NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 212 OF 2006

1. SMT. POOJA PRASHAR
R/O. 1734, BRAHAMPUTRA APARTMENTS SECTOR 29,
ARUNVIHAR
NOIDA - 201 303
2. MS. CHANDNI PRASHAR
1734 BRAHAMPUTRA APARTMENTS, SECTOR 26,
ARUNVIHAR,
NOIDA - 201 303
3. TUSHAR PRASHAR
1734, BRAHAMPUTRA APARTMENTS SECTOR 29M
ARUNVIHAR,
NOIDA - 201 303 .....Complainant(s)

Versus

1. DIRECTOR INDRAPRASTHA APPOLLO HOSPITAL &
ORS.
SARITA VIHAR, DELHI MATHURA ROAD,
NEW DELHI - 110 065.
2. DR. MR RAJ SHEKHAR
NO. 12, GROUND FLOOR, SOUTHERN AVENUE,
MAHARANI BAGH,
NEW DELHI - 110 065.
3. MEDICAL COUNCEL OF INDIA
SECTOR 8, POCKET 14, DAWARKA,
NEW DELHI - 110 075
4. MEDICAL COUNCEL OF INDIA
SECTOR 8, POCKET 14, DAWARKA,
NEW DELHI - 110 075
5. DELHI MEDICAL COUNCIL
368, 3RD FLOOR PATHOLOGY DEPARTMENT MAULAANA
AZAD MEDICAL COLLEGE, BAHADUR SHAH ZAFAR
MARG,
NEW DELHI - 110 002 .....Opp.Party(s)

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

For the Complainant :
For the Opp.Party :

Dated : 24 Jan 2023

ORDER

Appeared at the time of arguments:

For Complainants	:	Ms. Pooja Prashar, in-person Mr. Tushar Prashar, in-person Mr. Lalit Bhasin, Advocate
For Opp. Party No.1	:	Ms. Nina Gupta, Advocate Ms. Rimjhim Naudiyal, Advocate
For Opp. Parties No.2 & 3	:	Ex-parte
For Opp. Party No. 4	:	Mr. Praveen Khattar, Advocate

Pronounced on: 24th January 2023

ORDER

DR. S. M. KANTIKAR, MEMBER

1. This Complaint has been filed by legal heirs of late Col. (Rtd.) Ashok Prashar under Section 21(a)(1) of the Consumer Protection Act, 1986 against the Director, Indraprastha Apollo Hospital, New Delhi/Opposite Party No. 1 and Dr. MR Rajasekhar of Dept of HPB Surgery and Organ Transplant/Opposite Party No. 2.

2. On 21.01.2004, Col. Ashok Prashar (since deceased for short, the 'patient') consulted the Senior Surgeon Dr. C. J. Desai at Appollo Hospital, Ahmedabad. He was diagnosed as Space Occupying lesion (SOL) in the right lobe of liver and advised treatment by Chemotherapy instead of the major surgery. The patient responded Chemotherapy and the size of SOL reduced from 10 cm to 8 cm within two months. Dr. Desai opined that surgery was out of question for liver SOL, until patient's platelet and WBC counts become normal. On 23.08.2004, the patient approached Dr. A. K. Sethi in Army Hospital and R & R at Delhi (for short, the AHRR), who advised Chemotherapy for 30 days. Thereafter, on 23.11.2004 in the same hospital, patient consulted Dr. Kannan and found that the SOL was static, 8 cm in diametre. He also opined that resection of SOL was risky. Thereafter, for further management, on 07.12.2004 the Patient consulted Dr. M. R. Rajasekhar (Opposite Party No. 2) the senior surgeon in HPB Surgery and Organ Transplant at Indraprastha Apollo Hospital, New Delhi (Opposite Party No. 1). The patient showed prescriptions of three previous consultants, but Opposite Party No. 2 took it casually. The Opposite Party No. 2 advised resection of SOL without proper examination and investigations. He further told that it was a minor operation, and patient will be cured in a couple of days. It was alleged that from the very beginning the Opposite Party No. 2 misled the patient. The patient's wife (Complainant No. 1) was willing not for the operation, but Opposite Party No. 2 managed to brainwash the patient with false promises. On 11.12.2004, CT Scan of whole body was done , it showed SOL of right lobe of liver with adherent gall bladder. The other abdominal organs, chest and pelvis were normal. The Complainant stated that, on 17.12.2004, the patient directly from his office went to Opposite Party No. 1 hospital and got admitted for surgery, without taking any family members. It was alleged that on the same day, he was taken to operation theatre (OT) and without informed consent, the surgery was started at about 6.30 pm and after 8 hours, patient was brought out of OT at 2.30 am, the total duration for the operation was 8 hours. It was alleged that, whole process of resection of SOL was done in surreptitious manner and it was not possible to remove only gall bladder without resection of SOL. It was alleged that Opposite Party No. 2 resected the SOL with gall bladder, but the OT notes (record) were manipulated /forged to create impression as SOL was not resected. The Complainants further alleged that patient bled heavily during operation, therefore, 40 units of blood, plasma, cryoprecipitate and platelets were transfused within span of 24 hrs. After the operation, due to deteriorating condition of patient at 7:00p.m. the patient was put on ventilator by Dr. S. Chawla, Sr. Consultant

in Anesthesia. Further, on 19.12.2004 at 5.20 am, the patient suffered heart attack, he was resuscitated. In the morning at 7.40 a.m., Dr. Vipul Rai examined the patient and advised urgent Echocardiograpgy (ECHO), but it was done in the evening at 7.30 p.m. Also, at 6.30 a.m dialysis was advised to correct renal failure, but actually patient was put on dialysis at 6.20 p.m., thus, there was delay of 12 hours to conduct Dialysis and ECHO. As per nurses daily assessment note, the dialysis machine became dysfunctional from 21.12.2004, but dialysis machine became non-functional but the hospital management did not rectify CRRT machine. Unfortunately, the patient died on 22.12.2004 in the Opposite Party No. 1 hospital. It was alleged that the complainant made request for Post Mortem (PM) /autopsy of the deceased but Opposite Parties refused by stating that the hospital was not equipped for PM. Therefore, in the alternative, requested for ultrasound study of deceased but it was also refused by Opposite Parties. The complainant wrote a letter to the Opposite Parties for the relevant medical records/documents, but the Opposite Parties deliberately withheld which might have either been destroyed or tempered.

3. The Complainants alleged that since SOL of liver was responding to Chemotherapy and the patient had good chance of living a normal life to full span. However, due to callous attitude of the Opposite Party No. 2, unnecessary surgery was performed which shortened life of the patient. The Complainants relied upon one research study done by team of doctors and scientists at New Castle University, wherein alternative to liver transplant was available by use of drug Sulphasalazine to reverse damages. The Complainants further stated in their complaint that the deceased was only bread winner in the family, retired in 1996 from Army service and receiving Rs.14,205/- per month as pension. Post retirement he was employed in Idea Cellular as a senior manager and receiving Rs. 79,818/- per month. Being aggrieved by the alleged negligence causing the death of patient, his legal heirs filed the Complainant before this Commission and claimed Rs. 1,28,25,000/- as compensation. During course of proceedings the Indian Medical Council (MCI) and Delhi Medical Council (DMC) were impleaded as Opposite Parties Nos. 3 and 4.

4. The Opposite Party No. 2 did not file written version, therefore, his right was forfeited. The other Opposite Parties have raised preliminary objection about the maintainability of the complaint as no cause of action against Opposite Party No. 1. It was submitted that the patient was diabetic and in November, 1994 suffered cirrhosis of liver with portal hypertension and hyper-spleenism. He became Hepatitis C positive in the year 2003 and during the investigations he was detected with SOL Right Lobe of liver. It was also confirmed from the multiple CT Scans, MRI USG Abdomen, FNAC and Laparoscopic biopsies done from various hospitals. In May, 2004, for SOL the patient received chemoembolization and thereafter, decision for resection of SOL was taken. The Opposite Party No. 2 explained about the major risk involved in the above procedure. Thus, the Complainant had knowledge of all risks involved in the surgery and only after that, he signed the informed consent form. Accordingly, all preparations were done and on 17.12.2004, he was taken for right hepatectomy. The physician clearance and cardiology clearance for surgery was taken at the time of surgery. During surgery large SOL was seen involving right lobe of liver. Intra Operative Doppler ultrasound liver revealed that there was no flow in the right portal vein with minimal flow in the left portal vein. Therefore, only Cholecystectomy was performed and further the decision of Right hepatectomy was deferred. The complainants were always kept informed about the prognosis and critical condition of the patient. The Opposite Party No. 1 further submitted that despite utmost care and caution taken during pre-operative and post-operative ICU care, but the patient expired on 22.12.2004. The Opposite Party No. 1 denied about the tampering of medical record. The Opposite Party No. 1 also denied that the patient was forced by the Opposite Parties to undergo liver resection surgery. The hospital had experienced doctors and team of surgeons, nursing and other staff.

5. The Complainant also made IMC (Indian Medical Council) as Opposite Party No. 3, which filed its affidavit through its Deputy Secretary with respect to the MCI Regulations, Ethics and Maintenance of medical record.

6. The complainant approached Delhi Medical Council (for short “DMC”), which held that there was no medical negligence on the part of Dr. Rajasekhar. The DMC filed its reply through Registrar, Dr. R. N. Baishya and stated that the instant complaint against the DMC is not maintainable under the purview of the Act, 1986, hence, it is liable to be dismissed against DMC. The Complainants are not consumers qua DMC. The disciplinary committee of DMC made inquiry with Dr. M. R. Rajasekhar.

7. We have heard the arguments at length from the learned counsel from the parties. The Complainant (son of deceased) argued that the Opposite Party No. 2 ignored the opinions of experts that the liver was unresectable and ignored specific finding of Army RR hospital that as per Child Pugh score 7, the liver was not resectable. The OPs destroyed and/or manufactured medical records. The operating Surgeon Dr. M.R. Rajashekar and the Anesthetist - Dr. B. Kaur were supposed to maintain separate OT notes. No OT record, no Doppler report, Cholecystectomy details were produced before this Commission. In the Death Summary, there was no mention of Cholecystectomy, but the Opposite Party No. 2 claims Cholecystectomy was done. Thus, the Opposite Parties have no explanation for those missing OT reports. The alleged histopathology report dated 22.12.2004 as evidence was not filed. The learned Counsel further submitted that SOL is usually treated by a team of specialists includes Hepatologist, an Onco Surgeon and a Radiotherapist. The plan of treatment is decided as per patient's requirements and if necessary, Chemotherapy. The patients scheduled for possible resection require preoperative assessment with angiography in conjunction with helical computed tomographic (CT) scan or MRI with magnetic resonance angiography. Information on arterial anatomy is helpful for the operating surgeon, which may segregate the patients from possible resection. The presence of tumor thrombi in the hepatic veins, the inferior vena cava, or the portal vein can significantly alter the treatment modalities. With the help of CT and MRI scans, it is possible to detect vessel involvement, if any, and for the decision to adopt surgical cure. The laparoscopic evaluation may detect metastatic disease, biliary disease or inadequate liver remnant and, therefore, obviate the need for need for open surgical exploration. Transcatheter arterial chemoembolization (TACE) or related therapies viz; lipiodol TACE and subsegmental TACE are recommended for unresectable liver cancer cases. That localized and locally advanced unresectable liver cancer appears to be confined to liver, but the surgical resection of entire tumor is not appropriate because of location within the liver or concomitant medical conditions such as cirrhosis. These patients may excellent liver function without associated cirrhosis. The Complaint filed several literatures from the research articles, text books.

8. The learned Counsel for the Opposite Parties vehemently argued that there was no negligence during treatment of the patient. The HCC is highly malignant tumour and having less survival rate. The Counsel reiterated their evidence on record and filed literature on the subject.

9. Perused the entire medical record, the relevant medical literatures filed by both the parties and given our thoughtful consideration to the arguments from both the parties.

10. It is apparent from the record that, initially, at Apollo Hospital, Ahmedabad, the patient consulted Dr. Chirag J. Desai, Consultant Surgical Gastroenterologist, who diagnosed the patient as a case of Cirrhosis of liver and enlarged spleen. After investigations, SOL was diagnosed and Dr. Desai ruled out surgical treatment for the instant patient till the Platelet and WBC counts became normal. Therefore, patient took Chemotherapy treatment at Apollo Hospital Ahmedabad. The size of the tumor was reduced from 11.5 cm to 8.5 cm. Thereafter, patient has also consulted Dr. (Lt. Col) A. K. Seth on 23.08.2004 and 05.11.2004 the, at Army Hospital R & R Delhi Cantt. who also confirmed the correct line of treatment adopted by Dr. Desai- Onco-surgeon. The patient was further examined by the Dr. (Lt Col) N. Kannan at same hospital on 11.11.2004, 23.11.2004 and 02.12.2004, who also expressed liver resection, was risky and advised to repeat chemotherapy (TACE). The CT Scan done on 11.12.2004 at Mahajan Imaging Centre revealed a large well defined heterogeneously enhancing mass in the right lobe of liver. It was bulging epiphytically from its inferior and medical aspect. The lesion involves the segments 5 and 6 it measure 8.7 cm X 8.5 cm X 10.1 cm. Multiple calcific areas are seen with areas of necrosis/cystic degeneration noted. Three other focal lesions are seen in right lobe of liver segments 5, 6 and 7 measuring between 2.3 to 3.8 cms diameter. The gall bladder lies just anterior to the lesion and is not separable from it. As per the OT notes and nursing record the Opposite Party No. 2 had not resected the SOL, but performed cholecystectomy only.

11. We have gone through the medical literature and the standard medical textbooks on Disorder of Hepato-Biliary system. The Hepato Cellular Carcinoma (CC) is known to be a soft friable and highly vascular tumor. For the large tumor in the right lobe of liver, there are more chances of rupture of tumor during surgery due to forceful retraction or due to difficult mobilization of right lobe. Thus, the injudicious mobilization of the liver carries risks of excessive bleeding from avulsion of the hepatic vein and inferior vena caval (IC) branches.

There will be prolonged ischemia of the part of liver because of rotation of the hepato-duodenal ligament: it may lead to iatrogenic tumor rupture and spillage of cancer cells into the systemic circulation.

12. Admittedly, Dr. M. R. Rajasekhar submitted before MCI that the liver resection was deferred in view of the poor Portal vein flow. due to liver failure, there was coagulopathy induced by tumour thrombosis. Therefore, 40 units of blood and blood products [Packed RBC (5), FFP (4), Platelet concentrates (4), single donor platelets (2), and Cryo precipitate (4)] were transfused during 24 hours to correct low platelet counts. In our view, the decision at the relevant time the blood / its products transfusion was justified.

13. The treatment option of liver resection in the case of HCC depends upon the size, number of tumors and the liver function tests. The surgical treatment is possible if size of tumour is less than 3 cm and normal liver function without presence of cirrhosis. According to Memorial Sloan Kettering Cancer Center (MSKCC), guidelines/criteria the resection of HCC shall not be done if:

(A) Size of tumor more than 5 cm

(B) Number of tumors more than one

(C) Positive lymph nodes from the primary

(D) Disease free interval less than 12 months

(E) Post-operative CRS level more than 200 ng/ml.

14. In our considered view, Complainants are not Consumer qua DMC or MCI within realm of the Act 1986. . The Complainants' alleged that the DMC and MCI have passed an order without any reasons on the complaint, without examining the relevant medical records before them and without hearing to the complainant. MCI has acted arbitrarily with bias to favor their fellow doctors. Therefore, it was unfair and amounts to an act of omission.

15. The pivotal question that whether it was a reasonable practice of the Opposite Party No. 1 and 2 during treatment of the patient? It is pertinent to note that Opposite Party No. 2 was the senior Consultant in HPB Surgery and Organ Transplant at the Opposite Party No. 1. The patient was known diabetic since 1994 and suffering from cirrhosis of liver with portal hypertension and hyper-spleenism. In 1995 he suffered haematemesis and was transfused blood. In 1997 he underwent Endoscopic Sclerotherapy and Banding. Subsequently in year 2003, he was diagnosed to be Hepatitis C Positive (HCV^{+ve}) and after investigation, found to have large SOL in the Right Lobe of Liver. Admittedly for treatment of SOL patient had consulted few doctors and hospitals, but it was inconclusive. In May, 2004, the patient received empirical Chemoembolization of right lobe of liver and the size of HCC became reduced from 10 cm to 8 cm, It was the same size when he approached Opposite Party No. 2 and after detailed evaluation of the patient decision of liver transplant was taken. The doctors thoroughly discussed with the patient and attendants about:

(a) Evaluation of Live Donor Liver Transplant.

(b) Trans-arterial Chemoembolisation and

(c) Resection of Hepatocellular Cancer (HCC) and chemotherapy followed by cadaveric liver transplantation.

16. As there was non-availability of compatible live donor for liver; the patient opted to undergo resection of SOL and then chemotherapy instead of waiting for cadaveric liver transplantation. In our view, the Opposite

Party No. 2 suggested appropriate line of treatment with due caution and care. It was not either negligence or deficiency on the part of the Opposite Party No. 2.

17. Since admission to the Opposite Party No. 1 hospital, the chronology of events revealed that the patient got admitted on 17.12.2004. At 11.00 a.m., patient was examined by Registrar/Incharge and it was a planned for Right hepactomy on same day. The patient underwent pre-anesthetic check-up and after written consent, the patient was taken for the surgery. Before surgery, it was advised to arrange 8 units of platelet concentrate and cryoprecipitate also. As per OT notes the procedure was exploratory laparotomy under G.A. On opening of the peritoneum, large SOL involving right lobe of liver mainly seg 5, 7 and 8 was noted, it was adhered to the right dome of diaphragm, thereby multiple adhesions all around the liver. Mobilisation of right lobe of liver and Chlecystectomy was performed. The intra-operative doppler USG liver showed no flow in right portal vein with minimal flow in the left portal vein, however, pre-operative CT abdomen did not show involvement of right portal vein. Therefore, in view of no right portal blood flow in the right portal vein, resection of SOL of right lobe was deferred. The hemostasis was achieved and liver tissue biopsy was not attempted. The abdominal drain No. 24 was put in the right paracolic area and the surgical wound was closed. Pre-operatively, platelet concentrates, PRC FFP were used. Also, on 18.12.2004, during recovery period, the Opposite Party No. 2 advised continuously blood and its products.

18. We have perused the order of Delhi Medical Council. The relevant paragraphs are reproduced as below:

> "During the procedures, as per the Operation notes of the said Hospital, the intra-operative Doppler USG Liver showed no flow in Rt. Portal vein, because of which the Rt. Hepatectomy was deferred. Post-operatively 'progressive acidosis, set in which led to kidney dysfunction. The patient was put on dialysis with complainant's consent. The condition of the patient continued to deteriorate and he succumbed to his illnesses on 22-12-04. The cause of death, as per the Death summary of the said Hospital being "Cardiorespiratory arrest due to 'severe metabolic acidosis secondary to profound Liver and secondary acute kidney failure."
>
> The patient came to the aid Hospital primarily for surgical treatment after exhausting other options of treatment at Army Hospital R & R, New Delhi and Apollo Hospital, Ahmedabad. At the said Hospital, the treatment provided was as per the accepted professional practice, as warranted by the prevailing clinical status of the patient. No medical negligence could be attributed on the part of the respondent in the treatment administered to the patient. The patient succumbed to his illness out of the natural history of the disease.
>
> Complaint stands disposed."

19. In furtherance, the MCI, vide Order dated 20.11.2016, dismissed the Appeal filed by the Complainant against the Order of DMC. The Ethics Committee of MCI held that no negligence could be attributed on the part of treating doctor – Dr. M. R. Rajsekhar.

20. This Commission for fair adjudication sought an opinion from the Board of medical experts at AIIMS, New Delhi. The opinion does not point out any negligence of the treating doctor. The opinion of expert medical board dated 24.05.2021 is reproduced as below:

- Hepatocellular carcinoma is a deadly cancer with a high incidence of mortality if curative treatment is not possible or attempted when feasible. Specifically, a large HCC with 2 additional nodules in the same lobe as in this case) in the background of cirrhosis has an extremely poor survival without treatment.
- Liver resection and liver transplantation were the 2 known curative surgical options available at that time, all other options were palliative in intent and the patient was made aware of the same.
- The case under question was beyond all the accepted guidelines/rules at that time for considering deceased-donor liver transplantation (DDLT), however, the possibility of living donor liver transplantation (LDLT) was still considered, keeping in mind that the tumour had shown partial response to trans-arterial chemotherapy without significant deterioration in the liver function. But LDLT was not an option for the patient as he had no suitable living donor and DDLT was contraindicated. Moreover in

2003/2004 cadaveric donation rates in India were abysmally low, with exceptionally long and unpredictable wasting times negating the entire purpose of liver transplantation.

- In the prevailing clinical scenario, liver resection remained the only option with the potential to cure. The fact that he had hepatitis C related cirrhosis with portal hypertension (PHT) increases the risk of surgery. But there is plenty of evidence that such resectional surgeries (large HCC with liver cirrhosis and PHT) have been carried out in many experienced centres from Europe, Hong Kong and US with operative mortality ranging between 5-18% in the era of late 90's and early 2000's. Despite the higher risk, the surviving patients (post liver surgery) had a long-term survival of 25% in most of the surgical series quoted in the literature in comparison to almost no possibility of long-term survival following treatment by palliative/alternative therapeutic modalities.

As per the available case documents:

- A proper diagnostic imaging was done to evaluate the extent of the tumour and underlying cirrhosis, there was no indication of main portal vein thrombosis in the CT scan.
- A high-risk informed consent (in writing) was taken, and the treatment options, surgical plan and potential complications were discussed and documented. Preoperative anaesthetic checkup, cardiac and pulmonary evaluation were done to complete the fitness evaluation, these were found to be acceptable as per documents.
- Indocyanine green elimination test was not available in India at that time; nalthough this has been extensively used by the Japanese/Chinese centres for evaluation of liver function status pre surgery, it is relevant here that, European/US centres did not use this test for functional evaluation of the liver at that time and many do not do so even now.
- Use of intraoperative ultrasound (IOUS) is customary during liver surgery for identifying tumor nodules and also for mapping the extent/line of resection, also to evaluate the vascular inflow and outflow of the future remnant liver; irrespective of the findings of preoperative CT scan.
- Mobilization of the gall bladder and cholecystectomy is often the first step of performing a right sided liver resection as this gives access to the hilar structures (portal vein, hepatic artery and bile duct) and specifically the right portal pedicle. Cholecystectomy is routinely done as part and parcel of major hepatectomy.
- The surgical notes show that the tumorous part of the liver was densely adherent to surrounding structures and there was significant blood loss (approx. 2 litres) during an attempt to mobilize the liver from the surrounding tissues.
- The above fact and the IOUS findings lead the primary surgeon to abandon the plan for hepatectomy and he then achieved hemostasis before closure
- Blood and blood products were transfused to make up for the blood loss and prevent further bleeding.
- Patient was provided intensive care in the postoperative period and all supportive measures were taken as per the available notes till his death due to multi-organ failure.
- The treating surgeon was an experienced liver surgeon; in fact he was one of the pioneers of liver transplantation in India and headed one of the few functioning liver transplantation programmes in the country at that time.
- The enquiry reports of the Delhi Medical Council and the MCI have clearly ruled out an act of medical negligence in this case.
- This medical board also upholds the Councils' observation and feels that although the patient's death was unfortunate, the available medical documents/case records do not support the act of medical negligence on the part of the treating team in this case.

21. Thus, from the preceding paragraphs, the DMC, MCI and the opinion of Committee of experts constituted at AIIMS, held that the medical negligence cannot be attributed conclusively upon the OPs. In the instant case, admittedly, it was SOL with metastasis and it was unresectable tumour as due to chemo embolization the tumour size was reduced from 10 cm to 8 cm. Therefore, in the interest of patient, the decision to operate the

patient as taken with due informed consent. We have perused the consent form and do not find any lacunas in it as per the operating findings, the gall bladder was adherent to the liver and therefore, it was resected and subsequently, it was confirmed as Chronic Cholecystitis. In our view, it might have caused bleeding to the patient, which required massive transfusion of blood and blood product. The OPs promptly transfused the blood and blood products including FFP, PRP and Chryopecipitate. It is known from the medical literature that HCC are highly vascular and highly metastasis. The survival in the cases of metastasis is very short. The Opposite Party No. 2, the senior liver specialist performed his duty in the interest of the patient and we do not find any ill intention or unfairness.

22. The Hon'ble Supreme Court in catena of judgments held that in every case where the treatment is not successful or the patient dies during surgery, it cannot be automatically assumed that the medical professional was negligent. In **Bombay Hospital & Medical Research Centre vs. Asha Jaiswal & Ors.**[1], it was held that **t**he allegations need to be proved with cogent evidence. Similarly on 20.04.2022, in the recent judgment, in the case of Dr**. (Mrs.) Chanda Rani Akhouri & Ors. Vs Dr. MA Methusethupathi & Ors.**[2]**,** it was laid down in no uncertain terms that merely because doctors could not save the patient, he/she cannot be held liable for medical negligence. The Hon'ble Supreme Court held in para (27) that:

> 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.

23. The Hon'ble Supreme Court in **Jacob Mathew's case**[3], observed as under:

> "When a patient dies or suffers some mishap, there is a tendency to blame the doctor for this. Things have gone wrong and, therefore, somebody must be punished for it. However, it is well known that even the best professionals, what to say of the average professional, sometimes have failures. A lawyer cannot win every case in his professional career but surely he cannot be penalized for losing a case provided he appeared in it and made his submissions."

24. Based on the foregoing discussion and respectfully following the precedents, in our considered view, the Complainant failed to prove medical negligence of the Opposite Parties.

Therefore, the Complaint is dismissed

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[1] 2021 SCC OnLine SC 1149

[2] 2022 LiveLaw (SC) 391

[3] (2005) SSC (Crl) 1369

.....J

R.K. AGRAWAL
PRESIDENT

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DR. S.M. KANTIKAR
MEMBER

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BINOY KUMAR
MEMBER