it goes without saying, a Level-II scan is performed whenever there is a specific request for the same by the referring doctor or the patient, therefore in the instant patient Anomaly scan was never done, as it was never asked. The treating doctor and the patient both had received four routine (Level-I) scan reports, but not raised any objections with the scan reports. Therefore, the treating doctor and the patient are now ESTOPPED from disputing the fact that a Level-II (Target / Anomaly) scan was not undertaken. **Doctrine of Estoppel'** is applicable in the instant case and the objections were never raised by the treating doctor. According to him, in the instant case;

> *1. The treating doctor and the patient both had no reasonable apprehension that the baby was suffering from any anatomical abnormality and therefore they did not request for a Level II scan more so when the Triple Marker Test showed no abnormalities in the baby.*
>
> *2. The treating doctor and the patient both had received four routine or Level I scan reports and not once did they raise any objections or express their dis-satisfaction with the scan report.*
>
> *3. Not once did the treating doctor refer back the patient to OP No. 1 / 3 with a request that he desired a Level II / Anomaly scan.*
>
> *4. Not once did the patient come back to OP No. 1 / 3 with a request that she wanted a Level II scan as she suspected anatomical anomalies in the foetus.*
>
> *5. Under the situation both the treating doctor and the patient are now ESTOPPED from disputing the fact that a Level II / Target / Anomaly scan was not undertaken.*

16. The treating Obstetrician was aware that the patient was elderly & had Gestational diabetes mellitus, she should have told the possibility of congenital malformations to baby (As incidence of congenital anomalies is 7-10 times more common in such patients). The Opposite Party No. 2 was not aware of the Gestational Diabetic status of the patient. Thus it was failure of treating Obstetrician not to advise genetic sonogram/ 3D/4D sonography, as the facilities were available in other centres in Nagpur.

17. The learned Counsel for the Opposite Parties submitted that the anomalies are missed during Level-II scan, even with best hands and centres.

- According to the Manual of Diagnostic Ultrasound (WHO publication) in collaboration with the World Federation for Ultrasound in Medicine and Biology, it is stated:

  Evaluation of feet and hands for anomalies is very difficult and that the lower part of each limb (tibia and fibula, radius and ulna) is the least easily visualized.

- In a study conducted at the Department of Orthopaedic Surgery, Southampton University Hospitals NHS Trust, Southampton, England, revealed that:

  Many case of congenital limb abnormalities referred for orthopaedic treatment are not diagnosed prenatally, despite ultrasound scanning.

- In another article "Evaluation of prenatal diagnosis of limb reduction defects" by Stoll C, et al revealed that:

  The percentage of prenatal detection of limb reduction defects was only 11.5%.

- Similarly in a study conducted by the Department of Radiology and Radiological Sciences, Vanderbilt University, Nashville, T.N., it was concluded that:

  Serious cardiac defect, microcephalus and many musculoskeletal deformities were missed by ultrasonography and that a negative prenatal ultrasonographic examination does not provide absolute assurance that a fetus is defect is free.

- The EUROSCAN Study Group to evaluate prenatal detection of limb reduction deficiencies (LRD) by routine ultrasonographic examination of the fetus, it was found that:

  The prenatal detection rate of isolated LIMB REDUCTION DEFECTS (LRD) was 24.6% (34 out of 138 cases) compared with 49.1% for associated malformations (55 out of 112). The prenatal detection of isolated terminal transverse LRD was 22,7% (22 out of 97).

- The March 2004 issue of Obstetrics and Gynaecology Clinics on the sensitivity and specificity of ultrasound to detect fetal –anomalies in their said study concluded that the detection rate for anencephaly malformation was the highest at 99.4% and that for foot deformity was the lowest at 17.2%.
- In other Scientific studies have established that anomalies of extremities and face are more likely to go undetected. He relied upon following various studies in his support,

  a) Spanish study by Mautinez et al the detection rate of LRD is very low

  b) American Journal of Obst Gynac 1995 Aug 173(2) 667-8 article by Gonclave rt al "The accuracy of prenatal USG in detecting congenital anomalies concludes that- USG is sensitive in detecting many lethal malformations however a negative prenatal ultrasound does not provide absolute assurance that fetus is defect free

  c) Article by Chovi R et al in ultrasound obst gynec 2001 Jan 17 (1) 22-29 also mentions main reason for lack of information were fetal position & fetal movements

d) Article by Stroll C et al in prenat diag 2000 oct; 811-8,

e) RCOG guidelines for routine USG screening in pregnancy 7/2/2006 also states about half of major abnormalities which cause serious difficulties will be seen on a scan & half will not be seen , this means that if your scan is normal there is a small chance that your baby will still have a problem

18. The learned Counsel for the Opposite Parties further argued that as a diagnostic tool the USG has its own limitations. The Complainants were aware that the Opposite Party No. 1 had two dimensional (2D) Sonography. Even the advanced 3D or 4D imaging techniques are also not 100% sure to diagnose all anomalies. The detection of anomalies necessarily depends on several factors *inter alia,* a) The physical condition of the mother (particularly obesity which greatly reduces the chances of an anomaly detection); b) Movement and position of the fetus; c) Abdominal scars; d) Extent of fluid and e) Prevalence and type of defect. These factors are only illustrative and not exhaustive.

He submitted that, admittedly, the Complainant No. 2 was obese, which is one of the factors, which could have adversely affected the detection rate. The Counsel made a reference to an article "Effect of material obesity on the ultrasound detection of anomalous fetuses" authored by Dashe JS et al, which concludes-

> "With increasing maternal BMI, we found decreased detection of anomalous fetuses with either standard or targeted ultrasonography, a difference of at least 20% when women of normal BMI were compared with obese women. Anomaly detection was even less in pregnancies complicated by pre-gestational diabetes. Counselling may need to be modified to reflect the limitations of ultrasonography in obese women."

19. A similar conclusion is recorded in a study on Maternal Obesity and Ultrasound Evaluation of Fetal Anatomy conducted by Jodi S. Dashe MD and associates, who concluded –

> “Increasing maternal BMI limits visualization of fetal anatomy during a standard ultrasound examination at 18 to 24 weeks. In obese women, the fetal anatomy survey could be completed during the initial examination in only 50% of cases. Counseling may need to be modified to reflect the / limitations of sonography in obese women."

20. The learned Counsel submitted that even if the report of the AIIMS medical board is assumed to be admissible, but prima facie the allegation of medical negligence is ruled out. The detection rate of LRD (Limb reduction defect) varies from 10% to 40%, it is achieved only when the ultrasonography is done with the conscious understanding that the patient is the high risk patient. The detection rate is attributable to several fortuitous circumstances like Gravid Uterus Foetal presentation, Amniotic fluid volume, Foetal cardiac activity, Placental position Foetal biometry, Maternal Cervix Maternal adnexae and not necessarily attributable to exceptional diagnostic skills.

21. Finally the learned Counsel for the Opposite Parties submitted that the USG reports given by the Opposite Party No. 1 were Level-I scans and reported correctly. He further asserts that even in a targeted scan, a limb reduction defect may not be detected, and therefore, the allegation of the Complainants about failure to detect the anomaly was not sustainable.

Findings :

22. Gynecologist and Obstetrician Dr. Sarita Bhonsule. As per her advice, 4 times patient's USG was performed around 9, 17, 26 & 34 weeks of pregnancy at M/s. Imaging Point (the Opposite Party No. 1). All the 4 times USG was performed by the Radiologist Dr. Dilip Ghike (Opposite Party No. 2") and reported as "Normal". In the reports, there were no comments on the limbs. It is pertinent to note that the patient was 37 years elderly **.** As per calculation her BMI was 28.7 kg/m^2 , she was overweight, but not obese. The role of Dr. Sarita Bhonsule was limited, she advised Triple Markers, which were reported as normal. However, admittedly she has sent the patient for USG without specifying routine or target scan. Thus, the defense of the Opposite Party No. 2 that he performed the Level-I scan every time is not as an accepted standard of practice.

23. We have perused all 4 USG reports performed by the Opposite Party No. 2, the reports are as below:

Date	**USG weeks**	**Report**
08.11.2006		**SONOGRAPHY OF PELVIS** A single gestational sac is seen in the uterus. Its size and shape is regular Foetal pole can be differentiated. Heart pulsations are present and are regular. Gestational sac is 37 mm & CRL is 22 mm. This corresponds with maturity of 9 wks. Cervix appears normal. No parauterine pathology seen.

08.01.2007	17-18	**SONOGRAPHY OF GRAVID UTERUS** Single viable intrauterine foetus is seen. Foetal movement and cardiac pulsations are well appreciated. Placenta is situated at fundus and anteriorly over body shows gr. 0 maturity. Liquor is adequate for this ges. Age **FOETAL BIOMETRY:** BPD is 39 mm, FL is 23 mm, AC is 124 mm These parameters correspond with sonic maturity of 17-18 wks. No obvious congenital anomalies seen in foetal head, abdomen and spine.
		SONOGRAPHY OF GRAVID UTERUS Single viable intrauterine foetus is seen shows changing lie. Foetal spine is on left side. Foetal movement and cardiac pulsations are well appreciated.

12.03.2007	26-27	Placenta is situated at fundus and anteriorly over body shows gr. 0 maturity. Liquor is adequate for this ges. Age **FOETAL BIOMETRY:** BPD is 70 mm, FL is 48 mm, AC is 218 mm These parameters correspond with sonic maturity of 26-27 wks. No obvious congenital anomalies seen in foetal head, abdomen and spine
12.05.2007	35-36	**SONOGRAPHY OF GRAVID UTERUS** Single viable intrauterine foetus is seen shows cephalic presentation. Foetal spine is on left side. Foetal movement and cardiac pulsations are well appreciated. Placenta is situated at fundus and anteriorly over body shows gr. II maturity. Liquor is adequate for this ges. Age **FOETAL BIOMETRY:** BPD is 86 mm, FL is 70 mm, AC is 303 mm These parameters correspond with sonic maturity of 35-36 wks. No obvious congenital anomalies seen in foetal head, abdomen and spine.

Discussion:

24. We have perused the evidence affidavit jointly filed by the Opposite Parties Nos. 1 and 2. On factual matrix, the Opposite Party No. 2 submitted that the first USG was performed on 08.11.2006, which showed single gestational sac with normal size and shape. Fetal heart was normal. It corresponds with the maturity of nine weeks. The Opposite Party No. 2 collected fee of Rs. 400/-. On 08.01.2007, follow-up scan for maturity was performed, which revealed the grade-0 placenta. The fetal bi-parital diameter was 39mm, femoral length 23mm. The findings were corresponding with 17 to 18 weeks of gestation. There was no obvious anomaly seen in the fetal head, abdomen and the spine. Therefore, it was mentioned in the report, "not all anomalies can be detected on Sonography". The next scan was performed on 12.03.2007, the parameters were corresponding to 26 to 27 weeks of gestation and not revealed any anomalies in the head, abdomen or spine. On 12.05.2007, for maturity, follow-up USG was performed, which was reported as normal findings without any anomalies in the fetal head, abdomen and spine.

25. The Opposite Parties have filed two expert opinions in their support. One from Dr. Nitin Chaubal, having 22 years of experience, a practicing Ultrasonologists working at Jaslok Hospital at Mumbai and Thane Ultrasound Centre at Thane. The second opinion was from Dr. Pratibha Pendharkar, the Professor of Radiology and Dean, Indira Gandhi Medical College, Nagpur. In both opinions, they have commented upon the qualification of Dr. Dilip Ghike, the infrastructure of Image Point and various aspects of USG during pregnancy. According to both, there were no deficiencies in service or deviation from the established line of management of the Opposite Parties. Dr. Dilip Ghike performed the scans as and when prescribed by the referring doctor and correctly diagnosed that there were no congenital anomalies in the head, abdomen and spine of the fetus. They also noted that there was no request either from the patient or the treating doctor for anomaly scan.

26. This Commission, vide its Order dated 27.05.2009, called for an expert opinion from the Medical Board at AIIMS. The opinion dated 31.07.2009 revealed that Mst. Chidanand's anomalies would be classified as "Limb reduction deficiencies". The Board also expressed that, 'Limb anomalies should be searched for in all standard obstetric ultrasound examinations performed in second trimester (vide Annexure 1), in this case, on 08.01.2007 & 12.03.2007. The said report, however, does not comment on the limbs.' Finally, the Board was of the opinion that, 'limb reduction anomalies can be detected in standard obstetric ultrasound, but the detection rate is low as detailed above.'

27. It is an admitted fact that the Opposite Party No. 2 performed all 4 USG during the ANC period of Mrs. Anita (the patient). It is surprising to note that the Opposite Party No. 2 had performed only Level-I scan for all the times. His contention was the treating Gynecologist and even the patient did not ask for anomaly scan (Target scan level-II). We do not find any merit in such vague submission. It appears Opposite Party No. 2 is shifting the blame on the Gynaecologist. In our view, in absence of any referral from doctor, the ethical and legal duty

casted upon Radiologist is to take proper history, ascertain the gestational age and perform the relevant USG scan (Level). In the instant case the Opposite Party No. 2 failed in his duty of care and surprisingly, he performed all Level-I scan.

28. As per the International society for Ultrasound in Obst and Gyn (ISUOG) the "Practice guidelines for performance of the routine mid-trimester fetal ultrasound scan" [6] that for Limbs and extremities systemic approach by the Radiologist necessary to know presence or absence of both arms/hands and both legs/feet and it should be documented. Counting fingers or toes is not required as part of the routine mid-trimester scan. The simple mistakes do not give rise to liability whereas negligence does. Thus it reflects the concept of "standard of care". In some cases essentially, the violation of a rule may automatically give rise to an assumption of *"negligence per se."*

29. Let us examine in the light of law laid down Hon'ble Supreme Court whether there was breach of duty by Opposite Party No. 2 and he was guilty of medical negligence or not?

The Duty of care has been discussed in several judgments on medical negligence of Hon'ble Supreme Court and other courts worldwide. The Hon'ble Supreme Court in **Kusum Sharma and others v. Batra Hospital and Medical Research Centre & Others .** [7] discussed the breach of expected duty of care from the doctor, if not rendered appropriately, it would amount to negligence. It was held that, if a doctor does not adopt proper procedure in treating his patient and does not exhibit the reasonable skill, he can be held liable for medical negligence. The complainant is required to prove that the doctor did something or failed to do something which is the given facts and circumstances, no medical professional in his ordinary senses and prudence would have done or failed to do. Similar view was taken in the case **Jacob Mathew v. State of Punjab & Anr.** [8]

30. In two landmark judgments of Hon'ble Supreme Court in **Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole & Anr** **[9]** . and **A.S. Mittal vs. State of U.P** **[10]** have laid down certain duties of the doctor. The Doctor owes to his patient certain duties which are (a) a duty of care in deciding whether to undertake the case; (b) a duty of care in deciding what treatment to give; and (c) a duty of care in the administration of that treatment. A breach of any of the above duties may give a cause of action for negligence and the patient may on that basis recover damages from his Doctor.

31. Considering the Bolam's principle [11] , McNair, J. summed up the law as under:

> *"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. In the case of a medical man, negligence means failure to act in*

accordance with the standards of reasonably competent medical men at the time. There may be one or more perfectly proper standards, and if he conforms with one of these proper standards, then he is not negligent."

In the instant case the Opposite Party No. 2 failed to exercise the required ordinary skills and standards, thus held negligent.

32. Thus, collectively considering the facts, evidence on record, opinion from AIIMS expert medical board and the precedents *(supra)* of Hon'ble Supreme court, we have no hesitation to conclusively hold the Opposite Party No. 2 liable for the negligence, who failed to diagnose the structural anomalies of the foetus at 17-18 weeks . The early and correct detection could have helped the parents to take a decision to continue or terminate the pregnancy within 20 weeks as per MTP Act, 1983. The unfortunate birth of amelic baby could have been averted. It is well settled principle of justice that in a case where negligence is evident, the principle of *res ipsa loquitur* operates and the Complainant does not have to prove anything as the thing (res) proves itself. In such a case, it is for the opposite party to prove that he has taken care and done his duty to repel the charge of negligence. Thus to reduce such errors and patient grievances, there is need for overall national guidelines from academic bodies (ICMR) or the government (health).

Compensation:

33. **"Damages"** is the legal word for the loss or harm that result to a person from the wrongful acts of another person. To remedy that damage, the law compensates the victim through a monetary award. Damages are then split into two major types: compensatory and punitive. Compensatory damages are designed to "compensate" the victim for specific types of injuries for which assigning a monetary value is fairly easy, such as medical bills, loss of wages, and loss of future earning capacity. Compensatory damages can also include non-economic damages like pain and suffering, loss of consortium, and loss of enjoyment of life. Punitive damages do not compensate the victim; rather, they are designed to punish wrongdoers for behaviour that is considered to be particularly wilful, wanton, or egregious.

- **Economic and Non-Economic Damages**
- **Economic damages** , also known as special damages, reimburse a victim for financial costs related to the negligence. They cover medical expenses related to the treatment or therapy for injuries. They also cover lost income if the victim's injuries caused them to miss time at work. A victim may be able to recover damages for future medical expenses, as long as the calculation is not overly speculative. Such damages may be supported by documentation, such as medical bills.
- **Non-economic damages** , also known as general damages, are less easy to quantify. They most commonly cover the pain and suffering that the victim endured, in addition to any reduction in their quality of life. If the negligence resulted in a permanent disability, a

victim may be able to get compensation for their future loss of earning capacity. Non-economic damages often need to be supported by more than just documentation.

34. The use of ultrasonography has dramatically changed the practice of medicine, particularly in the field of obstetrics and gynaecology. With the help of high resolution prenatal ultrasonography, the average number of imaging studies per pregnancy has increased and consequently the prenatal USG diagnostic process has also resulted in obstetricians being exposed to a higher litigation risk which is gradually increasing because of advanced technology the images are getting easier to interpret and patients' higher expectations to diagnose subtle foetal anomalies. A major concern in relation to failure to detect congenital anomalies surrounds major structural abnormalities. The main reason for litigation in this area is failure to offer termination of pregnancy as a result of failure to diagnose the defects at early stage.

35. Adverting to the Compensation in the medical negligence cases, as the quantum is highly subjective in nature as the human life is most precious. During arguments the mother of child (Complainant No.2) submitted that the compensation for negligence cannot completely cure the injury sustained by the parents and the child and their claim of Rs.10,08,80,637.62/- is justified. The Complainants are claiming actual medical expenses Incurred so far Rs. 1,32,711/-, for mental agony Rs. 3,00,00,000/- as it was loss to the parents to have a normal child and their lifelong agony due to the sufferings of their child Chidanand who cannot lead normal life and will remain dependent. They further claimed Rs. 7,06,47,926.62/- for future expenses towards re-constructive surgeries, regular professional care & therapy and limb prostheses as per the growth of child. The Complainants claimed Rs. 1,00,000/- towards litigation expenses.

36. In the catena of judgments of Hon'ble Supreme Court, different methods to determine ' **just and adequate compensation'** were laid down. It was held that there is no restriction that courts can award compensation only up to what is demanded by the complainant. We would like to rely upon few judgment of Hon'ble Supreme Court viz **Sarla Verma & Ors. vs Delhi Transport Corp. & Anr** [12] **, Nizam's Institute of Medical Sciences Vs Prasanth S. Dhananka & Ors.** **[13] , Dr. Balaram Prasad vs. Dr. Kunal Saha & Ors. [14]**

37. The Hon'ble Supreme Court in the case, **National Insurance Co. Ltd. v. Kusuma, [15]** has held that payment of compensation to parents for the death of a child, including a stillborn, in an accident must be just and not be a pittance. A Bench of Hon'ble Justices D.K. Jain and R.M. Lodha said:

> "The determination of the just amount of compensation is beset with difficulties, more so when the deceased happens to be an infant/child because the future of a child is full of glorious uncertainties.

The Bench, however, cautioned the tribunals, saying the amount of compensation awarded was not expected to be a windfall or bonanza, nor should it be niggardly or a pittance. "Whether there exists a reasonable expectation of pecuniary benefit" was always a mixed question of fact and law, but a mere speculative possibility of benefit was not sufficient.

38. It should be borne in mind that the Divine possible complications will make any amount of good care with good intention of a Doctor commiserating with existing practices and will make him to face the fate of self-decimation. There are certain possible for a grey areas to exist in patient care, where a professional is called upon to make a decision, when he possibly has to throw a dice and take a refuge in statistical possibility of particular event happening.

39. Many times the voice was raised about need for Caps on damages in medical negligence cases. In our view, a cap will often apply only to non-economic damages, while allowing a victim to recover any amount of economic damages that they can prove. The caps existed on the idea that they would restrict a victim's ability to file medical negligence complaints. In our view, theoretically this would improve healthcare and reduce costs, but in reality this is a myth.

40. In this case, no doubt, the doctor (Opposite Party No. 2) could have helped the patient, had he been more careful in his reporting, though, how useful, it would have been considering MTP (Abortion) laws. It is not the intention of the Court or Commission to let go the Doctor for his mistake, which definitely need a rap on the knuckle, but that rap should not break his skull. Apparently, in the instant case, congenital anomaly is play of nature, one of nature's wraths, which human kind is facing since time immoral. In alleviating this wrath of nature, this Doctor cannot be sacrificial lamb which would make whole profession to work under proverbial Damocles Sword.

41. We would like to rely upon the case **National Insurance Co. Ltd.** **[16]** *(supra),* wherein the Bench further said:

> *"The word 'just' connotes something which is equitable, fair and reasonable, conforming to rectitude and justice, and not arbitrary. To exercise the discretion to determine the amount of compensation, is also coupled with a duty to see that this exercise is carried out rationally and judiciously by accepted legal standards, and not whimsically and arbitrarily, a concept unknown to public law."*

42. The child is at present about 14 years old. We have to consider several points while awarding the compensation like the actual expenses already incurred on medical treatment, travelling and emotional sufferings of the parents. The Complainants (1 & 2) have filed the receipts of recurring expenses till date for child's medical care and for day today activities. It was

informed that to take care of her child, the Complainant No.2 Anita left her job also. The parents often go through embarrassment, social stigma and severe stress/depression due to their disabled child. The Complainants' claim of Rs.3 crore for mental agonies appears to be highly inflated and is not justified. However, we con not ignore that the child needs artificial prostheses for his hands and legs throughout his life and to be changed periodically depending on age and growth. The letter dated 07.08.2008 of Otto Block about the maintenance and repeat expenses stated that the tailor-made artificial Modular Trans-Tibial Endoskeletal Prostheses costs about Rs. 6 to 8 lakh each time. Therefore, in our view, the disabled child deserves just and fair compensation.

43. Based on the discussion above, the medical negligence is attributed to the doctor and his Imaging Centre. The Opposite Parties Nos. 1 and 2 are directed to pay, jointly and severally, Rs. 1.25 Crore to the Complainants. Out of the said amount, Rs. 1 Crore shall be the compensation to the disabled Mst. Chidanand for his welfare, future expenses for treatment and purchase of limb prostheses. The amount shall be kept in the form of Fixed Deposit (FD) in any Nationalised Bank (preferably State Bank of India) in the name of Mst. Chidanand till he attains majority. The balance amount of Rs. 25 lakh shall be paid to the parents of Mst. Chidanand (Complainants Nos. 1 and 2) towards the mental agony and allied expenses. The parents can draw periodic interest on the FD for the regular health check-up, treatment and welfare of their child. The Opposite parties shall pay Rs. 1,00,000/- towards the legal expenses.

The Order, in entirety, shall be complied within 3 months from today, failing which the entire amount shall carry interest @7% per annum till its realisation.

The Complaint is partly allowed.

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[1] William's Obstetrics 22 nd Edn

[2] Rumack Diagnostic Ultrasound 4 th Edn

[3] Callen's Unltrasonograpgy in Obst. & Gynec. 6 th Edn

[4] J Ultrasound Med 28:1015- 1018.0278-4297

[5] Williams Obstetrics- 22 nd edition

[6] Ultrasound Obstet Gynecol 2011; 37: 116–126

[7] (2010) 3 SCC 480

[8] AIR 2005 SCC 3180

[9] AIR 1969 SC 128

[10] AIR 1989 SC 1570

[11] Bolam vs. Frien Hospital Management Committee (1957) 2 All ER 118

[12] 2009 (6) SCC 121

[13] 2009 (6) SCC 1

[14] (2014) 1 SCC 384

[15] (2011) 13 SCC 306

[16] (2011) 13 SCC 306

......................J
R.K. AGRAWAL
PRESIDENT
....
DR. S.M. KANTIKAR
MEMBER